

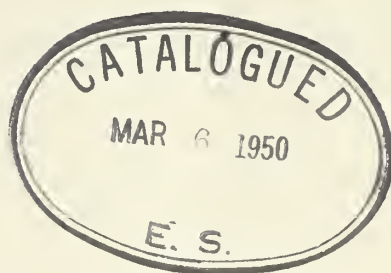
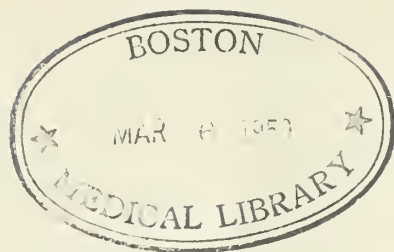
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VOLUME 52

NUMBER 1



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PRESIDENTIAL ADDRESS

Gilson Colby Engel



AIMS OF THE WOMAN'S AUXILIARY

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GENERAL PRACTITIONER ESSENTIAL TO PROPER PRACTICE OF MEDICINE

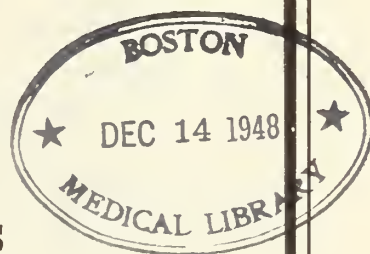
An Editorial



OUR CANCER PROGRAM

Pages 45 and 56

(SEE DETAILED SUBJECT INDEX, PAGE 88)



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(1) Follis, R. H.; Jackson, D.; Eliot, M. M., and Park, E. A.: *Am. J. Dis. Child.* 61:1 (July) 1943.

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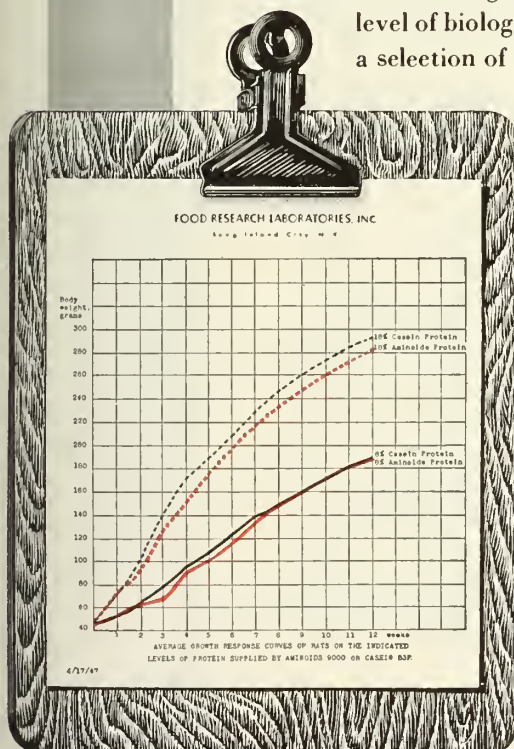
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Lysine	2.44	5.8
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Milton-Luce		
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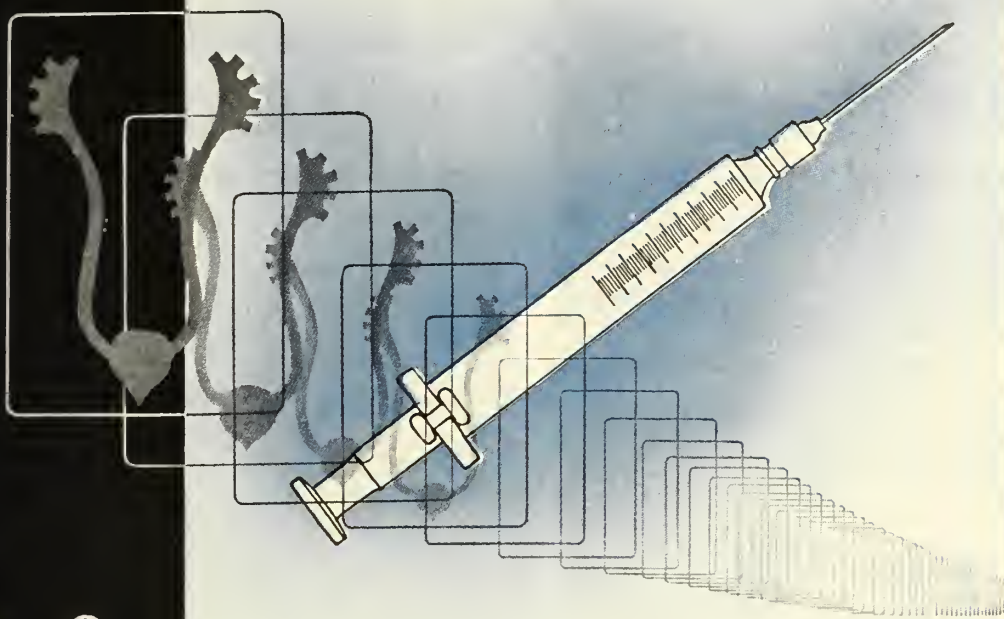
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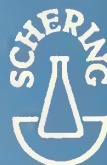
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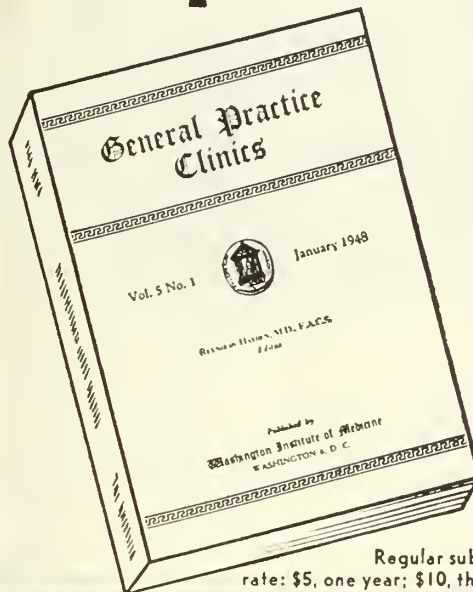
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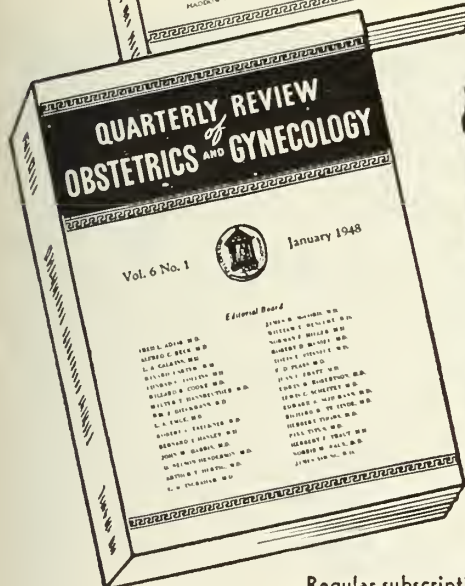
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LETTERS

Exception Taken

MY DEAR DR. DONALDSON:

I am surprised that the distinguished editor of THE PENNSYLVANIA MEDICAL JOURNAL should allow a mistake to appear in its pages as follows, "The first hospital in America, the Pennsylvania Hospital, was established in 1751."

I do not take exception to the second part of the sentence. You will find in Watson's *Annals*, volume 1, page 460, the following: "By the Ms of John Smith, Esq., on the 11th of the 8th month 1751, he notes that he, with Dr. Bond and Israel Pemberton inspected the late dwelling of Mr. E. Kinsy, Esq., and were of the opinion it would be a suitable place to begin a hospital."

The Pennsylvania Hospital was started in said dwelling located on High Street. It remained there for four or five years when it moved to its present location, 8th and Spruce Streets. The cornerstone in this building is marked with the date 1755.

So far we are in agreement as to the first part of the sentence quoted above. I disagree violently with your statement that the Pennsylvania Hospital was the first hospital in America.

The first institution to take care of the sick, the poor, and the insane was known at its inception as the Philadelphia Almshouse. It was located first on a square of ground known as the Green Meadows, bounded by Third and Fourth, Spruce and Pine Streets, bought from Alden Allen for two hundred pounds. There a brick building was erected in 1731 or 1732.

From there it was moved to a plot of ground bounded by Spruce and Pine, 10th and 11th Streets, belonging to the widow Collender and purchased for eight hundred pounds.

With the growth of the city new quarters had to be secured and on January first, 1829, the present site on the west bank of the Schuylkill River in Blockley Township was bought for the sum of fifty-one thousand five hundred and twenty-eight dollars and twelve and one-half cents. This is to this day known as the site of the Philadelphia General Hospital, often spoken of as Blockley, under which name it was known at the time of its relocation.

The name Blockley was used in connection with a number of other institutions, the Blockley Baptist Church, the Blockley Library, the Blockley Post Office, the Blockley Brass Band, the Blockley and Merion Turnpike or Plank Road, now Lancaster Avenue.

The Philadelphia Almshouse, having been the forerunner of the Philadelphia General Hospital for almost a century, was an integral part of Blockley. No change occurred until December, 1919. Upon that date through legislative action, an act for the better government of cities of the first class of this Commonwealth, known as the City Charter, the care of the indigent and insane was transferred to a new department—the Department of Welfare. The Philadelphia General Hospital was continued under the Department of Health.

The development of the Philadelphia Almshouse into the Philadelphia General Hospital was marked by the change of name only. The intrinsic public service ren-

dered suffering humanity remained the same through the years.

Quoting from a letter written by J. A. Penniman, provost of the University of Pennsylvania, "I find the question at issue not one of etymology but of fact. If the Almshouse at the time of its foundation actually did the work of what we call a hospital, it would be regarded as a hospital from the start."

That it actually functioned as a hospital is brought out by an entry in the Poor Day book as of the year 1739, which book is at the Pennsylvania Historical Society. Page 34 reads as follows: "Cash paid Dr. William Shippen for physic twenty pounds." On page 6 is another entry, "Cash paid Robert Osborn and wife ten shillings for nursing."

Names often have obscured the identity of institutions. The American Philosophical Society was first called the Junta; the University of Pennsylvania, the Charity School. The Almshouse, not having been known as a hospital from the start, does not in any way disqualify it as such. The City of Philadelphia rightly prints on its letterheads

The Philadelphia General Hospital
Founded 1732

However, the fact that the Philadelphia General Hospital claims antecendence over the Pennsylvania Hospital does not in any way detract from the splendid achievement of the Pennsylvania Hospital. Medical men will acquire as much wisdom and learning at one as at the other.

It is not known who were the first physicians connected with the Philadelphia Almshouse. The destruction of records through vandalism, "the dust of ages" the eating tooth of time, leaves us little information. There exists, however, a formal announcement dated May 18, 1769, of the re-election of Drs. Cadwalader, Evans, and Thomas Bond.

In 1769 Dr. Bond was 57 years of age, so that in all probability he had served for a number of years previous to that date.

Frederick Porteous Henry, M.D., states: "The City Almshouse, now the Philadelphia Hospital, has a hospital department, the oldest in the Colonies."

Thomas Westcott, M.D., states: "Here commenced the Philadelphia Hospital in connection with the Almshouse about 1732, then the first hospital established in the United States."

Watson's *Annals*, volume 1, page 62, says: "The Poorhouse it contains the sick and insane as well as the poor."

On page 1071, the *Journal of the American Medical Association*, under date of March 28, 1931, gives the date of the origin of the Philadelphia General Hospital as of 1732, the Pennsylvania Hospital as of 1751.

Horace Mather Lippincott, speaking of the Almshouse, says: "There lodged the poor, the sick and the insane and this hospital department of the Almshouse was the first in the United States."

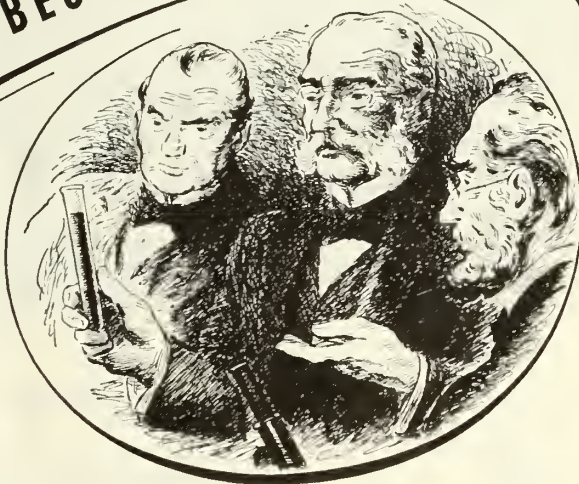
I trust this will convince you of the error of your way.

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proved it in public health

Carlos Finlay, of Cuba, a bacteriologist, believed that yellow fever was transmitted by the stegomyia mosquito. His original experiments did not provide definite proof of his theory. However, he continued his search in co-operation with Walter Reed and the Yellow Fever Commission. The work of the Commission finally proved that infected mosquitoes could transmit the



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Booklet on request

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I am ninety years old, in fairly good health, although I do not play golf any more.

With sincere regards, I am yours,

JOHN WELSH CROSKEY, M.D.,
Fort Washington, Ambler, Pa.

P.S.—The current letterhead of the Philadelphia Department of Public Health includes the following: "Philadelphia General Hospital (established 1732)."

J. W. C.

DEAR JOHN:

I am sorry to learn that you no longer wield a triumphant niblick but even more delighted to know that you still read THE PENNSYLVANIA MEDICAL JOURNAL, maintain an activated cerebrum, and wield a trenchant pen. I hope to be on deck when you qualify for due recognition by your State Medical Society as a Pennsylvania centenarian. In the meantime I shall sing your praises as a wide-awake nonagenarian and appreciate, as long as I am editor of our JOURNAL, your keeping a critical eye on the pages of the JOURNAL.

Your communication of July 7 has been forwarded to Dr. Howard K. Petry, Harrisburg, who is charged with the responsibility of preparing the 100-year history of The Medical Society of the State of Pennsylvania to be published early in 1949.

I am sure it will be helpful to his office staff, and your correction will be gladly acknowledged in an early issue of THE PENNSYLVANIA MEDICAL JOURNAL.

With kind personal regards, I remain,

Cordially yours,

WALTER F. DONALDSON,
Secretary-Treasurer-Editor.

Memo to Walter F. Donaldson, M.D.

A QUESTION OF DEFINITION

Mr. Leo E. Brown of the Committee on Public Relations has checked again the authenticity of the statement placed in the JOURNAL and he finds that it is substantiated by two sources. One appears in the book entitled "The Early History of Medicine in Philadelphia" by George W. Norris, published in 1886 for private distribution, in which it stated on page 125: "The foundation of hospitals among us produced the most important effects on the character of the medical profession, and forms a great era in our progress. The Pennsylvania Hospital, the first of these institutions established in the country, was erected principally by the contributions of the benevolent citizens of Philadelphia, though aided by a grant of 2000 pounds from the Colonial Assembly, and received its charter in 1751."

The other source is in the "Standard History of the Medical Profession of Philadelphia" by Frederick P. Henry, A.M., M.D., published in 1897 by Goodspeed Brothers, Chicago. On pages 32 to 34 inclusive there is mention of the Pennsylvania Hospital being the first one established and also it explains the work of the individuals directly responsible for its establishment.

We feel that Dr. Croskey is correct if the old almshouses are to be considered as hospitals. However, it is merely a matter of definition and our point cannot be proven in any other way. We thought that you might like to be informed in the matter, therefore, this explanation.

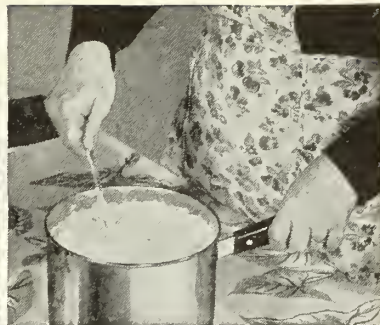
ROBERT L. RICHARDS, Staff Secretary,
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The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Biltmore Hotel in Los Angeles, Calif., May 16-19, 1949.

For full particulars write the secretary, Dr. Thomas D. Moore, 899 Madison Ave., Memphis 3, Tenn. Essays must be in his hands before February 15, 1949.

MILEY B. WESSON, *Chairman,*
Committee on Scientific Research,
American Urological Association.



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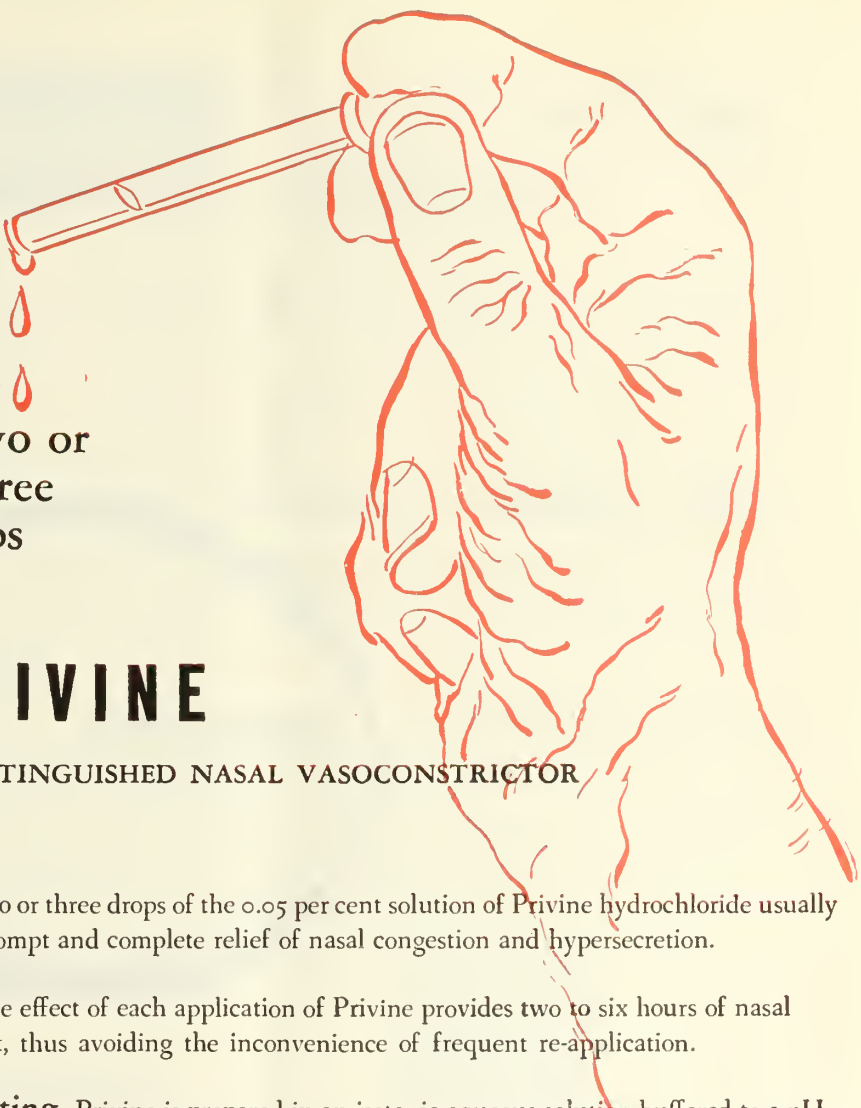
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“even in serious infections . . .”¹

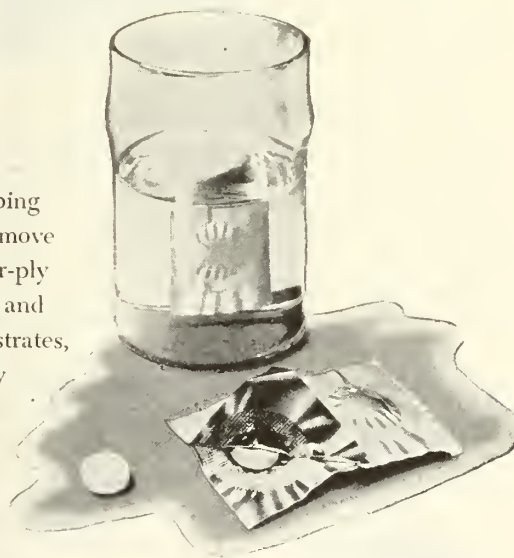
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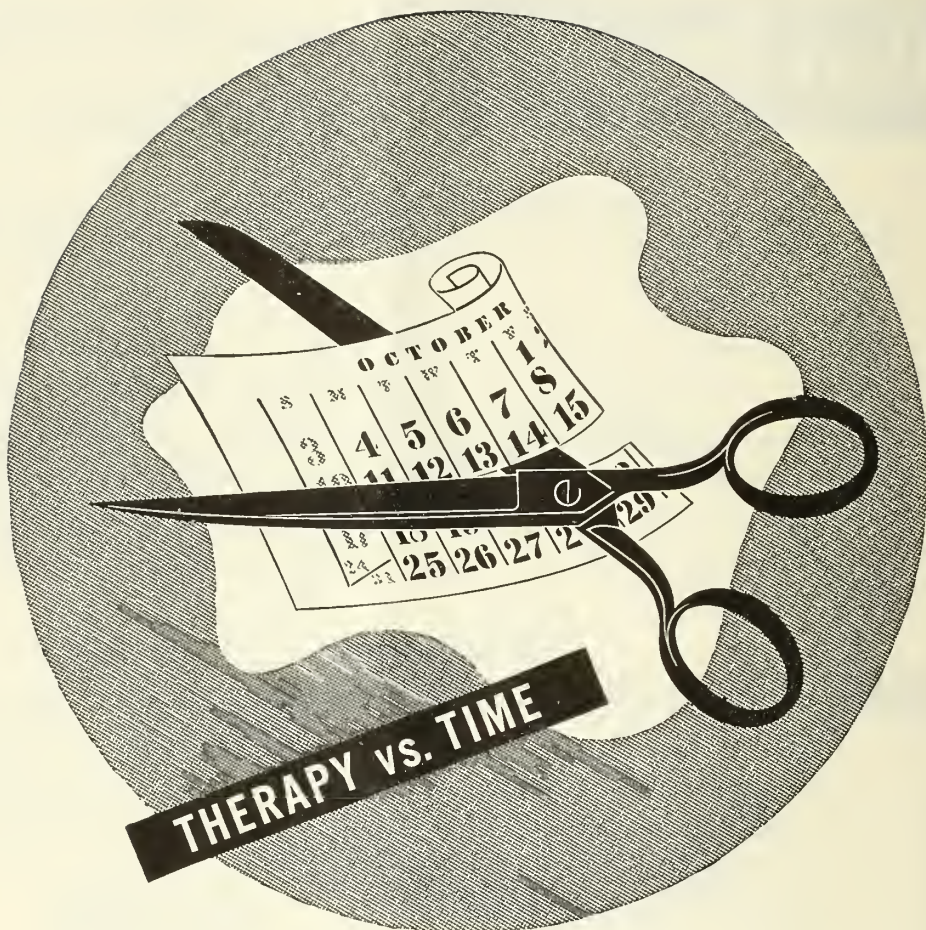
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¹. Hoffman, W. S., and Volini, I. F.:
Am. J. M. Sc. 213:520 (May) 1947

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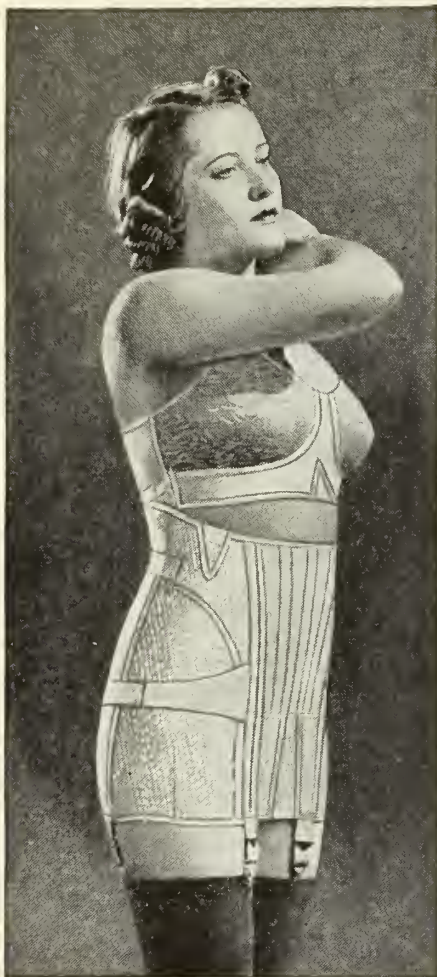


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THE PENNSYLVANIA MEDICAL JOURNAL

VOLUME 52

OCTOBER, 1948

NUMBER 1

PRESIDENTIAL ADDRESS

GILSON COLBY ENGEL, M.D.
Philadelphia, Pa.



DR. HESS, honored guests, ladies and gentlemen: It is indeed with mixed emotions that I stand before you tonight about to assume the presidency of The Medical Society of the State of Pennsylvania at its Centennial Celebration. First, I cannot help but feel deeply the real honor that has been bestowed upon me by the medical profession of this state. Second, I can assure you of the deep feeling of responsibility that I have to the tasks that lie ahead.

My predecessor, Dr. Elmer Hess, has served you well. I know of the energy and tireless effort that he has put forth during his administration, always with sincerity of purpose for the improved health of this Commonwealth. It has been his distinct honor to close the chapter on the first 100 years of organized medicine in Pennsylvania and you all know that he has done this admirably.

I wish also to pay tribute to a man who is responsible for the organization of this Centennial Celebration. As you all know, I refer to Dr. Edward L. Bortz, the immediate past president of the American Medical Association, who has served as chairman of the Centennial Committee. I am sure you will agree that he and his committee have made a great contribution.

One hundred years ago Dr. Frederick Reinhold, while on his way to visit a patient at Liberty in Tioga County, was attacked and killed by a panther. It is hard for us, sitting here tonight, to realize that Pennsylvania was such a wilderness 100 years ago.

What has happened to effect the health and happiness of the citizens of this Commonwealth in the past century? Let us think of the improvements in transportation, communication, electric light, radio, television, and numerous others, all of which have contributed to make our lives easier and happier. All of these inventions would be almost worthless to us had not medicine in that same time made rapid progress. I would like to cite a few of the outstanding contributions of medicine in this same period. Anesthesia, asepsis, antisepsis, and chemistry have contributed to marvelous advances in surgery that have made unthought-of operations not only possible but safe. X-ray, radium, bronchoscopy, antitoxins for tetanus and diphtheria, and vaccination against smallpox are a few. Yellow fever has been wiped out and this disease in 1793 killed 4044 people of Philadelphia. This represented a loss of 10 per cent of the population. Dysentery, typhoid, and numerous epidemic type diseases have been stamped out. The advent of the antibiotics, such as penicillin, streptomycin and others, has helped us to control infections that formerly took many lives. The discovery of insulin in the control of diabetes; the discovery of hormones and vitamins; and one could go

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on for a whole evening enumerating the many contributions that the medical profession has made to mankind, at times at the sacrifice of their own lives—this under a free system of medicine.

May I give you a few figures to emphasize these achievements. One hundred years ago in the city of Philadelphia 46 per cent of those born were dead before they reached 20 years of age. In the light of today's figures that to me is truly startling. In the year 1900 life expectancy in the United States averaged 40 years. In 1947 this had been increased to 67 years, an increased life span of 27 years. In 1900 twenty-seven work days were lost per worker per year due to illness, while in 1947 this was reduced to five days per year.

While we have been able to increase the life span and a number of people today are living to be 100 years of age, our next responsibility is not only increased longevity but increased physical and mental activity. Our knowledge of degenerative diseases must be increased tremendously, and we look for the achievement of this end in greater research on fat and protein metabolism. We must also consider the great potentialities of atomic energy which will undoubtedly open new vistas for the cure of diseases. Up to now we have looked on nuclear fission as serving us only in the event of war. Its great blessing, I believe, lies in its development for industrial and health purposes.

Ladies and gentlemen, American medicine is truly and justly proud of its record of achievement, but we are not satisfied. There is much to be done in the years to come.

It is because of these advances in medicine that you today live to enjoy the many achievements of industry. Without health the wealthiest citizen in the United States is poor.

It is most unfortunate that in recent years in planning improved health for this nation the doctors have to forfeit considerable time in fighting ideas and ideologies which we know will be detrimental to the health of the citizens of this country. Some of our social planners in Washington, and particularly in the Federal Security Administration, have been using taxpayers' money to create the idea that the public needs a federally controlled system of medicine. Their program calls for a multi-billion dollar plan under federal control with, naturally, the accompanying patronage. This plan for a compulsory sickness tax is not the answer to the problem in a free nation, and yet our President, currently a candidate for re-election, is committed to this program which has been sponsored by his under-

lings. I believe that the past record of American medicine speaks for itself. This record cannot be matched by any other country in the world.

In contrast to the President's commitments on the national health problem we have the commitment of his leading and logical opposing candidate, who states: "Compulsory socialized medicine is no good; no variation of it is any good. It has never worked wherever it has been tried; it cannot be done; it never will be done. I am unalterably opposed to it. It won't work and will lower our standard, and I venture our death rate would mount from the very day it was passed."

Health Leadership

While I hate to interject any political note in this address, I nevertheless feel that American medicine and the American public should go to the polls next November with their eyes wide open as to the commitments of the candidates of the major parties.

Senator H. Alexander Smith, chairman of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, requested the Brookings Institute of Washington, D. C., a non-political and non-profit organization, to do a survey on "The Issue of Compulsory Health Insurance." I would like to state here a summary of their conclusions. The report is an exceedingly thorough study of the national health problem and is covered in a book of 267 pages.

"No great nation enjoys better health than prevails in the United States. Under a voluntary system of medical care the United States has made greater progress in the application of medical and sanitary science than any other country. It is doubtful that the medically indigent could be effectively covered by compulsory insurance. Government regulation under compulsory health insurance would be far more difficult than any other large field previously entered by the government, and would discourage initiative and development. It does not seem possible that politics could be eliminated from medical care. A real danger exists to the end that government action would impair the doctor-patient relationship and hence the quality of medical care."

The feeling and decision of this committee was that the problem would be better solved, first, if the national or state governments would devote their resources and energy to research and development in the field of public health, health education at school level, the teaching of preventive medicine, and the providing of systematic care of the indigent and medically indigent. The other important recommendation is for more cooper-

ation in the sponsoring and development of hospitalization and medical service plans known as the Blue Cross and Blue Shield.

This, ladies and gentlemen, is a thorough study with report and recommendations by an unbiased, non-profit corporation and these conclusions were reached after a thorough study of the evidence. This, to me, seems to be a sound approach to this problem.

The non-profit hospitalization and medical service plans known as Blue Cross and Blue Shield seem to me to be the answer to the economic problems of medical care. They have enjoyed rapid growth throughout this nation. Both of these plans are non-profit, are governed by the insurance commissioners of the various states, and their boards serve without pay. The Medical Service Association of Pennsylvania, which is the Blue Shield plan in this state paying the doctors' bills, has enjoyed a growth of 125.9 per cent during the past year. These plans have and are growing at a tremendous rate all over the country. President Truman and his appointed administrators have never cooperated to support these non-profit plans. A setup for government employees' participation has never been entered into by our federal government.

We ask ourselves, why? The answer must be that the administration is afraid to cooperate for fear it would hurt their plan for a compulsory sickness tax. This nation long ago discovered that it could not survive half-free and half-slave. The American way of life today cannot thrive and survive half-free and half-regimented.

Your state society is again a leader in creating a Committee on Emergency Medical Service for Atomic Defense. It has also been the leader in the creation of a regional committee with similar name and purpose. This regional committee is composed of representatives from New York, New Jersey, Pennsylvania, Delaware, Maryland, Virginia, and the District of Columbia. This regional committee has organized, met and formulated basic plans, and is now waiting for the Federal Office of Defense to draw up its plans so that our program may be correlated with that of the government. The doctors of this commonwealth have planned for the care of patients in the event of an atomic war in advance of the government planners.

I personally believe that the time has arrived to think soundly of a long-range program which eventually will lead to happier and healthier people in the United States and in the world. Some of my recommendations may seem startling, but I can assure you that they are being made after considerable thought. First, I advocate a decen-

tralization of power and planning from the national to the state level. The life and problems of the individual states vary so much that planning on the national level cannot draft a standard plan for all communities which would be either fair or sound.

Second, with regard to the distribution of medical services in normal times and as a protection for our citizens against atomic warfare, I would offer the following suggestions. I believe firmly that the idea of large cities should be a thing of the past. Industry, large insurance companies, and the like should move into rural areas and create new and smaller cities all over the country. What are the advantages of this program? First, it would start new, self-supporting small cities which would have their own hospitals and which would attract doctors and nurses to the rural areas, and I believe would go far in solving the problem of the lack of medical care in rural districts. Second, it would break up the concentration of political power into smaller units which should make them more responsible to the citizens they represent. Third, it would decrease population density of the big cities and definitely be a protection for our citizens in the event of an atomic or bacterial war. Fourth, since most un-American activities are born in large cities, I believe it would have a tendency to discourage these groups. They cannot hide out in smaller communities. Fifth, the educational system under such planning could bring a better program to more people than it serves today. And last, the individual himself would be happier and have more time to think and enjoy life and to take a more active part in community activity in a smaller town.

I would like to mention here something concerning the doctors of tomorrow. Organized medicine must recognize its responsibilities to the medical students. They are receiving a higher type of education than ever before in the history of medicine. One must realize that the medical student of today has practically no contact with organized medicine until he starts to practice. He is trained for all other phases of his work and should be indoctrinated into his responsibilities to the medical organizations while still a student. You might ask what are the purposes of The Medical Society of the State of Pennsylvania, and I believe every student should know these. I quote from the Constitution of this organization:

"The purposes of this Society shall be to federate the medical profession of the Commonwealth of Pennsylvania; to unite with similar state medical societies to form the American

Medical Association; to extend medical knowledge and to advance medical science; to elevate and maintain the standards of medical education; to advocate and support the enactment of such legislation as will accrue to the health and well-being of the public; to enlighten and direct public opinion in regard to health and hygiene."

I believe firmly that at least one lecture a year should be given in each medical school in the Commonwealth devoted solely to the purposes of the county and state medical societies and the American Medical Association with a full explanation of their purposes. I believe, also, that particularly in the Allegheny and Philadelphia County Societies at least one meeting night a year should be devoted to medical students, interns, and residents. I would further recommend that all county societies appoint at least one or more young members on all committees. These young men have fresh ideas and will work if given a task. They will, however, lose interest if they have no responsibility in their societies' activities.

It is the student of today who will be the man of medicine of tomorrow—not you or I. We must build on a long-range program if we hope to render better medical service to the people of America.

Civic Responsibilities

The medical society must not only be a leader in the health problems of the community but must also assume leadership in all civic problems as well. Almost every problem considered by our municipal and state governments either directly or indirectly affects the health and happiness of the citizens of Pennsylvania, and are therefore our problems. Have we not dedicated our lives to these principles? And, since we have, we must assume the responsibility of civic leadership. We must assume this leadership with clear, progressive, and productive thinking, not living in the past but assuming a strong, positive attitude in the promotion of legislation that will enhance the physical, mental, economic, and spiritual status of every citizen in this commonwealth. The political party and its wishes become secondary if it conflicts in any way with ideals which are sound in promoting better health for the citizenry.

To be specific, The Medical Society of the State of Pennsylvania has recommended that only trained and qualified personnel be appointed or employed in health departments and in mental health departments of this commonwealth. This, we believe, is exceedingly important for the welfare of the citizens of every municipality or

any state. Qualified personnel should be employed regardless of political affiliation, and if key men are not available in this state, then we must obtain them elsewhere. The politicians up to now have not listened to our plea and it is up to the citizens whom we are trying to protect to create such a strong public opinion that our political leaders will listen to their cry.

The House of Delegates two years ago passed a resolution, which was forwarded to our Governor, requesting that the position of Secretary of Health be made a major secretariat. After two years it is still a minor secretarial position in his cabinet, and we believe that the health of the citizens of this commonwealth is sufficiently important that the Secretary of Health should be of a major status in the cabinet. With this same thought in mind one can easily understand how a capable person chosen to work in the Health Department would be timid about giving up a permanent position for one which may prove tentative. We have urged that a merit system be created in the Department of Health to guarantee the employees of that department some security of position. This again has been ignored by the political leaders of this commonwealth.

In like vein I believe that the health of this nation as a whole is extremely important and demands the creation in the next Presidential cabinet of the position of Secretary of Health. We as citizens should strongly urge the Presidential candidates to consider the creation of such a post, and I urge the House of Delegates to pass such a resolution, a copy of which should be forwarded to the candidates.

Mental health does not belong in the Department of Welfare, but should at least be moved under the Secretary of Health. Only then will it begin to receive the attention that it badly needs. If you realize that 51 per cent of hospital bed occupancy in the United States is utilized by mental cases, you can readily understand the urgent necessity of placing more emphasis on mental health.

Ladies and gentlemen, the medical profession must take a strong position in these matters and to obtain better standards they must have the full support of the press, the radio, and you, the citizens.

The medical and nursing professions are so closely allied in the care of the public that their problems become ours. We are faced today with a shortage of nurses and the prospects are that this situation will get worse. This shortage today is estimated to be 40,000. There will be 355,000 graduate nurses by the end of 1948. This will still leave a shortage of 130,000 accord-

ing to the estimated needs. A recent survey showed that 42 per cent of registered nurses are not practicing and that 32 per cent of student nurses drop out of school before graduation. Thus there is a high degree of loss before and after graduation.

The aims of the nursing profession for higher education are laudable, but I wonder at times if this is not obtained at the sacrifice of good old-fashioned bedside nursing. The primary purpose of Florence Nightingale was to render nursing care to the sick. I believe that it is important for us to keep this in mind today. How then can this problem of shortage be overcome?

I would suggest the creation of two types of nurses: First, those taking the three-year course that we have today, these girls to be eligible for an R.N., and with further training they may receive an A.B. degree. This group would become the supervisors and teachers.

We all saw how it was possible to teach basic nursing in a short course in the last war. The Red Cross nurses' aides were of great service and proved the point that basic nursing could be effectively taught in a short time. I believe that a one-year course could produce very efficient bedside nurses. These graduates could be called Corps Nurses or any other name, and they would serve under a trained nurse and also do home nursing, which is a lost art. I would strongly urge that the House of Delegates recommend such a plan to the nursing profession as a "must." The nurse shortage is acute and demands immediate action if the doctor-nurse team is to render adequate service to the public.

Instructional Programs

The graduate education courses given for rural physicians in geographically distributed areas are indeed excellent. Dr. Charles Wm. Smith, chairman, and his committee members have really had splendid results from their endeavors. The demands for these courses have called for the creation of new centers and the Institute has become an outstanding state medical program in the United States. These programs deal with basic science correlated with pathologic states. The efforts of this committee should be given excellent support by the Society and its members. I ask for continued support by the staff of lecturers and by the enrolled physicians.

In considering the educational program of the Society, it carried my thoughts to these annual meetings. I asked myself this question: Are we giving the doctors of this Commonwealth what they want in the way of a scientific program?

The answer, to my mind, was No. We have become so highly specialized and we have so many scientific sections that I believe we have lost sight of a general training program.

As an example, should a general practitioner want to know something about the thyroid, there may be a speaker on this subject in the Surgical Section. Should the practitioner attend this section meeting, he will hear discussed the surgery of the thyroid. Perhaps next year he might hear a program on the thyroid in the Medical Section. I believe this is wrong, and if the section idea is continued, there will be a growing lack of interest in this phase of the meeting. We must realize that these specialty groups have their own meetings throughout the year in different organizations.

After due consideration my recommendations, which may not be popular with some, are as follows: First, for our meeting in 1949 I recommend the creation of a Scientific Program Board to be composed of newly elected chairmen of each section and the officers of the State Society, this board to elect its own chairman.

The general plan would call for one lecture in a large auditorium for each period that all groups could attend, these lectures to be formulated on the basis of symposia. For example, again using the thyroid, there could be one paper on the prophylaxis of goiter, one on the medical treatment, one on the surgical aspects, one on the pathology of the thyroid gland, another on the modern concepts of thyroid physiology, a paper on radioactive substances in thyroid disease, and numerous other subjects dealing with this problem. Such a symposium would be interesting to all groups and, most of all, the general practitioner, THE BACKBONE OF AMERICAN MEDICINE, could hear every phase of a disease covered in one lecture period. This, to my mind, would offer more to all of our members and would bring also to the specialty groups the correlation of a disease to all of the respective specialties and the general practitioner. There has been a trend in the meeting this year to strive toward this end and I hope that this trend is the beginning of a full swing to the type of program I recommend. I hope this recommendation will have the support of the House of Delegates and the Board of Trustees. We must improve this phase of our annual meetings. This is imperative.

Under the educational program we believe that education of the lay public is exceedingly important and I would like to pay tribute on behalf of the Medical Society to the late Mrs. Edna Kech. When she became Director of Health

Education in Pennsylvania, with groups of local county medical societies she arranged programs for the people of Pennsylvania on cancer and numerous other subjects. She was really a pioneer in the stimulation of lay education on health problems and she developed such an outstanding program that it became a model for other states in this nation. The medical profession and the people of this commonwealth owe her a great debt of gratitude.

Your state society has embarked on a realistic public relations program. Dr. Howard K. Petry, as chairman, has served well. This committee, I believe, is one of the most important in the Society, and I feel that its activities should be rapidly expanded. This will cost more money, but the money spent will pay high dividends. It involves an educational program for doctors and the people of this commonwealth. We must bring before the people the newer knowledge concerning disease and public health. We must actively engage in promoting legislation that will improve the physical and mental health of our people. We must enlist the aid of the public in supporting this legislation. This is a task for our public relations committee.

The public must be told that this society in the past, and more in the future, is acting in their interest. I cite just one of the many examples—the promotion of legislation requiring smallpox vaccination. What a blessing that has been to mankind! The Medical Society of the State of Pennsylvania sponsored that legislation in 1849. To accomplish our hoped-for aims for better health we must have the full support of the citizens of Pennsylvania, and may I caution you, the people of America must fight to preserve the principles that have made America the free nation that she is. Other forces are at work today, particularly the Communists, and they have made inroads in America which threaten our very existence. Do you realize that when Communism had its birth in Russia there was one Communist to every 2300 citizens? It may startle you to know that today in America there is one Communist to every 710 citizens. That is how real this threat is to the people of America. Your power to fight this threat lies in your right as a citizen to vote. Your vote is stronger in defending American principles than any gun you might shoulder in defense of your country. You must awaken to the reality of this threat and you must act while there is still time. I urge you strongly to use your efforts to defend the free principles of government and the covenant of the four freedoms that we have proclaimed to the world.

I would ask for the full support of all physicians of Pennsylvania in behalf of the World Medical Association. I believe that this is a way to internationalize better medical services for the people of the world. But even of greater importance, to my mind, is the strong possibility of the contribution that this organization would make toward the creation of a permanent and lasting peace.

The Woman's Auxiliary to The Medical Society of the State of Pennsylvania has had a splendid record in the past and I know has great plans for the future. Their key task in organized medicine, I believe, is that most important rôle of public relations. Through their connection with women's clubs and other organizations, they are in a position to spread news of what medicine is doing in the way of research and legislation to improve the health standards in America. Theirs is the task of crystallizing public opinion to force the improvement of health standards in this country.

To my mind, there is no one who knows the doctor better than his wife. There is no one who has made more sacrifices in life so that he may better serve humanity—no one who has worried more about him as she daily sees his heavy duties heading him for an early approach to the inevitable. I wish to pay tribute here to the doctors' wives. I know that anything I have been able to accomplish in my career has been due to the fact that my own wife has been understanding, inspiring, and has made many sacrifices. On behalf of the doctors of this commonwealth I wish to thank all of you who are doctors' wives, as you are the ones who are really living a life of service to others.

In closing, I would like to rededicate my life to the service of mankind by serving humanity and my profession. I will earnestly try to serve you as President of The Medical Society of the State of Pennsylvania with honesty, sincerity of purpose, and untiring effort.

I wish to ask the members of this society to be considerate in their requests upon me to attend meetings throughout the State. If I attend meetings of the Board of Trustees, committees, and councilor districts, these alone total well over one hundred during the year, and you can realize from this the tremendous demands that are made for this phase of the work alone.

I need the cooperation and advice of every member and of lay organizations for a successful administration. We face the unknown of the second 100 years with courage only because of the strength and inspiration that come from our Almighty God. With His help we cannot fail.

THE TREATMENT OF EPILEPSY

MATTHEW T. MOORE, M.D.

Philadelphia, Pa.

I HAVE been asked to compress the subject of the treatment of epilepsy into a concentrated, digestible capsule for your consumption. I hope, unlike other capsule concentrates fed the public, that mine will not be seriously wanting in important ingredients.

At the very outset, it may be well to call to mind that epilepsy is not a disease, but merely the expression in manifold forms of abnormal discharges arising in disturbed ganglion cells of the brain which may be provoked by a host of conditions. The corollary in treatment requires, therefore, that we be ever conscious that it is not a convulsion as such we are treating, but rather an epileptic display in a total human being with progenitors, a past and present environment, and an unknown future.

Before plunging into the subject of therapy itself, a consideration of proper and adequate treatment of a disorder implies a definitive diagnosis, otherwise one may be guilty of treating something the patient does not have, or of not treating something he does have. In line with the latter, your attention is called to the fact that in addition to the usually recognized three forms of epileptic seizures, (1) motor (grand mal and jacksonian), (2) petit mal, and (3) psychomotor, there are numerous, frequently unrecognized, epileptic variants. These aberrant forms of epilepsy are determined by the anatomical location of the discharging focus, and are variously exhibited as uncinat fits, paroxysmal abdominal pain (abdominal epilepsy),¹ laryngeal epilepsy,² musicogenic epilepsy,³ paroxysmal transient headaches (pseudomigraine),⁴ outbursts of pathologic laughter,⁵ temper tantrums, hallucinatory episodes, recurrent nausea and vomiting, vertiginous attacks, fainting spells, choking sensations, visual disturbances as scotomata, micropsia and macropsia, and many other somatosensory and motor displays.⁶

Only by education and recording of experience with various forms of treatment can we overcome the hold of superstition and tradition in the

treatment of epilepsy. Celsus⁷ records that the Romans swallowed the blood of a wounded gladiator as a certain cure for the "sacred disease." In ancient times, the imbibition of the blood of freshly slaughtered animals was also considered a specific. This form of treatment, however, was not confined to the ancients, for it is still used in this year of medical enlightenment as has been told me by the proprietor of a large abattoir. The treatment of epilepsy today fortunately is based on sounder principles because of physiologic and pharmacologic research, and the advent of electro-encephalography.

Nowadays, the treatment of epilepsy presupposes thorough study of each case with respect to a detailed and exhaustive history, physical examination of all the bodily systems, and the use of special examinations such as laboratory procedures in the field of hematology, endocrinology and allergy, roentgenography, electro-encephalography, and when indicated, cerebral angiography and pneumo-encephalography. This is imperative to ascertain the presence of demonstrable factors producing the type of seizures known as symptomatic epilepsy. When such data reveal the presence of an intracranial space-taking lesion as a brain tumor or abscess, surgical attack, in accessible lesions, is indicated. Focal traumatic scars or post-meningitic adhesions should be excised by the Penfield technique⁸ if medical treatment proves ineffective. If studies reveal the presence of endocrine disorders such as hyperthyroidism, hyperparathyroidism, and hyperinsulinism; allergic diathesis; blood dyscrasias; cardiac dysfunction such as Adams-Stokes disease; infections such as syphilitic meningo-encephalitis; intoxications and the like, as causal agents, then appropriate treatment of these conditions is in order. Not all cases of symptomatic epilepsy are amenable to specific treatment as just mentioned, e.g., cerebrovascular disease, degenerative lesions, and various forms of encephalopathies, and resort then must be had to anticonvulsant medication.

Those cases in which the cause of the epileptic display is unknown have been designated as idiopathic or cryptogenic. The terms are ill-ad-

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From the University of Pennsylvania Graduate School of Medicine.

vised because there must be some cause for an obvious disorder, and the modern concept has it that all forms of epilepsy have an underlying morphologic or biochemical disturbance of brain tissue.

The relatively large group of so-called idiopathic epileptics must be treated by a total attack of the problem, and not by the commonly practiced one of medication alone. This means that the whole individual and his environmental constellation are subject to treatment. Broadly speaking, this requires the creation of a somewhat protected milieu of contentment, the development in the patient of emotional balance and stability, the elimination of the stigma attached to epilepsy by the lay public, and by employers, the opportunity for work, appropriate moderate exercise and participation in non-dangerous sports, normal indulgence in intellectual and social functions and pleasures, regular and sufficient hours of sleep, avoidance of fatigue, attention to the emunctories, and a carefully supervised dietary regimen. The latter should consist of a well-rounded diet comprising high vitamin, high protein, moderate fat, and moderate carbohydrate intake. Fluids need not be restricted, and should be sufficient to meet the needs of a balanced water metabolism. Alcohol in any form should be prohibited and known allergenic foods should be eliminated from the diet.

The actual anticonvulsant therapy with drugs must be of a flexible dynamic order. Preparations may be used singly or, if ineffectual alone, should be used in combination with other drugs, and imagination as well as trial and error should be exercised in such combinations and in the determination of dosage. Of the host of drugs which have been tested and employed, there are today but five truly effective ones. They are: (1) phenobarbital, (2) dilantin sodium (diphenylhydantoin sodium), (3) mesantoin (methylphenylethylhydantoin), (4) tridione (trimethyl-oxazolidine dione), and (5) bromides.

In the treatment of motor seizures of whatever variety, grand mal, jacksonian seizures, abdominal epilepsy, etc., phenobarbital should first be used singly. The dose for children closely approximates that for adults. This may vary from a total daily dose of 1 grain to 6 grains. If seizures are diurnal, dosage may be divided three or four times daily, and if the attacks are nocturnal, a single adequate dose is given before retiring. Should phenobarbital when given alone fail to control the attacks, it may be used in conjunction with dilantin sodium or mesantoin, both to be given in full therapeutic doses. If toxic manifesta-

tations of phenobarbital therapy appear, the drug should be withdrawn slowly, and the hydantoin preparations and/or the bromides substituted.

Perhaps the greatest advance in the treatment of epilepsy with drugs has been the development of dilantin sodium⁹ and mesantoin.¹⁰ These preparations are useful in both the motor and psychomotor types of seizures. Dilantin sodium was the first to appear on the scene and experience with it is greater than with mesantoin. Experience with both of these drugs indicates the advisability of starting with small doses and gradually building up to the effective dose capable of controlling attacks. I have found $\frac{3}{4}$ grain of either one of these drugs, given three times daily, as the most satisfactory starting dose. This is increased gradually within a week or ten days to $1\frac{1}{2}$ grains three times daily. With adults, $4\frac{1}{2}$ to 6 grains daily usually suffice to obtain satisfactory results, but as high as 9 grains daily may be given with impunity. Children, depending on age, may receive from 3 to 6 grains per day. Dilantin sodium is best given with meals, thus avoiding the gastric distress sometimes provoked by its alkaline reaction.

Dilantin sodium and mesantoin, though extremely useful drugs, are not without serious defects at times. Both may produce toxic symptoms in some patients, mesantoin presumably less so than dilantin. The toxic manifestations of dilantin consist of gastric distress, nausea, vomiting, dermatitis, headache, hypertrophy of the gums, ataxia, behavior disturbances, diplopia, nystagmus, rarely leukopenia, and increase of seizures. Mesantoin may produce toxic signs such as drowsiness, irritability, morbilliform, scarlatiniform, or eczematoid rash, deep crater-like ulceration in the legs, behavior disorders in children and adolescents, headache and a mild degree of unsteadiness of gait. Such symptoms may be controlled by dose reduction or complete withdrawal of the drug. If these drugs have been used alone and withdrawn due to onset of toxic symptoms, phenobarbital and/or bromides must be substituted. Dilantin or mesantoin may again be tried in slowly ascending doses.

Petit mal and its analogue pyknolepsy have been the stumbling blocks in the path of effective drug therapy for the epilepsies. With the advent of tridione,¹¹ a considerable percentage of petit mal sufferers have been afforded relief. Tridione is of questionable use in grand mal and psychomotor seizures. In my hands, it has been of no benefit in these last two disorders. Tridione also should be started with a minimal dose and gradually increased until the clinically effective dose is reached. If only partial results are obtained, it

should be increased to the point of toxic reactions, at which time the dose must be reduced at once. The dose required varies from 0.3 to 2.1 grams daily given in divided doses. For young children, the drug is available in 0.15 gram dulcet tablets and in solution. For older children and adults, it is given in 0.3 gram capsules. Although tridione has been highly commended in the literature, it may produce truly alarming toxic effects. The toxic manifestations in order of severity are photophobia, drowsiness, irritability, behavior disorders, skin rashes, agranulocytosis, thrombocytopenia, and aplastic anemia (two deaths reported).¹² When dilantin and mesantoin are being administered, it is advisable to have periodic blood counts done, but with tridione this is mandatory. Obviously these drugs should be withdrawn and others substituted with the appearance of any serious toxic symptom. However, none of the foregoing drugs should be withdrawn abruptly, except in the face of a serious toxic complication, since status epilepticus may ensue.

Although the bromides have been relegated to a subordinate position in the treatment of epilepsy since the introduction of the drugs already described, they still serve an important function and indeed may succeed when all other measures fail.

The alkaline bromides most commonly employed are the sodium and potassium salts, either in tablet form or conveyed in a palatable vehicle. Fifteen grains (1 gram), three times daily, is the usual adult dose, but regulation of salt intake may permit of smaller dosage. Up to 30 grains three times daily may be given. Children tolerate bromides well, and dosage should be gauged by age and weight. Another bromide preparation which I have found superior is calcibronat (calcium-bromine-galactogluconate). Depending on age and requirement, 1 to 3 drams (4 to 12 grams) of the granules of calcibronat are dissolved in water and given three to four times daily.

The bromides may produce an annoying acne, and also toxic symptoms such as anorexia, nausea, vomiting, apathy, delusions, hallucinations, thick speech, memory loss, impotence, and delirium. "These untoward reactions, however, in large part, lay not in the bromides themselves, but in the lack of knowledge concerning dosage, individual reactivity, and the influence of chlorides in the bromide displacement in blood serum."¹³ Patients using bromides must be seen regularly and symptoms of toxicity conscientiously looked for. These symptoms may appear when the blood serum titer is 150 mg. per cent

or more. The combined use of bromides and phenobarbital or the hydantoin, when properly regulated, often makes for a smoothly acting anticonvulsant. Several patients of mine who cannot tolerate phenobarbital or the hydantoin rely exclusively and with happy results on bromides.

A few remedial agents and methods will be mentioned in passing because they are now being used, but to a limited degree. One of these, the ketogenic diet, formerly in vogue in the treatment of epilepsy in children, is disappearing from the therapeutic scene because of the difficulty in its execution and the development of drugs which perform better. Glutamic acid,¹⁴ although ineffectual in the treatment of grand mal, seems to act as a synergist with phenobarbital, the hydantoin, and tridione in controlling petit mal and psychomotor fits in children. The large doses required (8 to 16 grams per day) and the unreliability of action make the use of glutamic acid of debatable value. Electric shock treatment¹⁵ has been given, with encouraging results, to patients in whom fits persist despite adequate treatment with the various anticonvulsant drugs, and in whom the attacks are unpredictable, and which may occur in awkward or dangerous situations. By this procedure, spontaneous seizures have been reported as controlled and diminished in number.

Status epilepticus is a real medical emergency and, despite the fact that it often terminates favorably without treatment, the frequency with which it results in death makes it imperative to resort to immediate measures for its control. When the materials are at hand, the following forms of treatment in their respective order of merit are: sodium phenobarbital (dissolved in distilled water), 6 to 8 grains for adults, 3 to 5 grains for children given intravenously; sodium amytal (dissolved in distilled water), 7½ to 15 grains for adults, 3¾ to 7½ grains for children given intravenously; 3 to 6 cc. of paraldehyde intravenously for adults, 2 to 4 cc. for children; ether anesthesia; chloroform anesthesia.

In conclusion, I repeat that the treatment of a patient presenting some form of epileptic disorder must not be approached lightly, but must be given full attention as regards thorough study, treatment of the entire individual and his environment, flexible and imaginative employment of drugs and procedures, and, above all, there must be an attitude of optimism surrounding the epileptic and in the minds of physicians concerning the problems of epilepsy.

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ILLUSTRATED FOLDER HIGHLIGHTS BLUE SHIELD PROGRESS IN STATE

Physicians will be interested in a pocket-size pamphlet in which the Medical Service Association of Pennsylvania reports to the medical profession of Pennsylvania on the progress of Blue Shield.

What the public thinks about "the doctors' plan" of voluntary prepaid medical care was checked during the past summer when Blue Shield subscribers were asked: "Were you completely satisfied with the way Blue Shield handled your doctor bill?" Ninety-five per cent of those who replied said that they were completely satisfied, the pamphlet reports.

From the viewpoint of business and professional leaders, Blue Shield has been welcomed everywhere. Employers are cooperating in making the Blue Shield plan available to their employees, and in many cases all or a substantial portion of the cost is being paid by industry, it is disclosed in the report.

The growth of Blue Shield membership from 7111 in 1941 to 244,170 on July 31, this year, is graphically portrayed. The Medical Service Association of Pennsylvania was the ninth largest in the country, as of June 30, when 227,172 subscribers and their dependents were enrolled. Its growth during the first six months of this year—51.44 per cent—led all other non-profit plans having 200,000 or more members.

Up to July 31 the total amount of physicians' services incurred was \$1,714,803. Starting with \$20,882 in 1941, this amount had exceeded \$1,000,000 at the close of 1947.

With 6537 participating physicians enrolled in the plan sponsored by The Medical Society of the State of Pennsylvania, the report emphasizes that Blue Shield's future in this state depends upon physicians' cooperation. Complete familiarity with the Blue Shield plan is urged upon physicians as essential, and full details about how it works are necessary for physicians' lay assistants and professional associates, it is pointed out.

In an introduction to the report, J. Arthur Daugherty, M.D., president of the Association, reminds that Blue Shield is fast becoming a byword throughout Pennsyl-

vania among men and women to whom it extends protection in time of serious illness or injury. He emphasizes that the facts presented in the pamphlet demonstrate that Blue Shield has "safely passed the hazards of its early days and has emerged into the bright promise of a healthy future."

Physicians and members of their families may obtain copies of the report by writing to MSAP's executive offices, 222 Locust Street, Harrisburg.

ARE "EASTERN DOCTORS SUCKERS"?

Pennsylvania physicians who see more patients in dispensary service than they do in private practice should be interested in reading "An Answer to Tommy Brittain" appearing on page 70, this issue.

DOES THIS HAPPEN IN YOUR HOSPITAL?

The medical student must be taught that the general practitioner is not just a general practitioner because of his ignorance, laziness, lack of training, or some other form of deficiency, but that in the majority of instances he is a G. P. because of choice. He must be taught that the general practitioner is not just a "clearinghouse" for the specialist, as is so often quoted, and that he too is capable of making a responsible diagnosis in most instances. *He must be taught this by the specialist.* All too often we have heard the intern say: "I really wanted to do general practice, but when I came into the hospital and observed the treatment that was accorded him by the staff, I felt it necessary that I prepare myself for a specialty." There is no further explanation necessary.—*General Practice News*, September, 1948.

RHEUMATOID ARTHRITIS

475 Cases Treated with 721 Courses of Gold

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IN 1943 we¹ reported treatment of 122 cases of rheumatoid arthritis with 176 courses of gold; in 1945 we² added 137 cases treated with 241 courses; the present report deals with 216 additional patients treated with 304 courses of gold—a total of 475 cases of rheumatoid arthritis treated with 721 courses of gold. Solganal-B oleosum was the sole gold preparation used in this entire study.

Important among the factors contributing to the safety of gold therapy is the more recent trend toward lower dosage. A course of gold in our former publications consisted of intramuscular injections of 10 mg. twice weekly, four doses; 25 mg. twice weekly, four doses; 50 mg. twice weekly, four doses; and 100 mg. weekly, nine doses—a total of 1240 mg. Our present course consists of 10 mg. twice weekly, four doses; 25 mg. twice weekly, four doses; if improvement is shown at this point, the dosage is not increased, but 25 mg. is given weekly until a total of 790 mg. is administered; but if there is no improvement, 50 mg. twice weekly, four doses; 50 mg. weekly, nine doses—a total of 790 mg. The 100 mg. dose has been discarded entirely.

In the present series there were 144 female and 72 male patients ranging in age from 15 to 76. The cases were classified according to severity as in previous reports into four groups:

Group I. Typical rheumatoid arthritis of less than one year's duration (subjective symptoms only).

Group II. Changes in joints, with activity only slightly limited.

Group III. Changes in joints, with greatly limited activity.

Group IV. Dislocations, ankyloses, and contractures (patient confined to bed or wheel chair).

Twenty-six of the present series were in Group I, 74 in Group II, 114 in Group III, and 2 in Group IV. Duration of the disease at start of therapy varied from one week to twenty-eight years.

The results of treatment by age groups in the four groups are shown in Table I.

In this series 52.8 per cent were very much improved, 20.4 per cent much improved, and 16.2 per cent improved. These results do not differ materially from those previously reported, namely, 49 per cent with very marked improvement, 15 per cent with marked improvement, and 25 per cent with improvement. In the entire series, therefore, approximately 90 per cent of the patients were subjectively and/or objectively improved by gold therapy. However, subjective improvement may be on a purely psychologic basis. Therefore, when one considers that the "improved" group showed only subjective improvement, it is not permissible to include it in the category of objective improvement. While most patients in this "improved" group insisted that pain and stiffness were less severe, a critical analysis makes it difficult to attribute the improvement to gold therapy.

In 1945 we reported² 259 cases showing the following results of therapy:

	Cases	Per Cent
Very much improved	127	49
Much improved	40	15
Improved	65	25
Not improved	21	8
Worse	6	2

At that time we reported our results conservatively and suggested that the categories of Improved, Not Improved, and Worse be considered

From the Arthritis Clinic of the Philadelphia General Hospital.

The solganal-B oleosum used in these studies was supplied by Drs. Max Gilbert and W. H. Stoner, Schering Corporation, Bloomfield, N. J.

as one. This gave us the result of 64 per cent improvement.

In the present series of 216 cases, 35 (16.2 per cent) are improved and 23 (10.65 per cent) are in the category of No Improvement. Table II summarizes the results of treatment of the total 475 cases.

Following the same method of reporting as in our previous paper, we had improvement, both subjective and objective, in 68.3 per cent of our total of 475 cases, while the remaining 31.7 per cent showed no objective improvement.

Toxicity

Experience gained from this large series of rheumatoid arthritides has increased our ability to recognize untoward reactions in their early stages. Consequently, the incidence of reactions is greater in this third series than in the two former publications.^{1, 2} The slightest indication of untoward symptomatology, even mild itching, is recorded here as toxic reaction. In our first series of 122 cases receiving 176 courses of gold, we observed 11 per cent of untoward reactions; in our second series of 137 patients treated with 241 courses of gold, we observed 10.3 per cent of untoward reactions; in the present series of 216 patients receiving 304 courses of gold, we

observed reactions in 15 per cent of the courses and in 21 per cent of the patients. Of the 47 reactions observed, 41 occurred during the first course, 4 during the second course, and 2 during the third course. The average total dosage of gold at the time of toxic reaction was 738 mg. The smallest dosage followed by toxic reaction was 30 mg., and the largest dosage was 4030 mg. This may indicate that reactions to gold may be either allergic, due to true sensitivity to gold, or on a pharmaco-toxicologic basis in which there is a certain tolerance to gold which, when exceeded, results in toxic reaction.

Table III shows the frequency of occurrence of the several toxic manifestations of this series.

Distribution of toxic reactions among the four grades of severity was as follows: 2 reactions in Group I, 14 reactions in Group II, 30 reactions in Group III, and 1 reaction in Group IV. This distribution does not differ significantly from that of the cases of the entire series which was: 26 cases in Group I, 74 cases in Group II, 114 cases in Group III, and 2 cases in Group IV.

Similarly, no significant correlation existed between the occurrence of toxic reactions and the results of treatment as referred to in our previously published grouping: (1) very much improved, (2) much improved, (3) improved, (4)

TABLE I
RESULTS OF TREATMENT (Present Series)

	Group	Under 20	20-29	30-39	40-49	50-59	60-69	70 and over	No.
Very much Improved	I	0	3	2	3	2	0	1	11
	II	0	2	5	12	9	4	0	32
	III	1	7	7	26	13	13	3	70
	IV	0	1	0	0	0	0	0	1
Much Improved	I	0	2	1	2	2	1	0	8
	II	0	1	2	4	9	4	0	20
	III	0	3	4	4	3	1	1	16
	IV	0	0	0	0	0	0	0	0
Improved	I	0	0	2	3	2	0	0	7
	II	0	1	2	3	6	1	0	13
	III	0	0	3	2	5	3	1	14
	IV	0	0	1	0	0	0	0	1
No Improve- ment	I	0	0	0	0	0	0	0	0
	II	0	0	1	4	4	0	0	9
	III	0	2	2	2	4	4	0	14
	IV	0	0	0	0	0	0	0	0

TABLE II
RESULTS OF TREATMENT (Total 475 Cases)

	<i>Present Series</i>	<i>Previous Series</i>	<i>Per Cent</i>
Very much improved	114	127	50.7
Much improved	44	40	17.6
Improved	35	65	21.1
Not improved	23	21	9.3
Worse	0	6	1.3
Total (475 cases) ...	216	259	100.0

no improvement. Twenty-two cases with toxic reactions were very much improved, 8 were much improved, 10 were improved, and 7 showed no improvement.

Reactions occurred significantly more frequently in female patients; 39 (27 per cent) of the 144 females and 8 (11 per cent) of the 72 males showed toxic symptoms.

Since our earlier publications, several factors have combined to make the use of gold therapy less hazardous. Indeed, the clinician less experienced in this field, if he observes the well-established routine precautions against gold intoxication, and if he has available BAL (2,3-dimercaptopropanol, British anti-lewisite) in case of gold reaction, may now use gold salts with relative impunity.

The recent therapeutic application of BAL³ to gold poisoning not only diminishes the fear of the otherwise devastating toxic reactions from gold but also gives promise of the long-awaited explanation of the mechanism of action of gold in rheumatoid arthritis since it is probable that the sulfhydryl groups in the dithiol BAL replace the dithiol protein-metal compounds in the tissues, restoring the normal enzyme systems by a mechanism similar to that now known to operate in BAL therapy of arsenic poisoning.

Gold therapy has been unjustly discredited due to various factors, among which are (1) incorrect diagnosis, (2) neglect of supplemental supportive therapy, and (3) too late use of gold. One of the common errors in diagnosis is confusion of rheumatoid arthritis with gout and hypertrophic arthritis, in which cases gold is entirely inefficacious. Attention was given in this series to the usual supportive therapy. If hemoglobin was below 65 per cent or the erythrocyte count below 3,000,000, two and sometimes three transfusions were given before gold therapy, and anti-anemic medication was given concurrently. All physical deficiencies extraneous to the arthritic condition, such as menopause, gastric ulcer,

cardiac conditions, etc., were given appropriate conventional therapy. Arthritis was not permitted to overshadow any coexisting abnormality. The general medical, hygienic, and dietary care of the patient was given special attention. It has been stated frequently, and recently⁴ by those timid in the use of gold, that this form of therapy should be reserved as a last resort. However, those clinicians^{5, 6, 7} now most expert in application of gold therapy are agreed that withholding gold in a proved case of rheumatoid arthritis is unfair to the patient.

No correlation was obtained between changes in sedimentation rate and toxic reactions. Nine of the 47 toxic reactions occurred in patients with increasing sedimentation rates; 33 patients of this series of 216 showed increase in sedimentation rates during gold therapy; 16 of these showed very marked improvement, 6 marked improvement, 7 improvement, while only 4 showed no improvement.

In this series 36 per cent of high sedimentation rates and 31 per cent of the entire 475 cases returned to normal during gold therapy. In general, it may be stated that reduction in sedimentation rate indicates favorable progress of therapy, but an increasing sedimentation rate is not necessarily indicative of unfavorable progress. Early hope concerning the value of sedimentation rates in the study of arthritis is not realized by our experience.

For the correction and prevention of deformities, physostigmine salicylate and atropine sulfate combination⁸ proved to be of considerable benefit. It not only relieved muscle spasm, there-

TABLE III
47 REACTIONS FROM 304 COURSES OF GOLD
IN 216 PATIENTS

<i>Reaction</i>	<i>No. of Cases</i>
Dermatitis	16
Stomatitis	8
Pruritus	6
Pruritus and dermatitis	4
Pruritus and stomatitis	2
Dermatitis of eyelids	1
Dermatitis of eyelids and leukopenia	1
Dermatitis and cirrhosis of liver	1
Seborrhea of hands	1
Seborrhea of back	1
Stomatitis and edema of lips	1
Stomatitis and thrombocytopenia	1
Conjunctivitis and iritis	1
Conjunctivitis and corneal ulcer	1
Furunculosis of ear	1
Purpura hemorrhagica	1

by preventing further deformity, but by so doing there was considerable lessening of pain.

Summary

1. A total of 721 courses of gold therapy in 475 cases of rheumatoid arthritis resulted in subjective and/or objective improvement in 90 per cent, and in definitely objective improvement in 64 per cent.

2. Toxic reactions were encountered in 15 per cent of the courses, 21 per cent of the patients.

3. Gold therapy may be employed in rheumatoid arthritis with safety if conservative dosage is used, if vigilance against incipient toxic reactions is maintained, and if treatment is stopped and the antidote BAL is employed immediately upon appearance of the first toxic symptoms.

4. Gold therapy is not to be considered as a panacea. Results as above can be expected if the patient is considered as a medical problem and if one adheres to the criteria for treatment.

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VENEREAL DISEASE NOTES

From the Pennsylvania Department of Health

In a recent conference of physicians who are in charge of syphilis control in the various state departments of health in northeastern United States, including Pennsylvania, Dr. John Mahoney, director of the Venereal Disease Research Laboratory, United States Public Health Service, Staten Island, made the statement that the laboratory of the future must give a *quantitative* serologic test service if it expects to furnish information that is of value for clinical purposes. In other words, the "1, 2, 3, 4 plus" is obsolete.

It appears that the stumbling block to such refinement is a lack of trained technicians. Dr. Claude P. Brown, director of the Department of Health laboratories, at the seminar on syphilis held by the Department of Health on April 1, 1948, made practically the same statement. Dr. Brown has given yeoman service to serology in the central laboratory of the State Department of Health. Here he conducts a *quantitative* serologic test service on patients with *early* syphilis who have been treated with penicillin. By means of this refinement it may now be determined whether patients with *early* syphilis have been cured.

Quantitative serologic testing of patients with *late* syphilis is a waste of time and money. In fact, any kind of serologic testing in late syphilis is valueless in determining whether a cure has been effected.

The serologic titer of the pregnant woman who has been treated for early syphilis with penicillin probably falls more slowly than in early syphilis that is not associated with pregnancy. In Ingraham's series the average time required for reversal of the serology of the postpartum woman was 245 days. Therefore, the birth of a healthy child is *not* dependent upon the *serology of the mother* at the time of birth.

At the same seminar, Dr. M. S. Falk of the Institute for the Study of Syphilis, University of Pennsylvania, stated:

"It is not infrequent for an infant whose mother was treated with penicillin during pregnancy to have a positive blood serologic test after birth. In most instances this positive STS in the newborn infant represents only placental transfer of the mother's reagin. Usually by the end of the third month the infant will have become seronegative. The STS may remain at high titer, or an initial decline in serologic titer may be followed by a rise. Under such circumstances the child should be considered syphilitic and treatment should be instituted without delay."

In accordance with an act that was sponsored jointly by the Commission on the Control of Syphilis and Venereal Disease of The Medical Society of the State of Pennsylvania and this department in 1945, the services of the laboratories operated by the State Department of Health are free to the pregnant woman for the performance of the serologic test. No longer need she be declared indigent to enable her to receive the benefit of this free service in the interest of her unborn child.

EDGAR S. EVERHART, M.D., Chief, Venereal Disease Division.

The Ragweed Extermination Plan for Philadelphia

Results of the First Year's Survey

GEORGE I. BLUMSTEIN, M.D., JAY SPIEGELMAN, M.D., and
VICTOR HIRSCH, M.D.
Philadelphia, Pa.

IN THE spring of 1947 the director of the Department of Housing and Sanitation of the City of Philadelphia called a meeting of physicians interested in allergy to determine the feasibility of exterminating the ragweed plant within the county limits. Interest in this field had been stimulated by the discovery of a selective chemical agent that, when used in proper concentrations, would kill plants such as plantain, ragweed, and poison ivy without affecting surrounding edible or ornamental vegetation. The advantages of this method of weed elimination were in the rapidity with which this program could be executed, the relatively large area that could be sprayed with a small operating staff, and the low cost of such an operation when compared to the older and more costly method of extirpation by hand. A program of this sort, if found to be successful, would be of far-reaching value in the field of preventive medicine. Various authors¹ have estimated that from 10 to 12 per cent of the population are allergic. A more conservative figure, however, as given by Cooke,² is about 7 per cent. When one considers that a large proportion of this group are seasonal allergies due to pollens, a successful program would thus benefit a large group of people in a city of two million population, such as Philadelphia.

Since ragweed pollen is air-borne and has been known to be carried as far as fifteen or twenty miles,³ it becomes evident that to have a successful program one must have a knowledge of the sources of pollen from the surrounding communities. This knowledge can be obtained only by means of accurate pollen surveys of the suburbs surrounding metropolitan areas. If high concentrations of pollen are found to contribute materially toward our local counts, then it may be necessary to extend the ragweed elimination program to include them. Several communities adjacent to Philadelphia were invited to par-

ticipate in the ragweed extermination program, but declined because of lack of funds.

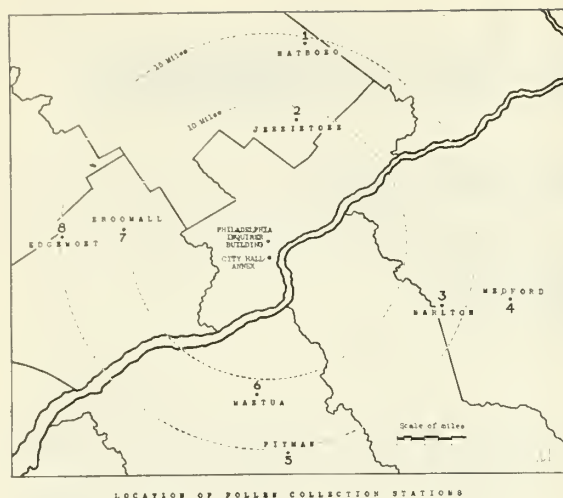
The City of New York has for many years publicized the efforts it expended to eradicate ragweed. It was natural, therefore, that one of its boroughs should have been the first to undertake ragweed elimination with the newer chemical agents. In 1946 the Department of Health of Brooklyn undertook a five-year ragweed extermination program with Dr. Matthew Walzer acting as consultant.⁴ The duration of the program was decided arbitrarily, the consensus of opinion being that any period shorter than the stated one would not permit the investigators to judge the beneficial effects accruing from such extermination. While no definite time limit was set for the Philadelphia project, it was felt that its successful operation during the first year would automatically warrant a continuation of the program until the investigators could calculate the benefits derived from it.

Procedure

In order to evaluate the effectiveness of the program and to gain more information concerning pollen concentrations in Philadelphia and vicinity, a pollen survey was conducted from Aug. 15, 1947, until Sept. 30, 1947, as described below.

A central city pollen shelter was set up on a balcony outside of the fourteenth floor of the Philadelphia Inquirer Building. This site had been used for several previous years and pollen count statistics were available from this station for those years. Another shelter was set up for comparative purposes atop City Hall Annex, only about one-third of a mile from the first shelter. This latter shelter was designated as Station 0. Pollen shelters were then set up in surrounding communities in all four cardinal directions. Fig. 1 shows the location of these stations with their approximate mileage from the center of Philadelphia.

From the Allergy Clinic, Mt. Sinai Hospital, Philadelphia.



LOCATION OF POLLEN COLLECTION STATIONS

No. 1. Hatboro, Pa.	18 miles
No. 2. Jenkintown, Pa. ..	9 miles
No. 3. Marlton, N. J.	14 miles
No. 4. Medford, N. J. ...	18 miles
No. 5. Pitman, N. J.	20 miles
No. 6. Mantua, N. J.	11 miles
No. 7. Broomall, Pa.	11 miles
No. 8. Edgemont, Pa. ...	16 miles

Fig. 1

Standard pollen shelters⁵ were placed fifteen feet above the ground in unobstructed sites near the geographic centers of the selected communities. Such sites were invariably adjacent to gasoline stations so that the attendant might care for the exposing, collecting, and mailing of slides. All slides were covered with a thin layer of petrolatum and exposed for twenty-four hours. No dyes or stains were used to aid identification. The slides from our numbered suburban stations were mailed daily to the Philadelphia city laboratories where technicians, trained and supervised by one of us (G. B.), did the actual counting. The standard slide area of 3.6 sq. cm. was counted for each slide submitted. This area has been accepted by the National Pollen Survey Committee of the American Academy of Allergy as the standard area for the conversion of ragweed pollen counts from the gravity slide area to cubic yard equivalents.⁶

The chemical agent selected for ragweed extermination was 2,4 dichlorophenoxyacetic acid, commonly called 2,4 D and marketed commercially under various trade names as a weed killer. This agent was first prepared in 1939^{7, 8, 9, 10} when it was tested as a fungicide. Early in 1942 research was instigated to study the toxic effects of this agent on plants, and its selective destructive properties were thereby determined. At

present 2,4 D is put up in three forms: (1) the dry powder—sodium salt, (2) an aqueous solution of the triethanolamine salt, and (3) the esters in combination with emulsifying agents and carriers. It was this latter form that was used in this work.

The 2,4 D kills most field, pasture, and lawn weeds without killing the desirable lawn and pasture grasses or the cereal crops of wheat, corn, oats, rice, or barley. It is especially effective against the following: ragweed, plantain, dandelion, bendweed, wild lettuce, milkweed, poison ivy, thistle, wild mustard, cocklebur, chickweed, and the various clovers. Its effect is manifest only when the leaves are green and the plant is growing actively. When sprayed on plants, 2,4 D is absorbed and penetrates into the roots, and therefore kills the entire plant. This cycle requires from two to four weeks for its completion. The spraying in an extermination program, therefore, should be carried out two to four weeks in advance of the pollinating period.

In Philadelphia, during 1947, the 2,4 D was applied by two methods: first, with a spray truck, by using a spray of 75 to 100 pounds pressure at the nozzle and a concentration of 3 pints per 100 gallons of water. By this method



Fig. 2

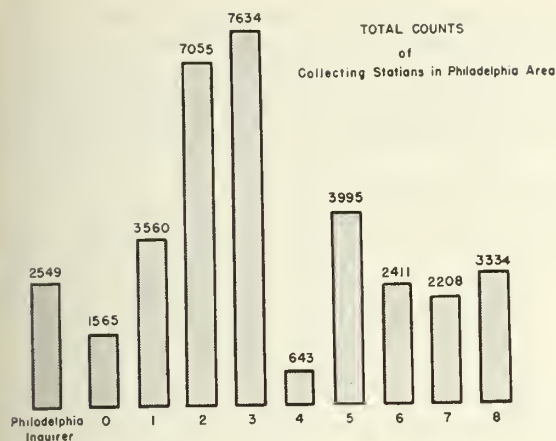


Fig. 3

the workers were able to spray at the rate of 15 gallons per minute. Approximately 150 gallons were used per acre. This method has several obvious advantages, the chief being that much larger areas can be sprayed in shorter periods of time. The second method employed a hand spray that had a 25 pound nozzle pressure. This yielded a very fine mist and permitted greater coverage per unit volume of solution. With this method a more concentrated solution was used, one pint per gallon.

The concentrations to be used in this exterminating program were decided by the trial and error method. Test areas were sprayed with varying dilutions of the agent. The lowest concentration of 2,4 D that destroyed ragweed plants within two weeks was selected as our standard concentration.

During the first season the program did not allow for a city-wide comprehensive spraying program because of the lack of trained and untrained personnel. The plan was publicized in all of the newspapers, and spraying was done only on a complaint basis. The Department of Health was notified of the existence of ragweed in a certain locality by a resident of that community. An inspector was dispatched to the site and, if ragweed was found to be present, the area was sprayed. From June 30 until September 1 approximately 5,222,320 square feet were sprayed. The areas sprayed are shown on Fig. 2. As can be seen, approximately three-fourths of the spraying was done across the northern part of the city, covering the suburban sections of Germantown, Chestnut Hill, Oak Lane, Logan, and Mayfair.

Results

The graph for this season is typical of those usually obtained, the pollen concentration reach-

ing its peak in the first week in September and then gradually diminishing, with a very low count for the period after September 15. The total count (obtained by adding each daily count) was 2549 pollen granules per cubic yard of air. This is lower than the counts of 5634 in 1945, and 3834 in 1946 (Fig. 4), at which time there was no ragweed elimination program in effect. However, it is not possible to attribute this drop in 1947 to the 2,4 D, since counts in other localities were generally lower than in the previous years. The counts from other cities for the same period (Brooklyn, Pittsburgh, Cleveland, and Toledo), as furnished by Durham,¹¹ are represented in Fig. 5. Ragweed extermination programs were carried out in Brooklyn during 1946 and 1947.

The counts obtained at our other stations were in part reliable and in part unreliable, for the reasons that will be discussed. Station O, which was atop City Hall Annex, had to be discarded because there were fifteen days out of a total of forty-six (33 per cent) for which slides were not available. This occurred because of the fact that the city employee assigned to expose and collect the slide did not work over week-ends. The total count for the remaining days was 1565 granules per cubic yard, which compares favorably with our Philadelphia Inquirer Station for a similar period.

Station No. 1, at Hatboro, Pa., was fairly reliable; only one day was unreported. The total count was 3500 granules per cubic yard, about 40 per cent higher than our central city count.

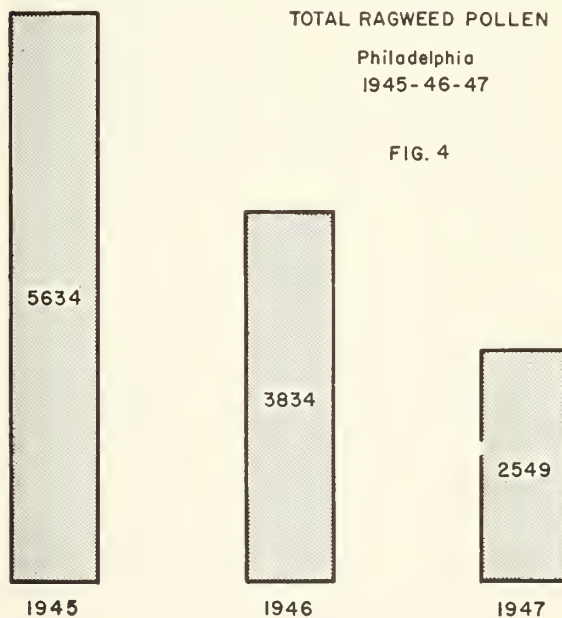


Fig. 4

Station No. 2, at Jenkintown, Pa., was felt to be unreliable. There were no slides obtained on thirteen days. The total count for the remaining time was 7005 pollen granules per cubic yard, far higher than our central city count. The daily

fluctuations, however, were rather bizarre, with counts going from several hundred or even a thousand on one day to almost zero the next day.

Station No. 3, at Marlton, N. J., is subject to the same criticism as is Station No. 2, although

DAILY POLLEN COUNTS FOR PHILADELPHIA AND ENVIRONMENT 1947

	Station 1	2	3	4	5	6	7	8	0	Inquirer
August										
15	—	86	2	26	13	9	18	6	—	12
16	9	1	62	1	17	20	13	29	—	15
17	25	—	0	2	11	9	31	7	—	13
18	39	—	21	4	25	—	97	20	—	31
19	138	—	5	27	11	9	27	29	—	11
20	72	32	6	1	79	7	26	103	—	26
21	60	6	54	—	49	57	37	62	48	19
22	61	2	72	22	25	88	28	19	46	17
23	24	112	80	3	73	36	22	65	—	23
24	145	32	74	150	12	28	28	62	8	43
25	189	96	3	2	48	43	*	*	66	55
26	172	107	522	2	130	31	62	73	75	51
27	*	274	1	1	221	12	61	110	36	27
28	151	119	1	2	206	157	150	271	96	124
29	183	—	6	5	149	100	67	87	61	90
30	50	—	16	6	182	168	140	74	37	102
31	200	—	672	1	415	197	34	299	—	54
September										
1	327	—	421	2	283	17	104	205	—	216
2	165	—	13	9	236	—	228	90	317	138
3	261	2202	20	0	278	253	201	282	73	144
4	307	1509	279	3	118	—	121	297	150	219
5	88	1084	—	2	110	392	107	16	84	135
6	193	29	460	13	249	—	9	111	—	116
7	68	408	513	55	142	4	0	7	—	86
8	62	6	171	199	265	116	16	157	6	84
9	234	295	1215	4	106	85	57	137	26	92
10	1	9	562	9	58	75	72	108	47	40
11	47	484	184	4	145	81	42	76	19	64
12	80	107	860	2	118	124	125	149	168	49
13	93	—	1015	0	6	82	114	106	63	144
14	38	—	87	1	21	61	31	11	—	87
15	7	11	77	19	53	47	25	126	92	67
16	23	9	40	12	33	21	34	48	14	53
17	8	—	20	8	11	—	22	18	10	9
18	0	6	11	2	8	10	8	13	6	16
19	9	—	0	9	23	10	12	9	7	14
20	10	4	52	2	3	21	8	11	5	10
21	2	5	—	10	52	—	3	4	—	4
22	16	—	16	6	2	28	15	26	1	9
23	0	7	5	10	2	3	4	3	4	8
24	0	4	1	2	*	*	5	4	0	11
25	0	0	15	1	2	1	3	1	0	3
26	2	6	0	1	1	2	1	3	0	3
27	1	0	0	0	0	5	0	0	0	5
28	0	0	0	0	2	2	0	0	0	3
29	0	0	0	1	1	—	0	0	—	2
30	0	3	0	2	1	—	0	0	0	2
Total	3560	7055	7634	643	3995	2411	2208	3334	1565	2549

— No slide received for this day.

* Slide broken in transit.

slides were missing on only three days. The total count was 7634. The same type of bizarre fluctuations existed here and it was felt that possibly the attendants at these two stations were not too conscientious or punctual about exposing and collecting the slides.

Station No. 4, at Medford, N. J., only a few miles away from No. 3, had a total count of only 643 granules per cubic yard of air. This was in marked contrast to the high count at Station No. 3, and was discarded as unreliable because of the atypical graph and the low total count.

Station No. 5, at Pitman, N. J., was fairly prompt in mailing the slides and the daily figures were rather typical. The total count was 3995 pollen granules per cubic yard, approximately 60 per cent higher than in central Philadelphia.

Station No. 6, at Mantua, N. J., had a total count of 2411 pollen granules per cubic yard. The figures from this station cannot be relied on because of the fact that there were eight days unaccounted for, including two in the first week in September when counts would ordinarily be fairly high.

Station No. 7, at Broomall, Pa., submitted daily slides, but two slides were broken in transit and could not be counted or reported. The total count was 2208 granules per cubic yard of air, slightly lower than our central city figures.

Station No. 8, at Edgemont, Pa., was considered to be reliable. One day is unaccounted for because of a broken slide. The total count was 3304 pollen granules per cubic yard of air, about 30 per cent higher than our central city figures.

Discussion

One can readily see from the above information that one of the shortcomings in this program was our inability to secure reliable workers to expose, collect, and mail the slides to the laboratory. As the result of this deficiency, four of the ten stations (Nos. 2, 3, 4, and 6) were discarded as unsatisfactory. This represents 40 per cent of the total project. Sufficient reliable material remains, however, to justify this report.

The extermination program itself was far from satisfactory, since it was done only on a complaint basis and missed many areas that were heavily populated with ragweed. The absence of trained personnel during the first year of this program militated against a comprehensive block survey to detect ragweed prior to spraying. This likewise accounts for the relatively small area covered during the 1947 season. Plans are now being made to train an adequate staff to conduct a block survey, in the hope that the main ragweed-bearing areas within the city limits might

be detected and eradicated before the next pollinating period. It would also seem desirable to place our shelter on the periphery of the city limits so that full-time city employees could be held responsible for exposing and collecting the necessary slides.

It becomes immediately evident from the first season's results that in order to evaluate the effectiveness of a large scale ragweed extermination program, it would be necessary to collect data over a much longer period of time. Such a program should extend over a period of at least five years. The health authorities of Philadelphia are lending all of their available support to the execution of such a program. The results will anxiously be awaited by the ragweed sufferers in the city.

Our experience has cited the need for establishing certain standards in the undertaking of a ragweed extermination program. An outline of such a plan might prevent other investigators from repeating some of the errors inherent in such a program. Such an outline is presented:

1. A program of this type is feasible only in large metropolitan cities. Smaller communities derive too much of their atmospheric pollen from the surrounding area to warrant the undertaking of such a comprehensive program for the elimination of such a small percentage of the total pollen count. Likewise the benefits accruing from such a program would hardly justify the expense involved.

2. There should be at least one centrally located pollen shelter, preferably in the center of an obstructed roof of a tall flat-top building.⁵ Porches, window ledges, etc., are not satisfactory locations.

3. Shelters should be set up in all cardinal directions within a radius of fifteen or twenty miles. This should serve to identify the source

Fig. 5

TOTAL RAGWEED POLLEN COUNTS
IN OTHER CITIES

	1945	1946	1947
BROOKLYN	600	853 *	1003 *
PITTSBURGH	2325	6600	3449
CLEVELAND	6437	5483	4035
TOLEDO	10793	5650	14307

Figures represent pollen granules per cubic yard of air.

* Ragweed elimination program in effect

Fig. 5

of heaviest pollen concentration that inundates the city. Shelters should also be placed about the periphery of the city to determine the relative amount of pollen derived from each of the surrounding suburbs.

5. Pollen shelters should be situated so that the attendants would be immediately under control of the Department of Health. This could best be done by locating them on some public building where full-time employees can be taught the proper method of preparing and exposing the slides and charged with the responsibility thereof. If possible, mailing of specimens is to be avoided because of the risk of loss or breakage of slides.

6. Counting of slides should be done by trained technicians working under the direct supervision of a physician or botanist experienced in this field of work.

7. Spraying of areas populated with ragweed should be planned in advance of pollinating season in order to allow for full and complete coverage of the area within city limits. Spraying should be done early, and with adequate crews, starting about July 15, so that it may be completed by August 15. The assistance of a botanist in instructing the surveyors on the identification of ragweed would be a great asset.

8. Lastly, in order to have a successful program, there must be close cooperation and coordination between the department of health, an interested allergist, and a botanist, the latter two acting as advisors for the program.

Such a program has been sanctioned by the Department of Health of Philadelphia and will be instituted in the forthcoming year (1948).

Conclusions

1. A pollen survey was conducted in conjunction with a ragweed extermination program in Philadelphia during the summer of 1947. It was found that in the majority of cases the pollen

concentration in the surrounding communities was 30 to 40 per cent higher than in the central city area.

2. Certain deficiencies in the program were uncovered. These are concerned chiefly with the methods of exposing and collecting slides, location of pollen shelters, and the complaint method by which areas were selected for spraying with 2,4 D.

3. An outline of a satisfactory program has been set forth for the use of any other group contemplating such a campaign.

4. The need is demonstrated for a long-range program to determine the benefits that might be derived from such a weed extermination program.

We would like to express our appreciation and gratitude for the assistance and cooperation offered in this work by Mr. Herbert Packer, director of the Department of Housing and Sanitation of the Department of Health of Philadelphia; Mr. Thomas Manion, his deputy; and the late Dr. William T. Rees, recently director of the Department of Laboratories, without whose cooperation and efforts this program would not have been possible.

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The Cancer Situation in Pennsylvania

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PRACTITIONERS of medicine and surgery recognize the value of past and present histories in dealing with the problems of individual patients. Those actively engaged in public health administration also must approach their mass problems of disease prevention and control by periodic statistical reviews of the past and present incidence and prevalence of disease in state or other government units.

Purpose of Study

In taking up his new duties as Chief of the Division of Cancer Control of the Pennsylvania Department of Health, the writer suggested at a meeting of the Commission on Cancer of The Medical Society of the State of Pennsylvania held on June 9, 1948, that a brief study and report on the present status of malignancy in the Commonwealth of Pennsylvania would be of timely interest and value. The commission approved this suggestion, and this paper is the result.

In selecting a subject for such study and report, "The Cancer Situation in Pennsylvania" seemed particularly appropriate in view of the fact that just twenty years ago a paper under this same title was presented by Drs. Appel, Arner, and Wood of the Pennsylvania Department of Health before The Medical Society of the State of Pennsylvania which was published in THE PENNSYLVANIA MEDICAL JOURNAL of December, 1928. This paper was based more or less on a study of the twenty years previous to 1928. The present study brings our knowledge fairly up to date as to the continuing increase of cancer and includes brief comments on some of the factors involved.

Statistical Data and Comments

Mortality.—With the assistance of the Bureau of Vital Statistics of the Pennsylvania Department of Health, we are able to present statistical data in the form of tables showing the number of deaths and death rates for 1946 as compared with those for 1906, 1916, 1926, and 1936; rela-

tive rank of cancer among the leading causes of death for the same periods; and cancer deaths by age and sex for 1946.

It is evident from Table I that an increasing number of persons have died of cancer during the past forty years in Pennsylvania. The number of deaths and death rates per 100,000 population increased fairly constantly during the two decades 1906 to 1926, while a somewhat greater increase is shown for the twenty years 1926 to 1946.

Compared with 14,776 deaths from cancer in 1946, a further increase is noted in the preliminary figures for 1947 when 14,995 such deaths were recorded. Most recent data for the month of March, 1948, show 1291 deaths from cancer. If this approximate number per month holds for the year 1948, the number of cancer deaths for the present year will reach a total well over 15,000.

TABLE I

NUMBER OF CANCER DEATHS AND RATES IN
PENNSYLVANIA 1906-1946

Year	Deaths	Rates*
1906	4,208	58.9
1916	6,526	78.3
1926	9,172	98.6
1936	12,047	122.9
1946	14,776	144.4

According to facts brought out in Table II, there has been a definite shift in the number of deaths and in death rates from different causes during the past forty years. Whereas in 1906 and 1916, among the leading causes, cancer ranked seventh and in 1926 ranked fourth, in 1936 and 1946 it was the second cause of death in the Commonwealth, ranking only below heart disease.

Table III shows the number of deaths from cancer in Pennsylvania by age and sex during 1946, the last year for which complete figures are available. From this table it is evident that no age group is exempt from cancer. However, the first significant increase in the number of deaths apparently occurs in the age group 35 to

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* Per 100,000 total population (estimated).

44 years. This would seem to indicate that our concentrated attack on cancer involving prevention, diagnosis, and treatment should begin among young adult groups. These early years of life also are the ones during which the importance, diagnosis, and eradication of the so-called "precancerous" conditions must be stressed.

In this connection, mention should be made of the growing evidence and significance of occupational cancer. Pennsylvania is one of the most important industrial states that are manufacturing and handling carcinogenic materials such as coal tar products and other hydrocarbons and their derivatives and presents a real opportunity for an interesting and significant survey which might result not only in the prevention or reduction of occupational cancer but also lead to factual data as to the cause and control of cancer in general. Such a survey is planned as a part of the program of the Division of Cancer Control of the Pennsylvania Department of Health. One important need in the knowledge and control of occupational cancer is that physicians ascertain the entire occupational history of their patients, including any present or past carcinogenic occupational exposures.

TABLE II
LEADING CAUSES OF DEATH IN PENNSYLVANIA
1906-1946
(Rank at Ten-Year Intervals)

	1906*	1916†	1926	1936	1946
Heart disease	4th	2nd	1st	1st	1st
Cancer	7th	7th	4th	2nd	2nd
Cerebral hemorrhage ..	6th	6th	5th	3rd	3rd
Nephritis	5th	4th	3rd	5th	4th
Pneumonia (all forms)	2nd	1st	2nd	4th	5th
Tuberculosis (all forms)	1st	3rd	6th	6th	6th

So far as sex is concerned, cancer deaths for the year 1946, as noted in Table III, still show a somewhat larger number for females (7702) than for males (7074). However, in comparison with former years, the number of such deaths among males apparently is increasing at a greater rate than among females. Also to be noted is that for the two important decades of life, 55 to 75 years, the deaths among males (4221) outnumber those among females (4000). About thirty years ago a national authority said that "cancer is a disease of special interest to women." At least the figures for 1946 in Pennsylvania no longer support such a statement. As a matter of fact, while not relinquishing our efforts in regard to the prevention and control of cancer among women, we must give increasing atten-

tion to the problem as it relates to the male population.

Morbidity.—Based on the ratio suggested by the National Cancer Institute of five living persons with cancer to each annual death from the disease, 14,776 deaths in 1946 would indicate that upwards of 75,000 persons in this state are now suffering from this disease in its various stages. Who are they? Where are they? How adequate is the medical attention and follow-up they are receiving? What "precancerous" conditions may have preceded—and what steps might have been taken to prevent the development of malignancy? To locate or find these cases, and to bring all possible medical, nursing, and social services to bear on their early diagnosis, prompt and adequate treatment, and follow-up should be the prime objectives in Pennsylvania's cancer control program.

So far as finding and recording living cases is concerned, this has been stimulated by the Division of Cancer Control of the Pennsylvania Department of Health through the organization of a tumor record system in cooperation with hospitals and physicians. To date, 63 hospitals out of a possible 250 in the State which might be expected to report are now registering their cases with our Division. As of Dec. 31, 1947, there were 3638 living cases of cancer recorded in our Division for the previous year. Thus, while a good beginning has been made, we have a long way to go in knowledge of living cases. Recorded living cases are still far below recorded deaths, to say nothing of the goal of five living cases per annual death. It is hoped that such a Tumor Registry, in addition to the requirement that cancer be reported as a notifiable disease, eventually will result in obtaining the complete life history of the incidence and prevalence of cancer in the Commonwealth, and point the way

TABLE III
NUMBER OF CANCER DEATHS BY AGE AND SEX
IN PENNSYLVANIA—1946

Age Groups	Males	Females	Total
0-9	32	23	55
10-14	20	16	36
15-19	21	9	30
20-24	26	22	48
25-29	26	59	85
30-34	45	96	141
35-44	259	606	865
45-54	929	1297	2226
55-64	1961	1878	3839
65-74	2260	2122	4382
75 plus	1495	1574	3069
Total	7074	7702	14,776

* 1906—Diarrhea and enteritis—3rd (under 2 years).
† 1916—Diarrhea and enteritis—5th.

TABLE IV

NUMBER OF LIVING CASES* BY AGE AND SEX
IN PENNSYLVANIA—1947

Age Groups	Males	Females	Total
0-9	25	16	41
10-14	15	4	19
15-19	8	20	28
20-24	11	20	31
25-29	10	56	66
30-34	18	88	106
35-44	87	353	440
45-54	227	509	736
55-64	425	575	1000
65-74	444	377	821
75 plus	203	130	333
Unknown age	11	6	17
Total	1484	2154	3638

to a more comprehensive program of prevention and control.

As mentioned previously, there were 3638 living cases of cancer recorded in our Division during the year 1947. Thus, in addition to the foregoing analysis of cancer mortality, it is now possible to study these available records of cancer morbidity.

Table IV indicates the number of living cancer cases recorded in the Tumor Registry of the Cancer Division of the Pennsylvania Department of Health by age and sex for the year 1947. As indicated in Table III, covering cancer deaths in 1946, so also in Table IV showing the number of living cancer cases registered in 1947 the first significant increase occurs in the age group 35 to 44 years, which again emphasizes the need for concentrating educational and diagnostic efforts among early age groups.

Of interest is the fact that, of 3638 living cases registered, 2154 were females and only 1484 were males. Comparison of these figures with the total number of cancer deaths in 1946 for females (7702) and males (7074) shows that relatively more cases among women are being diagnosed and registered at the various tumor clinics. Women apparently have been made more "cancer-conscious" than men and are seeking earlier medical advice. Of importance also in this connection probably is the greater accessibility of female organs, such as the breast and uterus, to positive diagnosis. Of the 2154 cases among women, nearly 91 per cent were proven microscopically, while of the 1484 cases among men about 82 per cent were so proven.

In an analysis of the 3638 living cancer cases registered with the Division of Cancer Control in 1947, the primary sites involved showed the following percentages for males and for females: *Males* (1484 cases) — prostate and bladder 23.65; intestines and rectum 15.90; skin 15.09; stomach 7.01; others 38.34. *Females* (2154)—breast 29.85; uterus and cervix 26.83; intestines and rectum 10.12; skin 8.82; others 24.37.

As time goes on and more and more cases are registered with the Division of Cancer Control, it will be possible to study the records from the standpoint of such important data as occupation, time elapsing from first symptom to first physician visit, reasons for delay in diagnosis, and results of treatment. More knowledge of these factors will help point the way to our future programs of prevention and control of this disease.

Conclusion

We must admit that the battle against cancer—not only in Pennsylvania but throughout the United States—is now a major engagement of the first magnitude which must challenge the ability, active interest, and leadership of professional and lay workers and of official and voluntary organizations.

If we are wise, we will assume that the evidence at hand represents—at least in part—a real, actual increase in cancer. It is difficult to determine how much of the increase may be merely relative—due to such possible factors as better diagnosis, improved statistical records, increase in the average expectation of life at birth, with a greater percentage of people living in the older age groups and the control of other diseases with a lessened mortality, particularly in the early decades of life.

Our present-day cooperative efforts and programs in Pennsylvania aimed at prevention, early diagnosis, and prompt and adequate treatment through such media as (1) education of professional and lay groups, (2) statistical research based on better reporting and a well-organized central Tumor Registry, (3) fundamental laboratory research on cancer, (4) cancer detection services for apparently well persons, and (5) tumor clinics for consultation, diagnosis, and treatment must be promoted with utmost vigor and determination. Let us be optimistic enough to believe that the next ten or twenty years will show marked progress if not ultimate victory in our understanding and control of cancer in this Commonwealth!

* Registered with Division of Cancer Control.

Deaths from Selected Causes in Pennsylvania, March, 1948

County	All Causes, Excluding Stillbirths	Still- births	Infant Deaths	Maternal Deaths	Cancer	Heart Disease	Intra- cranial Lesions of Vascular Origin	Nephritis	Pneu- monia	Tuber- culosis
Adams	41	2	3	0	6	13	7	2	1	0
Allegheny *	1341	65	98	3	184	459	99	73	70	25
Armstrong	51	3	3	0	6	23	3	4	1	0
Beaver	115	3	6	0	18	37	8	11	3	2
Bedford	31	1	5	0	2	8	2	3	3	1
Berks *	251	6	4	0	21	104	25	11	3	8
Blair *	132	6	9	0	21	43	12	7	2	0
Bradford	66	3	5	0	6	33	3	5	1	0
Bucks	91	2	6	0	11	39	9	6	0	1
Butler *	71	4	10	0	2	23	11	3	2	2
Cambria *	184	14	18	1	16	76	14	9	9	2
Cameron	7	0	0	0	0	4	3	0	0	0
Carbon	50	0	3	0	8	14	8	4	1	0
Centre	53	5	3	0	1	20	1	2	3	0
Chester *	100	3	8	0	10	30	11	8	6	1
Clarion	24	1	2	0	2	13	2	2	0	0
Clearfield	67	1	4	0	12	20	6	2	5	0
Clinton	41	2	5	0	3	13	5	4	1	0
Columbia	48	3	2	0	6	20	4	1	0	2
Crawford	64	1	6	0	10	25	4	3	4	1
Cumberland *	71	1	4	0	9	24	9	1	0	1
Dauphin *	186	7	9	0	24	62	17	18	8	2
Delaware	260	8	11	1	37	87	31	13	9	4
Elk	38	0	3	1	4	11	5	3	3	0
Erie	173	8	12	0	28	61	19	10	4	4
Fayette	167	14	13	0	20	63	18	13	9	2
Forest	6	0	1	0	0	2	1	0	0	0
Franklin *	72	5	11	0	13	21	4	6	2	1
Fulton	5	0	0	0	1	3	0	0	0	0
Greene	42	1	3	0	3	11	6	6	1	1
Huntingdon	35	4	0	0	6	16	3	0	2	0
Indiana	41	4	1	0	6	13	3	1	2	1
Jefferson	40	4	2	0	5	10	6	4	1	0
Juniata	13	1	1	0	0	7	1	0	1	0
Lackawanna	276	8	19	0	40	106	28	7	9	5
Lancaster	180	8	12	0	24	61	20	8	7	5
Lawrence	81	2	5	0	12	26	6	5	1	0
Lebanon *	57	7	4	0	2	23	2	7	3	0
Lehigh *	191	11	8	0	27	70	11	9	5	2
Luzerne	346	19	21	1	30	126	26	26	16	10
Lycoming	104	5	6	1	13	45	8	10	1	1
McKean	39	3	2	0	4	11	7	3	0	1
Mercer	106	3	8	0	12	42	6	6	6	0
Mifflin	44	3	5	0	6	14	5	3	1	0
Monroe	35	2	4	0	6	9	4	3	1	1
Montgomery *	280	8	13	1	33	102	21	19	9	4
Montour *	30	1	3	0	4	8	4	1	1	2
Northampton	148	8	6	0	26	61	14	2	5	1
Northumberland	94	1	3	0	9	43	11	5	4	2
Perry	18	0	2	0	1	9	1	1	0	0
Philadelphia *	2149	34	96	3	359	810	136	148	86	75
Pike	5	0	0	0	1	3	0	0	0	0
Potter	15	2	0	0	0	9	1	0	2	0
Schuylkill	193	11	8	0	28	67	12	11	8	3
Snyder	20	0	2	0	3	10	3	0	1	0
Somerset *	69	2	4	0	10	19	13	4	7	1
Sullivan	6	0	0	0	1	1	1	1	0	0
Susquehanna	21	1	1	0	6	9	1	0	0	1
Tioga	35	2	2	0	4	17	4	0	0	0
Union	15	1	0	0	2	6	0	0	0	3
Venango *	63	2	4	0	21	20	4	3	1	1
Warren *	41	0	3	0	6	15	4	3	2	0
Washington	175	5	16	0	22	73	14	9	11	2
Wayne *	32	2	2	0	5	11	4	2	1	0
Westmoreland *	253	14	15	1	29	92	31	23	16	2
Wyoming	20	0	1	0	2	7	2	2	2	1
York	179	9	7	1	18	78	19	14	2	3
State and Federal institutions	318	0	1	0	24	87	13	8	23	73
State totals	9615	356	554	14	1291	3199	796	578	388	260

* Exclusive of deaths occurring in State and Federal institutions except general hospitals.

THE PENNSYLVANIA MEDICAL JOURNAL

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EDITORIALS

GENERAL PRACTITIONER ESSENTIAL TO PROPER PRACTICE OF MEDICINE

Dr. Arthur C. Christie, of Washington, D. C., in a splendid article* appearing in the August issue of *Medical Annals of the District of Columbia*, wisely sets the pattern for success in the general practice of medicine and then undergirds it with specific advice to layman and practitioner that will assure ever improving medical service to the public and professional success to the practitioner.

To the layman Dr. Christie counsels:

"The general practitioner is essential to the proper practice of medicine; his place cannot be taken by the specialist, the group, the clinic, or the hospital staff. If the people are to have constant medical care when they require it in their homes, the general practitioner will continue to carry about 80 per cent of the load. It is time for both the profession and the laity to be aware of his important place in the care of the sick and to institute measures, educational and otherwise, to assure him of adequate remuneration for his services. The solution of this problem will be found in the gradual elevation of the level of

professional ability among general practitioners so that they can perform services now too readily turned over to the specialist. As such improvement in general practice takes place a like improvement in the average level of ability of specialists will naturally follow, because the latter will become fewer in number and will really be men of extraordinary training and ability as they ought to be."

To the doctor of medicine ambitious to become a successful general practitioner, Dr. Christie advises:

"To continue his education throughout his active life. The habit of daily reading and study, the preparation of scientific papers, attendance at medical society and hospital staff meetings, and occasional postgraduate courses are as much a part of the physician's professional life as is his actual practice of medicine. His work must be organized with this in view. He must arrange with a colleague or must have associates to care for his patients in his absence. More than that, he must so manage his affairs as to be able financially to meet the demands of continuing his education in addition to providing for his other professional expenses and caring for his family. This is not to advise undue emphasis upon money-making but only that it is the doctor's duty to adopt good business methods in conducting his practice. By charging reasonable fees,

* EDITOR'S NOTE: Quotations are abstracted from a much more comprehensive lecture given in the orientation course for new members of the District of Columbia Medical Society, delivered on April 10, 1948, by Dr. Christie.

keeping a simple but adequate accounting system, and budgeting his income to allow for educational expenses, the great majority of physicians in this country can keep themselves abreast of the advances of medicine. Too much praise has been accorded to the doctor who is careless in his financial arrangements with his patients. It is probable that failure to send bills to patients is just as often due to the doctor's distaste for bookkeeping or to evasion of an unpleasant duty as to altruism."

To the general practitioner and the specialist jointly, Dr. Christie recommends:

"Consultations between general practitioners and specialists are important and should be more generally observed than is the present practice. Every reference of a patient to a specialist should be considered a consultation, at least to the extent that an adequate history of the case is furnished to the specialist and a written opinion with description of treatment, advised or instituted, sent promptly by the specialist to the referring physician. It is essential that doctors strive for a better integration of medical practice. When a patient seeks treatment by a specialist without reference from a general physician, the specialist is under obligation to discover if the patient has had a general medical examination and to obtain a report upon it as well as upon any special examinations which may have been made. The essential unity of medical practice must be emphasized in the minds of all concerned with the care of a patient so that each new procedure is carried out in the light of all that has preceded it."

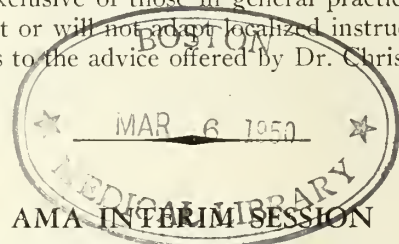
Reflecting his own optimistic philosophy of the professional career in medicine and offering reassurance to those who doubt complete realization, Dr. Christie offers:

"It is true that we are personally responsible for our own integrity and our own professional ability. Beyond that, it is a matter of cooperative and organized effort. You are called upon only to do your part, but nevertheless it is an important part and calls for the best that you can give. In giving it you will find a satisfaction beyond anything possible to one who devotes his energies solely to his own profit and pleasure. To those of you who feel that the idealism about which we have been talking has little relation to reality, let me quote a discerning statement of Carl Schurz; 'Ideals,' he said, 'are like stars; you cannot reach out and touch them, but like the mariner on the waste of waters with only the stars for his guide, you may accept your ideals as

guide and they will lead you to your destiny.' To you who are apprehensive about the future of medicine because of the threats of bureaucratic control, let me say that it is through our devotion to the ideals which we have been discussing today that we can prevent the loss of all that has made our profession great in the past. The broadening of our outlook to include the whole field of our responsibilities is a much better defense against undesirable governmental action than all of the objections that we can make. Let us at least, in the words of Washington, which I have already quoted, 'set up a standard to which the wise and the honest may repair. The rest is in the hands of God.'"

To doctors of medicine, be they in general practice or specializing, who are mere onlookers in the "cooperative and organized effort" Dr. Christie refers to above, it should be clear that Dr. Christie's objective has been to convert each from the rôle of idle spectator to that of an understanding observer, and finally to that of an active participant "giving always the best that you can give."

In Pennsylvania the State Medical Society is realistically and consistently taking to a total of 1103 subscribing physicians in ten centers throughout the State didactic graduate education facilities adequate to keep the ambitious and studious general practitioner abreast of medical progress. With, in addition, periodic county and state medical society programs, the JOURNAL, and bulletins, who can successfully refute this claim exclusive of those in general practice who have not or will not adopt localized instructional facilities to the advice offered by Dr. Christie?



Registrations and hotel reservations are now being accepted for the second annual Interim Meeting of the American Medical Association at St. Louis, November 30 to noon, December 3, 1948.

On the eve of the Interim Meeting, Saturday, November 27, the first national Medical Public Relations Conference will be held under sponsorship of the AMA at the Statler Hotel.

Planned to be especially valuable to the general practitioner, the Interim Session will offer lecture meetings, conducted by medical leaders on conditions most often seen in daily practice. Subjects to be discussed include diabetes, heart disease, cancer, poliomyelitis, obstetrics, pedi-

rics, dermatology, genito-urinary conditions, hypertension, anesthesia, tuberculosis, jaundice, laboratory diagnosis, x-ray diagnosis, and physical medicine as applied to the treatment of arthritis.

Diagnosis and treatment will be stressed in a wide variety of clinical conferences which will be correlated with the lecture meetings. Leading practitioners from all sections of the nation will conduct these conferences.

Evening programs will feature distinguished speakers, the award of the general practitioner medal, and fun. Entertainment will be provided, free of charge to physicians and their guests of course, by stars of the amusement world.

A scientific exhibit with nearly 100 displays will show clinical and pathologic material on subjects dealt with in the clinical conferences.

Approximately 115 leading firms will display technical exhibits, which will include new products, equipment, and medical publications. All exhibits will be open from Tuesday at 8:30 a.m. to Friday noon, November 30 to December 3.

Papers will be read at the general scientific meetings in the St. Louis Opera House from 9 to 10 a.m. and from 2 to 3 p.m. each day. At least six demonstration units are planned for each half day in the scientific exhibit from 10:30 a.m. to 12 noon, and from 3:30 to 5 p.m. Small rooms will be provided for these demonstrations and provision is being made so that physicians can take all the notes they wish in comfort.

Intermissions in the program will be from 10 to 10:30 a.m., 12 noon to 2 p.m., and 5 to 6 p.m. each day.

Officers and members of the House of Delegates will stay at the Statler Hotel. Those attending the Medical Public Relations Conference will stay at the Lennox Hotel.

A registration form which enables the physician to save time by securing a registration card in advance is appearing in *The Journal of the American Medical Association* every other week until the Interim Meeting. A convenient blank for making reservations at a number of St. Louis' best hotels, which are within easy walking distance of the St. Louis Auditorium, is also printed in *The Journal*.

All reservations must be cleared through the Chairman, Subcommittee on Hotels, American Medical Association, Hotel Reservation Bureau, 1420 Syndicate Trust Building, St. Louis 1, Mo., and must be received before Nov. 9, 1948.

ARMY MEDICAL DEPARTMENT WANTS DOCTORS

The Selective Service Act of 1948 states:

"No person shall be inducted until adequate provision shall have been made for medical care and hospital accommodations for such person."

The *New York Times* of August 12 observes that:

"In addition to the 3900 young medical doctors, the Army needs 1300 interns and resident physicians, or a total of 5200 medical graduates. For the proper care of 1,360,000 troops, the Army Medical Department has set its sights at 6900 doctors. It now has 3000 including interns. At least 450 veterinarians are needed for food inspection.

"There was no official announcement of the Army determination to seek the change in the Selective Service law, but officials cognizant of the problems of young doctors believed they should be on notice, however informally, of the inevitability of inducting large numbers of them."

THE AUTOBIOGRAPHY OF BENJAMIN RUSH

The Princeton University Press is publishing for the American Philosophical Society the autobiography of Benjamin Rush, edited by George W. Corner. This distinguished eighteenth century physician, who at the present time is so much in the minds of all Pennsylvania physicians, was the author of the first American textbook on psychiatry and introduced the modern method of smallpox vaccination into the United States. The Princeton University Press is a non-profit organization dedicated to the advancement of scholarship.

Deaths from Selected Causes in Pennsylvania, April, 1948

County	All Causes, Excluding Stillbirths	Still- births	Infant Deaths	Maternal Deaths	Cancer	Heart Disease	Intra- cranial Lesions of Vascular Origin	Nephritis	Pneu- monia	Tuber- culosis
Adams	40	1	3	0	7	15	4	2	1	1
Allegheny *	1257	65	81	2	207	417	104	69	52	23
Armstrong	64	3	4	0	7	22	4	9	3	3
Beaver	117	6	6	1	12	32	10	6	4	5
Bedford	29	0	1	0	3	8	4	4	1	9
Berks *	213	11	16	0	35	63	25	11	6	0
Blair *	136	9	14	0	14	58	13	9	2	0
Bradford	57	2	3	0	8	25	6	3	1	1
Bucks	94	3	4	0	7	38	10	8	5	0
Butler *	68	2	1	0	13	21	6	6	4	0
Cambria *	171	10	13	0	17	71	13	8	9	1
Cameron	0	0	0	0	0	0	0	0	0	0
Carbon	37	1	2	0	3	20	3	1	1	1
Centre *	75	3	7	0	12	18	6	5	4	0
Chester *	192	3	8	0	16	43	8	3	4	2
Clarion	25	0	1	0	2	7	4	5	1	0
Clearfield	61	1	3	0	9	27	4	3	0	1
Clinton	22	0	3	0	5	6	0	4	0	0
Columbia	48	2	3	0	5	18	3	2	1	1
Crawford	72	2	1	0	7	32	5	2	1	1
Cumberland	62	4	3	0	11	21	8	8	1	1
Dauphin *	182	6	12	0	28	58	16	14	4	3
Delaware	242	16	15	0	43	99	25	7	3	0
Elk	23	1	2	0	0	12	1	0	0	2
Erie *	180	10	9	0	30	72	15	5	6	3
Fayette	152	12	13	0	18	59	15	6	4	0
Forest	2	0	0	0	0	1	1	0	0	0
Franklin *	61	2	3	0	3	20	5	7	3	0
Fulton	7	0	0	0	1	3	0	1	0	0
Greene	29	0	2	0	5	11	1	0	2	0
Huntingdon	41	2	1	0	7	14	3	1	2	0
Indiana	54	3	8	0	3	18	4	2	2	2
Jefferson	44	4	4	0	3	16	7	5	2	0
Juniata	9	0	0	0	0	3	2	2	0	1
Lackawanna	277	11	15	0	40	104	26	9	10	11
Lancaster	192	3	10	0	30	67	21	10	6	3
Lawrence	73	4	3	0	9	28	7	0	2	2
Lebanon *	67	2	1	0	8	24	5	4	3	1
Lehigh *	182	13	11	1	26	69	17	4	3	9
Luzerne	316	13	8	0	50	107	29	20	9	6
Lycoming *	105	2	6	1	16	43	8	6	0	1
McKean	41	4	5	0	4	10	1	4	1	0
Mercer	85	6	4	0	12	33	9	7	3	2
Mifflin	40	2	5	0	2	16	2	3	3	0
Monroe	35	2	1	0	5	14	5	3	0	0
Montgomery *	274	9	14	0	29	103	21	20	9	10
Montour *	31	0	6	0	5	7	2	2	3	0
Northampton	118	9	5	0	25	51	7	4	1	3
Northumberland	104	2	7	0	10	37	8	8	2	5
Perry	21	0	0	0	2	8	5	3	1	0
Philadelphia *	1991	38	67	4	322	780	136	118	66	77
Pike	6	0	0	0	1	3	0	1	0	0
Potter	11	0	3	0	2	3	0	0	2	0
Schuylkill	197	7	7	1	24	67	15	12	11	3
Snyder *	10	1	0	0	1	5	0	2	0	1
Somerset	62	5	3	0	5	21	7	4	1	0
Sullivan	5	0	0	0	1	4	0	0	0	0
Susquehanna	23	0	0	0	3	8	5	2	0	0
Tioga	37	3	4	0	2	16	6	2	1	0
Union	27	2	0	0	6	11	3	3	1	1
Venango *	57	6	4	0	10	16	7	2	3	0
Warren *	36	1	3	1	7	11	1	4	3	0
Washington	170	12	9	0	20	64	14	19	7	1
Wayne	35	0	1	0	5	13	3	2	1	3
Westmoreland *	200	14	20	1	25	75	22	12	5	3
Wyoming	17	2	0	0	1	7	1	1	0	1
York	144	6	8	0	24	55	17	8	2	4
State and Federal institutions	242	0	1	0	17	62	17	4	18	60
State totals	9007	363	477	12	1290	3290	762	521	306	268

* Exclusive of deaths in State and Federal institutions except general hospitals.

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*

8104 Jenkins Arcade

Pittsburgh 22, Pa.

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State From What It Is to What It Ought to Be.

GRADUATE EDUCATION MUCH IN DEMAND

Once again the members of the medical profession in Pennsylvania have proved their interest and volunteered their support of postgraduate education. Of those doctors residing in small urban centers, one in every five has enrolled for the current program of the Committee on Graduate Education.

Registrations have outnumbered those of last year and presently total 1103. Total registration for each of the ten centers is as follows: **Allentown—166, Clearfield—49, Erie—62, Harrisburg—192, Johnstown—97, Lancaster—149, Oil City—55, Washington—86, Wilkes-Barre—123, Williamsport, 124.**

Do Not Delay—Do It Now

The Committee on Graduate Education will appreciate receiving your suggestions for subject material to be included in future sessions. Constructive criticism is always welcome.

WAKEN EVERY TOWN AND VILLAGE

Letter No. 75, dated Sept. 20, 1948, from George F. Lull, M.D., secretary and general manager of the American Medical Association, is herewith abstracted:

DEAR DOCTOR:

With all the confidence of a boy whistling past a graveyard, Federal Security Administrator Ewing recently laid his new multi-billion-dollar health program, including compulsory sickness insurance, before the President and the American people.

Many of you, no doubt, read an abstract of his report in the newspapers. Ewing urged that subsidies for medical facilities by federal, state, and local governments be boosted to 4.1 billion dollars by 1960, or more than double the present yearly outlay of 2 billions. The proposed subsidies do not include costs of compulsory sickness insurance, which would add more billions to the taxpayers' bills. One can't help but wonder if there

isn't ever going to be an end to huge government spending.

Mr. Ewing, painting a rosy picture, devoted 52 pages of his 186-page report to demands for compulsory sickness insurance. After reading the report, one gets the impression that the government this time is really going to give the people something for nothing. But, as we all know, this is never true because every dollar which the government uses comes from the pocketbook of the American taxpayer.

Mr. Ewing's report, well written and cleverly presented, was packed with government health statistics. Many of these statistics couldn't help but lead the average person to believe that the health of the nation is deteriorating and that the health of the American people as a whole is terrible. Actually, many of the statistics are so general in their scope that they are misleading and, in many cases, are not supported by scientific fact. The report, for example, says that "every year 325,000 people die whom we have the knowledge and the skills to save." If the 40,000 deaths from accidents, included in this figure, are subtracted, this leaves only 285,000 that can conceivably be attributed to medical causes. Even this figure, medically speaking, is a broad statement and bears far more explanation than Mr. Ewing has given in his report. Man, it is true, possesses an infinite hope to live forever, but doctors cannot assure eternal life. For everybody pain comes too often and death comes too soon.

Of course, he would toss in the same old chestnut: "The record of Selective Service examinations during the war is widely known—5,000,000 men declared unfit physically or mentally for the armed services of their country." These figures are false. Certainly, Mr. Ewing must have read Dr. Maurice H. Friedman's *Reader's Digest* and the *Nation's Business* articles on Selective Service figures. The Brookings Institute report also disproves them.

While I have no intention of making a critical analysis of the Ewing report, since this will be done in a forthcoming issue of the *Journal AMA*, I can't help but notice certain discrepancies. In his foreword, for instance, Mr. Ewing stresses the "invaluable service" which the National Health Assembly performed in helping "to supply the substance of this report." Yet, 18 pages later, he says:

"I am compelled to urge, as strongly as I know how, that the Congress enact, as President Truman has recommended, a system of government prepayment health insurance. . . . No agreement was reached at the National Health Assembly with respect to national health insurance and hence this recommendation is not based on any action of the Assembly."

In other words, Mr. Ewing brushed aside the recommendations and wishes of more than 800 health leaders, who took no official action on any form of compulsory sickness insurance, and substituted his own to conform with New Deal ideologies.

AMA headquarters people had the following personal opinions of the Ewing report:

JOHN L. BACH, Press Relations: "Mr. Ewing's facts can be recognized as true only when committees and subcommittees in every town and village in the country have sat on them; when ample inquiries have been made; when the facts have been denied and reasserted; when they have been discussed again and again in the temples of medicine; when they have weathered many a heated debate in Congress—then only, at long last, after months or years, will anything so entangled and costly as socialized medicine be passed on to the American people."

DR. ERNEST B. HOWARD, Assistant Secretary: "Oscar Ewing's report, a deliberately misleading propaganda pamphlet based on untenable statistical data and appealing directly to the emotions, is the most clever broadside yet made by the small but adept political-bureaucratic group which hopes to convert America's free institutions to socialistically controlled puppets via compulsory sickness insurance."

DR. AUSTIN SMITH, Council on Pharmacy: "Like most of the statements emanating from proponents of socialized medicine, Mr. Ewing's report contains a plea for the saving of lives that cannot be saved solely by planning for controlled hospital and research facilities. He overlooks the fact that some illnesses and deformities cannot be prevented and that people will die anyway, even if solely from old age."

Physicians in every town and hamlet must organize to defeat the growing menace of socialized medicine in the United States, Dr. Ernest E. Irons, Chicago, president-elect of the American Medical Association, told the fourth annual National Conference of Professions in Chicago recently. The two-day conference, sponsored by the National Physicians' Committee, was attended by delegates from every state in the Union. The total registration was 284.

"Not one doctor in twenty has an adequate understanding of the socialized medicine threat to our democracy," Dr. Irons said in addressing a conference luncheon, September 7. He called the effort to legalize state medicine "an attempt to wreck democracy under the guise of governmental beneficence," adding:

"Successful opposition to it must be carried out on the county medical society level. It is not sufficient to fight only on the national or even the state level."

* * *

Harold Russell, the handless war veteran who won two Oscars in 1947 for his rôle in "The Best Years of Our Lives," lunched with a group of AMA people and Chicago health leaders recently.

Dr. Carl Peterson, secretary of the AMA Council on Industrial Health, and the Public Relations department called the group together, and exchanged views with Russell for more help for civilian amputees.

"During the second world war there were 17,000 amputations on account of direct war service," Russell said. "In the same period, as a result of accident and disease, there were 170,000 amputations."

Russell, his wife, and five-year-old son visited AMA

headquarters, posed for pictures which appeared in some newspapers, and discussed plans for launching a civilian rehabilitation center in Chicago.

* * *

Will C. Braun, business and circulation manager of the American Medical Association for fifty-four years, died at age 80 in Presbyterian Hospital, Chicago, on Sunday, September 12. Death was due to uremic poisoning. Mr. Braun retired as business manager of the AMA in July, 1946.

* * *

The proceedings of the third National Conference of County Medical Society Officers have been prepared in a 42-page booklet, which may be obtained from the AMA Council on Medical Service. The conference was held during the annual AMA session in Chicago in June. Dr. A. M. Mitchell, conference chairman, has announced that the fourth annual conference will be held during the AMA session in Atlantic City next June.

HIGH COURT FIGHT WON BY DOCTOR

Dr. Henry Junius Schireson, jailed in Pittsburgh in 1912, today had won a split decision by the Pennsylvania Supreme Court, restoring his medical license.

The license was revoked by the Dauphin County Court in May, when Dr. Schireson, who has been practicing in Philadelphia, appealed a decision of the State Board of Medical Education and Licensure on Aug. 22, 1947.

Today's Supreme Court ruling, signed by Justice James B. Drew, reversed the Dauphin County Court, called the evidence presented by the medical board "weak and inconclusive," and said that the alleged fraud has not been proved.

The board decided that Dr. Schireson had obtained his license in 1910 by "fraud, misrepresentation, and deception."

Justice Drew's opinion said:

"On the evidence presented it would be grossly unjust to revoke the appellant's license to practice in his chosen profession and thereby deprive him of his means of livelihood."

A dissenting opinion was filed by Justices William B. Linn, Horace Stern, and Allen M. Starnes.

In 1912 Dr. Schireson was sent to the Allegheny County Workhouse for ten months for allegedly fleecing patients in his plastic surgery clinic in Smithfield Street.—*Pittsburgh Sun-Telegraph*, Oct. 28, 1948.

FIVE-MINUTE MICRO-BLOOD SUGAR TEST WITH SIMULTANEOUS URINE SUGAR TEST

TO: The Physicians of America

SUBJECT: "Diabetes Detection Drive"

The finding of the million unknown diabetics in this country poses a direct challenge to the American doc-

tor. It is within his power to accomplish this feat. The existence of a million undiscovered diabetic patients in the United States has been demonstrated through a series of surveys, the most recent one conducted by the United States Public Health Service. The results of these studies now provide a springboard for organized medicine and a golden opportunity for physicians to seize the initiative *on their own* in this significant phase of public health.

The American Diabetes Association has planned a campaign to promote the early discovery and prompt treatment of the million undiscovered cases of diabetes. This campaign is unique in professional service, for according to plan the physician himself will be at the helm. Therefore, the plan cannot be prosecuted, or even started, without the endorsement and support of the entire medical profession through its governing bodies—national, state, county and local medical societies.

The plan proposed by the Association is simple, direct, and sure. Through local diabetes associations, related to the American Diabetes Association and with cooperation of local, county, and state medical societies over the United States and Canada, it is planned to carry out blood-sugar screening tests by a new five-minute micro-blood sugar method with simultaneous urinalysis for sugar with attention to the time in relation to the preceding meal. The procedure can be carried out apart from a formal laboratory. The equipment is still in the manufacturers' hands, but is to be available within two or three months. The only provision will be that the candidate must name a physician or clinic to which the results of the tests will be mailed for interpretation to the patient. *Under no condition* will a report be sent directly to the examinee. The effort is to bring the unknown diabetic patient under his own physician's care. There will be no statistics; no red tape.

Simultaneously, the American Diabetes Association will carry on an intensive educational campaign directed first toward doctors' postgraduate courses. It will be directed toward the layman by radio, newspapers, and other publicity channels in addition to the "A.D.A. Forecast," the Association's bi-monthly magazine, which brings to the diabetic patient home-spun articles on the disease by eminent authorities in the field. At the same time the Association will place in the hands of physicians over the country an authentic "Handbook of Therapy." Containing the most up-to-date information available, the handbook will assist the physician in treating diabetic patients.

The week of December 6-12, immediately following the interim meeting of the American Medical Association, will be proclaimed as "Diabetes Week." This will be the formal beginning, the kick-off, of the Association's Diabetes Detection Drive. From this start, the program will continue on a long-term basis.

The Association is determined to do its part in finding these million individuals and guiding them to you, their physicians, for treatment. May we count on your support when the matter comes up before your county or local medical society? The success or failure of the Diabetes Detection Drive depends upon you. *You* stand at the helm; this is *your* project.

Sincerely yours,

HOWARD F. ROOT, M.D., *Chairman,*
Committee on Diabetes Detection,
American Diabetes Association, Inc.,
81 Bay State Road,
Boston, Mass.

VETERANS ADMINISTRATION NEEDS PHYSICIANS

WALTER F. DONALDSON, M.D., *Secretary,*
The Medical Society of the State of Pennsylvania.

The Veterans Administration office, Wilkes-Barre, Pa., has several vacancies for physicians who are interested in immediate appointment as Rating Specialist, Medical, P-5, \$6,235.20 per annum. The salary is based on the standard Federal work week of forty hours, Monday through Friday. Applicants should not be over 62 years of age. However, this age limit does not apply to applicants entitled to veterans' preference.

The duties of such a position are to review evidence on compensation and pension claims, be responsible for the interpretation of the medical aspects of questions presented and of rating schedules, determine the competency of the evidence and of the sanity or incompetency of the claimant, and physical examinations may be made.

Interested physicians can secure further information on these positions by telephoning the undersigned at Wilkes-Barre 3-1131, extension 275, or by visiting this office.

Your cooperation will be appreciated.

B. BARNEY PALMER, Personnel Officer,
19 N. Main St.,
Wilkes-Barre, Pa.

Sept. 29, 1948

PHYSICIAN VACANCIES

Dr. Joseph A. Gilmartin,
Chairman, Child Health Committee,
The Medical Society of the State of Pennsylvania.

DEAR DR. GILMARTIN:

We would appreciate any assistance you could give in our quest for a resident staff at this school. We at present have positions open up through and including Senior Assistant Physicians A and B. The qualifications for these positions as outlined by the Department of Welfare are as follows and the term "psychiatry" in my interpretation, which I think would be substantiated by the Department of Welfare, must mean psychiatry and/or mental deficiency. Inasmuch as there is no certification for mental deficiency as such today, I believe that the qualifications required for Senior Assistant Physician A are largely invalid and a suitable individual would be accepted and approved by the Department who had good basic understandings of mental deficiency.

Assistant Physician B: Graduate of class A medical school, approved internship, and licensed to practice medicine in Pennsylvania.

Assistant Physician A: In addition to the above, a minimum of one year's experience in psychiatry under supervision approved by the "Bureau."

Senior Assistant Physician B: In addition to qualifications required for Assistant Physician B, a minimum of three years' experience in psychiatry under supervision approved by the "Bureau."

Pathologist-Roentgenologist: In addition to qualifications required for Assistant Physician B, and one year

of experience in his special field, a physician recognized, respectively, in pathology or roentgenology, by experience, training, and membership in a professional organization of pathologists or roentgenologists approved by the "Bureau." Certification of the candidate is optional, but not required.

Senior Assistant Physician A: "Certification" in psychiatry and/or neurology.

	Salary	
	Minimum	Maximum
Senior Assistant Physician A	\$6,300	\$6,900
Senior Pathologist	6,300	6,900
Senior Roentgenologist	6,300	6,900
Senior Assistant Physician B	5,100	6,000
Pathologist	5,100	6,000
Roentgenologist	4,500	4,800
Assistant Physician A	4,500	4,800
Assistant Physician B	3,900	4,200

General Conditions

1. The value of maintenance to be furnished to candidates employed under the above conditions, and to persons presently employed who qualify and are reclassified under the above classifications, shall be fixed at \$1,200 per year for full maintenance. The maintenance allowance for all other professional medical employees shall remain subject to maintenance allowance as now prescribed by the Executive Board.

2. Leave of absence for three months may be allowed in every third year of service for postgraduate work in a field approved by the Bureau. During such absence with leave, salary, expenses, and tuition shall be paid. Such leave of absence shall be subject to regulations to be hereafter prescribed by the Department of Welfare.

3. In addition, fifteen days' leave of absence with salary within each calendar year, and the equivalent of thirteen legal holidays with salary are permitted.

If you are by any chance able to find anyone who might be interested, I would be more than pleased to go into whatever negotiations are necessary. We want to keep the medical staff of high caliber and active and for that reason are not much interested in individuals with severe character defects or individuals much over 60 years of age.

GALE H. WALKER, M.D., *Superintendent*,
Polk State School,
Polk, Pa.

June 21, 1948

DEAR DR. GILMARTIN:

I appreciate very much your letter of September 7 suggesting that we advertise in *THE PENNSYLVANIA MEDICAL JOURNAL*, *Journal of the AMA*, *Journal of Pediatrics*, *American Journal of Diseases of Children*, and in some of the county medical society monthly bulletins our need for additional physicians on our medical staff.

At the present time we have vacancies for three physicians, the salary range of which is \$4,950 to \$5,280, with a deduction of \$1,200 annually for full family maintenance. We can offer only apartments at the present time, since all of our residences are occupied. Family maintenance includes meals, furnished apartment, laundry, linen, and maid service. The duties are largely those of general practice and pediatric practice. The hours are from 8:30 to 4:30 and the physicians take turns acting as medical officer of the day from 4:30

p.m. to 8:30 a.m. They have a day and a half each week off duty. There are two weeks' vacation a year with pay; two weeks' sick leave, if ill; and thirteen legal holidays. Our institution, as you know, is similar to Polk, being for feeble-minded cases which are uncomplicated by a psychosis.

With much appreciation, I remain

Sincerely yours,

JAMES S. DEAN, M.D., *Superintendent*,
Pennhurst State School,
Spring City, Pa.

Sept. 10, 1948

THE CANCER COORDINATING PROGRAM

Pennsylvania Cancer Bulletin No. 1, Sept. 24, 1948

This bulletin is the first of an expected series which will be forthcoming from the coordinated agencies fighting cancer in the Commonwealth of Pennsylvania. The purpose of it is to inform interested groups and individuals as to the progress which is being made in the fight against the nation's No. 2 killer.

Our mailing list is not complete, and if you have any suggestions as to who should receive these bulletins, please forward the names and addresses to Staff Secretary to the Committees, The Medical Society of the State of Pennsylvania, 230 State St., Harrisburg, Pa.

At the present time we are mailing copies to the following: (1) members and ex officio members of the Commission on Cancer and the Board of Trustees of The Medical Society of the State of Pennsylvania; (2) chairmen of the committees on cancer of the county medical societies; (3) executive directors and boards of directors of the Pennsylvania and Philadelphia Divisions of the American Cancer Society; (4) presidents of county units of the American Cancer Society; and (5) secretary or executive secretary of each state medical society.

Foreword

The following statement of a basic coordinated program of cancer control in Pennsylvania has been approved by the several agencies in the State concerned with the problem. These include the State Department of Health, the Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

The initiative for this step forward came from the Commission on Cancer in November, 1947, when the idea of a Coordinating Committee representing the four agencies was developed and put into action. This committee presented its original report on Feb. 1, 1948. This report, slightly amended, has subsequently been approved by all agencies. Much of the program has been in effect for some time; many of the items are in the process of development in one or another of the agencies. So far as is possible, the coordinating effort will be continued both at the state and district levels.

Seven Problems of Cancer Control in Pennsylvania

- I. Lay Education.
- II. Professional Education.

- III. Diagnosis and Treatment of Cancer.
- IV. Statistical Program.
- V. Research Program.
- VI. Organization.
- VII. Campaign for Funds.

Various phases of the above problems have been delegated to each agency. How responsibilities have been assigned by the Coordinating Committee is shown in the following outline:

- I. *Lay Education*—primarily a function of the American Cancer Society.
 - A. American Cancer Society—prepare, execute, finance.
 - 1. Publications.
 - 2. Releases for magazine, newspaper, radio, speech, placard, poster, and other educational media.
 - 3. Information centers in urban communities.
 - 4. Health education re cancer in secondary schools and colleges.
 - 5. Addresses or talks to lay groups by physicians or trained personnel.
 - B. Commission on Cancer.
 - 1. Provide basic material for A.C.S.
 - 2. Review material for facts, ethics, and good taste.
 - 3. Provide speakers through speakers' bureaus.
 - C. State Department of Health.
 - 1. Provide basic statistical material for A.C.S.
 - 2. Provide honoraria for medical speakers before lay audiences.
- II. *Professional Education*—primarily a function of the Commission on Cancer. A need for improved education of the profession in early diagnosis and treatment of cancer. May be subsidized by grant from the American Cancer Society or the State Department of Health.
 - A. Commission on Cancer—state-wide.
 - 1. Publications in PENNSYLVANIA MEDICAL JOURNAL—articles, editorials, notes.
 - 2. Specific cancer material, such as "How Your Doctor Detects Cancer," for distribution to all practicing physicians.
 - 3. Annual state convention, symposia, addresses, movies, exhibits.
 - 4. Graduate education institutes throughout the State.
 - 5. Graduate refresher courses at medical centers.
 - 6. Postgraduate fellowships in pathology and other basic training related to cancer.
 - 7. Undergraduate training in oncology, with development of departments of oncology in each medical school.
 - 8. Internship training in oncology, with emphasis on attendance at detection and tumor clinics.
 - 9. Support of the Wainwright Tumor Clinic Association.
 - Commission on Cancer—county.
 - 1. Publications in county bulletins—short items at frequent intervals.
 - 2. County meetings—provide speakers, movies, and exhibits, preferably in April; en-

courage local participation in addition to an invited speaker.

- 3. Graduate education institute in county.
- 4. Attendance at tumor clinics.
- B. American Cancer Society.
 - 1. Provide financial assistance by outright grant.
 - 2. Provide factual material.
- C. State Department of Health.
 - 1. Provide financial assistance by outright grant.
 - 2. Provide factual material.
 - 3. Train public health nurses, statisticians, and social workers in re cancer.
- III. *Diagnosis and Treatment of Cancer*—primarily a function of the Commission on Cancer. Detection centers, tumor clinics, hospital and office facilities may be subsidized by grants from the American Cancer Society or the State Department of Health.
 - A. Commission on Cancer.
 - 1. Detection examination of the well person in the offices of physicians interested in the problem, and in the detection centers to be developed in all urban communities, as a county medical society or hospital staff project, and subject to social service.
 - a. Recommend basic principles: scope, ethics, finance, personnel required and available.
 - b. Inspect and recommend for registry.
 - 2. Tumor Clinic—to be developed in all urban communities, as a county medical society or hospital staff project, and subject to social service.
 - a. Recommend basic principles: scope, ethics, finance, personnel required and available.
 - b. Inspect and recommend for registry.
 - 3. Added factors in management of clinical cancer.
 - a. Analyze and recommend re distribution and availability of diagnostic and therapeutic facilities in hospitals and offices; and personnel for tumor management—pathology, radiology, general and specialty surgery, medicine, general practice.
 - B. American Cancer Society.
 - 1. Provide financial assistance by outright grant for detection examinations in detection centers.
 - 2. Provide financial assistance by outright grant to such tumor clinics as are approved by the Commission on Cancer.
 - 3. Provide money by grant for transportation and home nursing care of cancer patients.
 - C. State Department of Health.
 - 1. Provide financial assistance by outright grant to tumor clinics approved by the Commission on Cancer for capital investment and for current operation.
 - 2. Collect and analyze statistics of all detection and tumor clinics and of office detection examinations.
 - 3. Collect information re diagnostic and therapeutic facilities and personnel, and recommend grants for correction.

- IV. *Statistical Program*—primarily a function of the State Department of Health.
- A. State Department of Health.
 1. Collect statistics re cancer incidence, morbidity, and mortality.
 2. Develop tumor registry: proved cases and cases not proved.
 - B. Commission on Cancer.
 1. Review statistics; analyze and report re delay in diagnosis and treatment (state-wide and county-wide).
- V. *Research*—primarily a function of the Commission on Cancer. May be subsidized by grant from the American Cancer Society or State Department of Health.
- A. Commission on Cancer.
 1. Recommend and review projects re research in cancer.
 - B. American Cancer Society.
 1. Provide outright grant of money for county level projects approved by the National Research Council.
 - C. State Department of Health.
 1. Provide outright grant of money for projects approved by the Commission on Cancer.
- VI. *Organization*—all agencies at state, district, and county levels and coordinating committees at state and district levels.
- A. Commission on Cancer, appointed by the president of The Medical Society of the State of Pennsylvania.
 1. Membership
 - a. Appointments should be staggered on a three-year basis, so that not more than one-third are retired in any one year.
 - b. There should be one or more from each councilor district.
 - c. There should be one or more from each medical school in the State.
 2. Committees: members of the state cancer coordinating committee, program, professional education, cancer detection, tumor management, research, and publication committees.
 - B. Division of Cancer Control, State Department of Health. The Chief shall be a physician trained in oncology.
 - C. American Cancer Society.
 - D. State Cancer Coordinating Committee of all agencies, made up of 3 members from the Commission on Cancer; 1 member, the Chief, Division of Cancer Control, State Department of Health; 2 members from the American Cancer Society, Pennsylvania Division; 2 members from the American Cancer Society, Philadelphia Division.
 - E. District Cancer Coordinating Committee, made up of district representative, Commission on Cancer; district medical councilor, American Cancer Society; district lay councilor, American Cancer Society; the chairmen of Cancer Committees of component county medical societies; captains and presidents of units of American Cancer Society.
- VII. *Campaign for Funds*—primarily a function of the American Cancer Society.

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since July 31. Figures in first column indicate county society numbers; second column, State Society numbers.

Aug. 1	Clarion	25	10342	\$7.50
	Mercer	86	10343	7.50
11	Luzerne	370-371	10344-10345	30.00
	Philadelphia	3113-3127	10346-10360	217.50

CHANGES IN MEMBERSHIP OF COUNTY SOCIETIES

New Members (5)

CLARION COUNTY: Thomas J. Ritter, Clarion.

MERCER COUNTY: Joseph H. Bolotin, Sharon.

PHILADELPHIA COUNTY: Samuel R. Moore, Jr., Philadelphia.

YORK COUNTY: John James Angelo and DeArmond J. McHenry, York.

Resignations (1), Deaths (15)

ALLEGHENY: *Deaths*—Harvey B. Speer, Coraopolis (Univ. Pgh. '03), August 5, aged 74; Harry W. V. Beals, Mayview (Temple Univ. '37), June 22, aged 38; Emmett D. Carmalt, Pittsburgh (Hahn. Med. Coll. '26), August 24, aged 54; Maurice E. Harwood, Pittsburgh (Univ. Pgh. '36), July 17, aged 44.

ARMSTRONG: *Death*—Howard M. Welsh, Leechburg (Univ. Pgh. '02), July 18, aged 74.

CHESTER: *Resignation*—Philip F. White, Rockingham, N. C.

CRAWFORD: *Death*—John Martin Kinnunen, Meadville (Univ. Pa. '31), July 9, aged 44.

FAYETTE: *Death*—Harvey B. McGarrah, Fairbank (Balt. Med. Coll. '93), August 24, aged 82.

LACKAWANNA: *Deaths*—F. Whitney Davis, Chin-chilla (Jeff. Med. Coll. '98), July 31, aged 74; Bruce G. Hamlin, Scranton (Hahn. Med. Coll. '00), July 30, aged 67.

LANCASTER: *Death*—Newton E. Bitzer, Lancaster (Univ. Pa. '98), August 15, aged 75.

MONTGOMERY: *Death*—Angelo A. Gallo, Pottstown (Hahn. Med. Coll. '26), August 14, aged 49.

PHILADELPHIA: *Deaths*—Edgar B. Clark, Philadelphia (Meharry Med. Coll. '28), August 15, aged 47; Edw. Roland Snader, Philadelphia (Hahn. Med. Coll. '21), August 7, aged 53; T. Turner Thomas, Philadelphia (Univ. Pa. '95), August 4, aged 82.

WARREN: *Death*—Erwin S. Briggs, Warren (Jeff. Med. Coll. '06), August 18, aged 71.

More than 3500 veterans from World War I are carried on Veterans Administration rolls as amputees (loss of hands or feet or both).

HAVE YOU USED THE PACKAGE LIBRARY SERVICE?

Have you taken advantage of the facilities offered by the package library of The Medical Society of the State of Pennsylvania? Over 95,000 reprints are now filed in the library for your use.

Prior to 1944 the average yearly number of requests was approximately 350. However, from 1944 to 1947 inclusive, there has been a continuous increase in usage. There were 899 requests filed during 1947, an increase of 196 requests over the total for 1946. During the first eight months of this year there have been 784 requests.

A package of reprints will be sent immediately for a loan period of two weeks to any member of the State Society. There is a charge of 25 cents for each subject requested to cover postage and part of the expense of collecting the material. Send requests to the Librarian, 230 State St., Harrisburg, Pa.

Subjects requested between August 1 and August 31 were:

Multiple myeloma
Prefrontal lobotomy
Orbital lobotomy
Skin temperature
Transorbital lobotomy
Cancer clinics
Alcoholism
Lichen urticatus
Rh factor
Postoperative uremia
Eye diseases
Procaine toxicity
Pancreatitis
Periarteritis nodosa
Boeck's sarcoid
Obstetric problems
Lupus erythematosus
Recurrent peptic ulcer
Antibiotics
Nephropexy
Parkinsonism
Foot and leg ulcers
Socialized medicine

Hamsters
Blood sedimentation
Pulmonary tuberculosis
Medical ethics
Diabetic diets
Barbiturate poisoning
Dysmenorrhea
Enuresis (2)
Arthritis
Cost of medical care
Medical economics
Cystitis
Vernal conjunctivitis
Trichomonas vaginalis
Depressants
Cold pressor test
Child welfare
Hypotension
Streptomycin
Physical examinations
Hypnosis
Obstetrics
Use of thyrothricin

Treatment of volvulus
Congenital deafness
Use of potassium
Vitamin P
Enzymes
Serum amylase test
Secretin
Glutamic acid
Homosexual disorders
Bacteriology
Infectious hepatitis
Heparin
Use of dicumarol
Fractures of the maxilla
Rhabdomyoma of the heart
Dupuytren's contracture
Technique of myelography
Pennsylvania Occupational Disease Act
Treatment of osteogenic sarcoma
Treatment of carcinoma of the cervix
Treatment of poliomyelitis (3)
Treatment of multiple sclerosis
Medical and dietary treatment of hypertension
Medical management of peptic ulcer
Abnormalities and deformities
Use of ultraviolet irradiated blood
Obstruction of the intestines
Pregnancy complicating diabetes
Jaundice in cirrhosis of the liver
Use of bronchoscopy in allergy
Therapy of varicose veins
Carcinoma of the larynx
Trichomonas infection in the male
Gastric and duodenal ulcers
Surgical management of hypertension
Hemologous serum jaundice
Spontaneous pneumothorax
Physiology of respiration
Penicillin in treatment of syphilis
Intestinal disorders in infants
Treatment of alcoholism
Sympathetic nervous system
Lobotomy for nervous and mental disorders
Drugs used for motion sickness
Teroprotein in the treatment of cancer
Urinary specific gravity
Atomic energy in medicine
Pressor drugs used in spinal anesthesia
X-ray therapy of Marie-Strümpell disease
Inflammation of the urethra
Rheumatoid arthritis
Health services in Great Britain
Internship in Pennsylvania hospitals

ARE "EASTERN DOCTORS SUCKERS"?

Pennsylvania physicians who see more patients in dispensary service than they do in private practice should be interested in reading "An Answer to Tommy Britain" appearing on page 70, this issue.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the co-operation of the Pennsylvania Tuberculosis Society
and The Medical Society of the State of Pennsylvania

IN the war against tuberculosis the mass x-ray survey may well be considered as a reconnaissance undertaken to discover where the enemy is hidden, so that practicing physicians in the area may attack the disease most effectively. It is upon their efforts, supplemented by services within the community and reinforced by public awareness of the problem, that success or failure in the control of tuberculosis depends.

THE COMMUNITY AS A FORCE IN THE CONTROL OF TUBERCULOSIS

Modern epidemiologic methods in the control of communicable diseases make it imperative for workers in the field to know where, when, who, and how many any given disease attacks. The swiftest and most efficient way to the heart of this problem in the field of tuberculosis is through x-ray surveys of large population groups, preferably those which compose large metropolitan areas. These present all manner of social complexity, racial variation, and economic resources.

At the beginning of organized control movements, it was believed that the most effective means of discovering the exact nature of the tuberculosis problem in the United States was through surveys of industrial, occupational, and racial groups. However, the knowledge thus secured was at best spotty and was likely to be misleading when the whole population of the country was considered. It was thereupon determined to delve into those vast reservoirs of human beings which are our great cities. Here are all the maladies that are suffered by mankind. Through a prompt discovery of the tuberculosis problem in the larger cities of our country, a reasonably exact knowledge of the extent of the problem could be realized, public action stimulated, and professional forces joined.

City-wide x-ray surveys can be conducted with relative economy of means and money. Concentration of personnel, machinery, and educational devices within densely populous communities provides, in certain respects, quicker and more valuable results than do studies conducted in sparsely settled areas. Previous expe-

rience in cities already surveyed indicates that if present facilities are fully utilized, the increased case load of tuberculosis will not present a grave problem to the community. Seventy per cent of all new cases discovered by mass x-ray survey are minimal and do not constitute a grievous public health problem. Most of these cases will be noninfectious; the disease process will be incipient; and the probability of serious progression, with adequate follow-up, will be slight. Such cases can be cared for by private physicians and public clinics, assisted by public health nurses and medical social workers. Sanatorium beds now occupied by noninfectious cases can be given over to far-advanced virulent disease which constitutes a menace to the local population.

Minimal, noninfectious cases are private physicians' cases, not sanatorium cases. The private practitioner can be a major force in the future control of tuberculosis in the communities of our country if he participates in follow-up activities after the survey has been completed. Through his efforts, minimal tuberculosis can be checked and, in individual cases, never become serious. Under the physician's care, needless distress and tragedy can be avoided. As a consequence of his vigilance, the general practitioner can reduce measurably the occurrence of deaths from tuberculosis.

Often communities can afford to enlarge present clinic and hospital facilities when they cannot afford to build new institutions. Recruiting professional personnel is always a serious problem everywhere. However, resolute efforts to procure and then train professional workers will



constipation due to inactivity

IN CONVALESCENCE . . . SENESCENCE

The inactivity following surgery or disease, and often encountered in the aged, makes constipation a likely occurrence. Dehydration, too, frequently is a significant contributing factor.

When the "smoothage" of Metamucil is employed in the management of constipation, normal evacuation is permitted without irritation or undue pressure on sutures and incisions. Thus straining is minimized.

Metamucil promotes smooth, normal evacuation by furnishing a non-irritating water-retaining colloidal residue in the large bowel.



METAMUCIL® is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%), as a dispersing agent.

RESEARCH IN THE SERVICE OF MEDICINE

SEARLE

be productive of fruitful results in the future.

An aroused community makes for organized action. An informed community acts collectively as a social weapon against any threat to its existence. A community aware of the problem confronting it and organized for effective action is the principal force in a program to control tuberculosis. Isolated leaders and their followers, no matter how well trained or how profoundly dedicated, have little potency without the strength inherent in the human and eco-

nomie resources of mobilized communities. By now it must be plain that the fight against tuberculosis is a social and economic movement as well as a disease problem. We now have enough information to be confident that an awakened unawareness of the people is the chief tool for triumph.

The Community as a Force in the Control of Tuberculosis, Francis J. Weber, M.D., Editorial, Public Health Reports, September 5, 1947.

DISINFECTANT ON HANDKERCHIEFS MAY HELP TO KEEP COLDS FROM SPREADING

Using a disinfectant on handkerchiefs might be one step toward preventing the "common cold" from spreading, according to the London correspondent of *The Journal of the American Medical Association*, writing in the February 28 issue.

Reporting on a lecture by Dr. C. H. Andrewes, F. R. S., of the National Institute for Medical Research, on recent research on the common cold, *The Journal's* correspondent said that "some recent evidence suggested that more unpleasant germs were spread from the nose than from the mouth and throat, which led to the question whether bacteria and viruses accidentally shaken from handkerchiefs might not be of great importance. Tests showed that many bacteria might be shaken out and remain in the air. Handkerchiefs from the later stages of colds were found to be particularly effective as germ distributors. Work now in progress suggested that impregnation of handkerchiefs with a disinfectant might make them much less dangerous in this respect."

PUBLIC RELATIONS DEBUNKED

Common sense points the way to good public relations for medicine. The primary requirement is that the individuals who comprise medicine—all physicians—earn good relations with the individuals who comprise the public—all patients. There is no short-cut, no easier way.

Medicine will have made its first step toward the acquisition of good public relations only when doctors learn from progressive thinkers within their ranks that the best guide to desirable medical public relations will be found in their own code of ethics. Thoroughly and completely debunked, public relations is, in every sense, nothing more nor less than fundamental human relations.—*The Journal of the Indiana State Medical Association*.

WHAT IS RIGHT?

This matter of rebates, sometimes classed with fee splitting (it may be a tarring with similar brushes), refers not alone to optical house rebates but to drug and prescription stores, orthopedic suppliers, et cetera, and is getting much unsympathetic and misunderstood publicity. It is so old that doctors were disturbed by it when we were in school.

We know doctors who made their examinations, wrote prescriptions, sent the patient to an optical house, and never saw patient or glasses again. But they received the rebate at the end of the month. Other ophthalmologists established fitting departments in their offices, bought at wholesale, and made a complete charge for a complete service to their patients.

In smaller cities where optical companies were not convenient, we had to render a complete service including frame fitting and adjusting, and made our own financial arrangements, with no optical company in between. Now optical companies are more widely distributed, and some doctors are too busy to bother with fittings and prefer to send their patients to the optician for fittings and delivery of glasses. *Thereby they release to someone else the duty and privilege of making the patient completely satisfied.* The doctor could well expect the optician who does part of his job to charge retail prices. If he accepts a rebate for this service, which he did not render, he is likely to give the whole medical profession bad publicity. He has.—*Journal of the Michigan State Medical Society.*

MATERNAL DEATHS BY COUNTIES

On page 48, this issue, will be found a listing of "Deaths from Selected Causes in Pennsylvania, March, 1948." The column "Maternal Deaths" totals 14, divided by counties as follows: Allegheny and Philadelphia, 3 each; Cambria, Delaware, Elk, Luzerne, Lycoming, Montgomery, Westmoreland, and York, 1 each. It is important that the causes for these deaths were determined and discussed by members of the medical societies in the counties where such deaths occurred.



Like expelling water from a sponge

Urinary Stimulation

Stimulation of urinary secretion with Salyrgan-Theophylline appears to be due chiefly to its renal action consisting of depression of tubular reabsorption. In addition, there is a direct influence on edematous tissue, mobilizing sodium chloride and water.

Salyrgan-Theophylline is indicated primarily in congestive heart failure when edema and dyspnea persist after rest and adequate digitalization. Gratifying diuresis usually sets in promptly and often totals from 3000 to 4000 cc. in twenty-four hours.

Injections at about weekly intervals help to insure circulatory balance for long periods of time.

Good results may also be obtained in chronic nephritis and nephrosis.

SALYRGAN THEOPHYLLINE

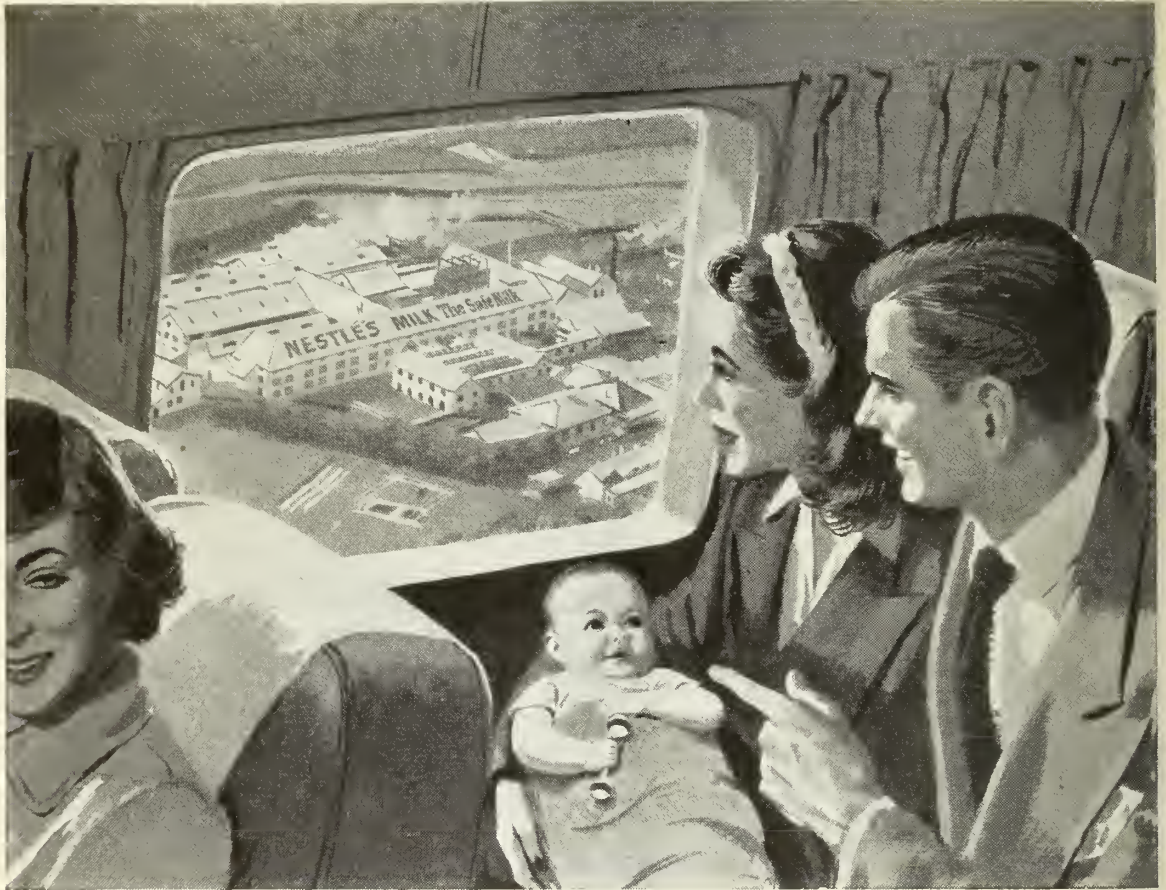
Brand of Mersalyl and Theophylline

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Enteric coated tablets for oral use.

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During the past 80 years Nestlé's has worked closely with the medical profession to develop quality milk foods for babies . . . and has met each advance in scientific knowledge of infant feeding with a corresponding improvement in product.

No wonder, then, that for more than three generations Nestlé's milk

products have been best known and most used for babies 'round the world.

The record shows that Nestlé's was the *first* evaporated milk fortified with 400 U.S.P. units of genuine Vitamin D₃ per pint. The quality of Nestlé's Milk is assured every step of the way . . . we even take the plant apart every day and wash it!

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doctors recommend
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EVAPORATED
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MRS. DANIEL H. BEE, *Editor*

547 Water Street

Indiana, Pa.

INCOMING PRESIDENT'S ADDRESS



Between Philadelphia, where this Centennial Meeting of The Medical Society of the State of Pennsylvania is assembled, and Reading, where the Auxiliary was founded twenty-four years ago, stretches the famous Horse-shoe Trail. As pioneers once cut

this pathway through the mountains, so, I like to believe, have Auxiliary leaders blazed a trail of service to the medical profession through the years.

Here I wish to pay tribute to the women who marked this road to the present. It is no easy task to attempt to get one's bearing and to continue the way. My pride in the honor you have conferred upon me is tempered with the knowledge that the future is obscure and with my concern that we shall be able to meet the demands made upon us.

During my term as chairman of councilors, I have tried to look with a long-range view, wishing I had spiritual binoculars, to see in what direction Auxiliary activity should move. I have searched the records of the past for the plan of the future and have discovered what we all know to be true: our founders planned wisely. The same basic thoughts are in the guide for today as in the pattern of yesterday. We have become a mature group with experience in working together, keeping together through the war, and testing our skills and friendships. Now that the younger members have returned to participate, we can intensify our efforts and make use of the vitality they give to our organization.

We live in a world of rapidly changing conditions; the horizon of duty is so broad as to be overwhelming. Of necessity we must make a critical survey of our activities and problems. Perhaps we shall want to reduce the number of tasks we attempt and concentrate in a few areas where our accomplishments will be most effective.

Within the Auxiliary there is room for every doctor's wife to serve. Whether her talents be

articulate and spectacular, or inarticulate and modest, she can still make a real contribution. The intangibles of friendship within our group can never be overestimated. They furnish the spiritual leavening we need to carry on.

We shall continue to do the specific things asked of us through the years: support the Medical Benevolence Fund generously, and circulate *Hygeia* comprehensively. We shall plan our own meetings to furnish a pleasant mingling of social affairs with programs that have a health emphasis.

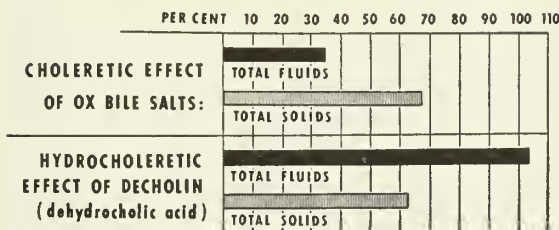
Auxiliaries are often merely social and money-raising appendages to their parent organizations. A medical society auxiliary has added purposes, namely, self-education of its members and interpretation of the physicians' work to the public. The pattern for our activities during the coming year has been developed with the active cooperation of the State Medical Society. It stresses these two fundamental aims, and can be carried out by an active county auxiliary or by an individual auxiliary member alone.

We could not initiate any new plans without acknowledging the recognition and assistance given to the Auxiliary during the past year by the officers and chairmen of the Medical Society. Drs. Hess, Engel, Donaldson, Buyers, Petry, and Palmer, and Mr. Perry and Mr. Brown of the executive staff, collectively and individually have counseled with us.

May I here express our debt of gratitude to Mrs. Bierly for her gracious leadership, for the groundwork laid during her term of office, and for her willingness to listen, to criticize, and to suggest. She gave freely and generously of time and thought, and your reception of current plans will be based on the ideas she shared with you in the recent past. The program we now present is the culmination of joint thinking as one trail meets another and a new year begins.

Our first aim—self-education.—All Auxiliary members should have some background information about the health legislative and medico-economic problems which face the profession. We should be familiar with some of the reference materials available, so that we can answer ques-

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Ivy, A. C., et al: Am. J. Dig. Dis. 7:333 (Aug.) 1940.

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tions ably. One of the needs of our time is informed public opinion. If we can present facts which can stand on their own merits without apology, we should not doubt our influence upon the thinking of others about the complex issues in which we are involved.

Sometimes we hear a member query, "Why must I know that? Isn't that for the laity?" To this member I can only say, "You are hiding your head in the sand." We can no longer live our little private lives in security. What we do and say and think influences not only our own lives and the professional status of our husbands but the kind of world in which our children will live.

All of this has been said before and much better than I can say it. But because of its fundamental importance it cannot be reiterated too often. Our best thinking, interest, and enthusiasm are needed.

It appears that each political party is concerned with some form of socialized medicine. We have been told that a "Dog Bill" will be presented at the next session of the State Legislature. On these two topics, compulsory sickness insurance and the value of medical research to medical progress, we must be able to speak competently.

The newest and probably the most objective appraisal of the health situation in this country is the report of the Brookings Institution, made at the request of the Hon. H. Alexander Smith of New Jersey who was chairman of the committee which heard the health bills in the Eightieth Congress. Not only do I hope but I implore each of you to study that report and be able to talk about the implications of its conclusions and recommendations (PENNSYLVANIA MEDICAL JOURNAL, May, 1948, pages 894-896).

We live in doctors' homes where drugs and surgical procedures are constantly being mentioned. We should be able to tell clearly and intelligently how safe they are, how useful to humanity they are, and why they have to be tested and standardized on animals before they are safe for human beings.

Our second aim — interpretation. — Health problems should be interpreted to our communities through speakers and movies before groups already assembled, and by radio. Through these mediums we reach a more diversified audience than is otherwise possible. Health institutes should be continued where they have proven popular.

Kits of bibliography, perhaps with suggested outlines for speeches, will be made available so that there will be some uniformity in the material presented throughout the State. We hope

that a number of physicians and Auxiliary members who have the skill to talk before lay groups in a way that the public will find acceptable will agree to prepare talks for this project and accept speaking engagements.

To facilitate the implementation of this program, printed materials which county auxiliaries can send to local organizations are being prepared. There will be a brief pamphlet based on the findings of the Brookings report which can be widely circulated to clarify misconceptions on the vital subject of good medical care without socialization. There may be another on the value of medical research. These flyers will be factual and of course non-political.

This administration will see only the beginning of the development of this program. We need a list of every club in every county. We will be grateful to the auxiliaries who, after consultation with their county medical societies, find it possible to experiment with this speakers' program this year. Planning can start with just a handful of people highly resolved and willing to work. Every auxiliary has its own resources in experience, leadership, and ways of accomplishing common objectives. The details of the venture will vary with the type of community and the size of the auxiliary. Building up working relationships with agencies and organizations in each county should be a part of the natural extension of this idea. We should let our communities know that the Medical Society and its Auxiliary are alert to and concerned about health situations and their solutions.

To distribute information within our own groups, there will be an outline of instructions for county presidents, also the informal news-letter following the style of last year.

The guide for county presidents is a development of the usual pages of material sent each fall, and of Mrs. Bierly's ABC booklet which was found to be so useful.

The news-letter will go to state and county officers and chairmen, giving directions, answering questions, sharing thoughts. Through this channel the state chairmen can speak to a larger number of members than through an individual letter directed to one chairman in each county. We hope that this method of sending out essential information will give added unity to our organization.

With our acceptance by the Medical Society as a participating auxiliary in helping to build public opinion, there comes the challenge and the stimulus to serve the medical profession with skill and effectiveness, albeit with great caution. I hope we will, each of us, face the year with imagination, courage, tact, and good humor, for



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1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, *Amer. J. Clin. Pathology*, 14:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, *J. Amer. Med. Tech.*, 8:606-14 (Sept.) 1947.

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one of the most important outlets for our activity which we can find—interpreting our husbands' professional community problems to the public.

As I have become acutely aware of the responsibilities which will devolve upon our whole Auxiliary, and especially upon the new board and upon me as your leader, as we continue the trail of service, I can only promise you our best efforts, and the Auxiliary pledge takes on new and very personal meaning, "I pledge my loyalty and devotion."

(MRS. PAUL C.) CATHARINE PALMER CRAIG,
President.

REPORTING ON REPORTS FROM THE COUNTIES 1947-48

Allegheny—sent out letters to members asking for \$3.00 contributions to the Benevolence Fund, which helps to account for their gift of \$1,091.

Armstrong—sold silver polish as a money-raising project.

Beaver—featured Medical Current Events at each meeting.

Blair—Heid a question and answer skit on *Hygeia*. They developed a catchy *Hygeia* jingle which they sing.

Bucks—Medical society and auxiliary will celebrate their centennial November 13.

Butler—voted to establish an aid fund for nurses.

Greene—has every eligible doctor's wife a paid-up member.

Huntingdon—placed five subscriptions to *Hygeia* in their county library. The Brookings report is also in use there.

Juniata—our smallest auxiliary has six members.

Lancaster—paid the expenses of two delegates to the state convention. They obtained 14 new members by using the membership flyer.

Lawrence—made a fine showing in community cooperation, campaigning for their local hospital drive.

Lehigh and *Westmoreland*—held public meetings, and had the honor of entertaining Dr. Edward L. Bortz, president of the AMA, who appeared as speaker on both occasions.

Mifflin—provided a speaker on nurse recruitment for every high school in the county. Their members are personally active in county welfare work.

Northumberland—cooperated with the local woman's club in sponsoring their health program. *Berks* used this method also.

Philadelphia—has its own Aid Association and takes care of those needing help in their city, therefore does not call upon the Benevolence Fund.

Schuylkill—contacted 68 high schools and asked them to have health assemblies. The follow-up showed 18 schools carried out the plan.

Venango—showed practically all the films available from the Harrisburg office to all high schools and some grade schools; 8900 people saw these movies.

Warren—sold Christmas holly as their money-raising venture.

Washington—mailed a copy of the year's program to every doctor's wife, with an invitation to join the Auxiliary.

Pennsylvania had four *Hygeia* winners in the last subscription contest:

Mercer placed first in Group 3, and thereby won \$40. *Westmoreland* placed third in the same group and won \$15.

Armstrong and *Blair* received honorable mention for fine records.

The winning state auxiliaries were Washington, Utah, and Wyoming.

Special mention should be made of the contributions of the county auxiliaries whose per capita gifts to the Benevolence Fund were outstanding: Montgomery, approximately \$7.00; Lebanon, \$6.00; Venango, over \$6.00; Bucks, \$4.00; Fayette, \$4.00.

Some county officers and committee chairmen keep notebooks of materials and information about their work for their own reference and to pass on to the next administration. This helps to give continuity to the Auxiliary program. Why not try it in your county?



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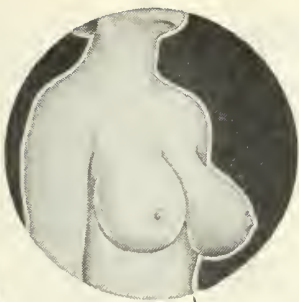
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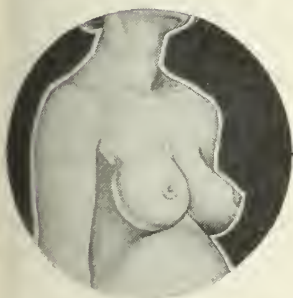
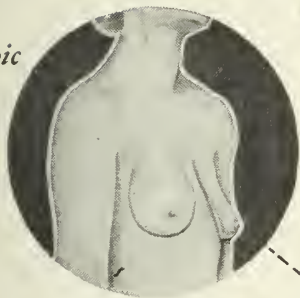
The above studies should be supplemented when possible with courses in mathematics, qualitative analysis, quantitative analysis, physical chemistry, foreign languages (Spanish, French, or German), sociology.

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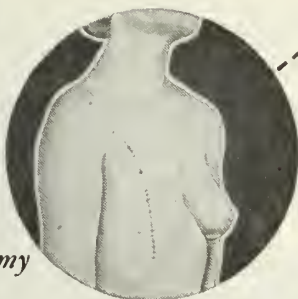
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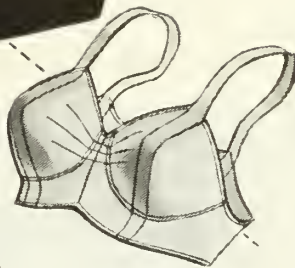


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AN ANSWER TO TOMMY BRITAIN

Tommy Britain is a British orthopedic surgeon currently popular in the United States for his hip arthrodesing operation. He has also published a book on structural principles of arthrodesis. He was a guest speaker on this subject at the recent AMA meeting in Chicago. I have known Tommy for fifteen years and we have sometimes disagreed.

During the Chicago AMA meeting a group of bone-setters gathered one evening at Ed (Year Book) Compere's house—a couple of Swedes—some Latins, Earl McBride (Oklahoma City), Stinchfield (New York City), Britain and myself. Tommy had been in this country some three weeks and we were interested in his observations and reactions, as he had visited most of our orthopedic clinics. He stated that there was a great difference in our mid-western practice, namely, the amount of time we devoted to our private practice. "Why," he said "in Cincinnati they devote 90 to 95 per cent of their time to their private practice." While he was there he went out to the Cincinnati General Hospital to see the show, and only four patients showed up. He asked what was wrong with the City Clinic, and was told that people prefer (and I guess in Cinncy can afford) to go to a private doctor.

Stinchfield thought that mid-western surgeons who could devote 90 to 95 per cent of their time to private practice were one-sided. He said that in New York City, where he is attached to a large clinic, he has only one day a week, twelve hours, to do his private work. He can give no more than ten to twelve hours a week to his private practice. Further, the average doctor in

New York City cannot make a living unless he has an important position at a clinic—such as he has, which requires him to do all of this charity work.

I was hopped on next—what percentage did my work run? I estimated 90 per cent private, and 10 per cent charity. Britain said "That's just about my observation through the mid-west. Why, these orthopods don't do anything but private work, charge fancy prices, and make incomes between \$60,000 and \$70,000 yearly. I think this is a terrible situation, and you should have state medicine." Now, I cannot follow the logic of such a conclusion at all. Britain was critical and he felt that in the mid-west the reason we had 90 per cent private practice was because we refused to do any more than 10 per cent charity work, and got our fees before our patients got their bread.

Of course, I disagreed with him, and I came home to think out why I did disagree. One of the false assumptions of Britain's is that all mid-western orthopods make "\$60,000 to \$70,000 yearly." We have some mid-western baseball players who make as much or more, but they are exceptions. Again, such a figure is a gross income statement from which operating expenses of a fairly large organization must be deducted. The veterans' service offers recognized orthopods jobs at \$11,000 per annum with all operating expenses furnished by the government. It has been estimated that such a salary is equivalent to the net income from a \$40,000 to \$50,000 gross practice. Yet, there are not many takers for this job which requires forty hours a week and no worries, even though many of us do not make this much money. WHY? Is it the paper work and loss of independence? So, we must throw out the

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argument that orthopedic surgery should be socialized because of the income of private surgeons, as the state is attempting to pay similar salaries.

But, why should these differences exist between the East and the West? I got to analyzing things and I find that I average about fifty hours a week (I always thought I worked about seventy or eighty hours per week). I average five hours at General Hospital, or 10 per cent charity—90 per cent private practice. To be sure, I see a number of doctors' wives, nurses, padres, and the like who are not fee patients but which takes time. However, they are the type of people that build a private practice, and are anything but charity cases. Nor do I find that I can logically credit the time I spend teaching or writing or attending the too numerous staff and medical meetings as charity work. One must credit these hours to the necessary circulation to stay in private practice. I feel that our critics are erroneously crediting their teaching hours to charity. Even so, we have the big swings of England and New York City reporting 85 per cent of their time devoted to charity work. The situation in Philadelphia, where I trained, is not greatly different. Cincinnati and Kansas City are just the reverse—90 per cent private and 10 per cent charity.

How can this be? I would say there are a number of fundamental differences:

IN THE EAST:

1. There are more rich and more poor—so that
 - a. There are more who can pay tremendous fees (\$2,500 for a hip operation)—and
 - b. There are fewer from a percentage standpoint who can afford a modest over-all cost of \$25 for a Colles fracture.

IN THE WEST:

We handle our limited income people on limited fees as private patients. In Boston there is a special hospital for poor people, not exactly charity cases you know, but for people who can afford to pay only \$250 for a surgeon's fee. We know of the too common instance in the East of the professor sending patients able to pay several hundred dollars to the clinic because it would hurt his prestige to charge less than several thousand dollars.

When I started practice in Kansas City fifteen years ago, it was a \$100 town. People expected a fee of \$100 for an operation whether it was carcinoma of the gall-bladder or a bunion. Inflationary trends have increased this to \$150, possibly \$200. The point is that we charge fees which our patients can pay, and by paying keep their self-esteem and independence.

IN ENGLAND:

Brittain said that he had about one day a week for his private work. The rest of the time is charity work. Let us omit the discussion of panel medicine in England and concern ourselves with the simple industrial problem of a coal miner with a broken back, common to both countries.

In this country the injured man is cared for as a compensation case, and the owner is liable up to certain limits by law for injuries to his employees. He generally sells this risk to an insurance company. An injured miner then receives ward treatment, his surgeon is paid a moderate fee, and his permanent partial disability at the end of treatment is evaluated by a state compensation commission.

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In England the miner with a broken back is taken to the Royal Hospital (equivalent to our city general hospitals). The owner of the mine where he was injured has salved his conscience by donating fifty pounds to the fall charity drive, part of which goes to the support of the Royal Hospital. The rest of the care is on the Crown (taxpayers to us.)

It is an honor to be the orthopedic surgeon at the Royal—the orthoped takes care of the broken back for free. In the more advanced areas the miner will then go to a convalescent center for rehabilitation and rating. The medical aspects of this later work are probably honorary also.



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MEDICINE—Intensive Course, two weeks, starting October 11.

Personal Course in Gastroscopy, two weeks, starting November 8.

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It is our opinion that this whole thing is wrong from the surgeons' standpoint and that an industry should be so set up that reasonable costs for medical care for employers should be included as part of the operating overhead.

IN THE EAST:

2. There are competing medical schools and clinics which, in order to establish attendance records, vie with service offers for the marginal patient. These become clinic patients in the East. In the mid-west they would be private patients.

There are other reasons—I have checked over the orthopedic attendance at General Hospital in Kansas City, and it averages a total of 450 visits per month. Ninety per cent of this work is traumatic work, as all of the traffic cases of the city, regardless of patient's status, are cleared through this clinic. Only about 40 visits a month then can be truly labeled orthopedic cases, or four new orthopedic cases monthly. This is a marked diminution in attendance even in my day. There are a number of factors which have cut this attendance. They are:

1. Widespread hospital insurance (it is estimated that one out of every three persons has it).

2. Veterans' aid and medical care.

3. Vocational rehabilitation—a Federal Act accepted by both the states of Missouri and Kansas, allocating funds for the reclamation of the disabled. (New York has this aid—do they use it?) A crippled man in Missouri or Kansas is not a charity case.

4. Polio Foundation—takes the children that take the time, and these children are private cases. They could be in New York City or Philadelphia.

5. Finally, our people are more generally prosperous than they were fifteen years ago.

So, we in the mid-west, by being willing to accept modest fees and to extend our insurance coverage, are in the enviable position of being paid for our work.

We like it!

We aim to keep it this way!

We extend our congratulations to Cincinnati for their record!

We think you Easterners are suckers, and are the ones who need housecleaning.—GARRETT PIPKIN, M.D., *Weekly Bulletin, Jackson County (Missouri) Medical Society.*

MEDICAL ETHICS—FACT OR FICTION

A recent revision of the Code of Ethics by the House of Delegates of the American Medical Association brings forcibly to mind the importance of these rules of professional conduct involving the relationships of physicians to one another and to their patients.

Medicine has placed itself in a commendable position by establishing definite ethical criteria for the guidance of the individual physician. Observance of this code should motivate the daily actions of every member of the profession. Furthermore, strict adherence to these principles of ethics should be insisted upon by organized medicine and immediate steps should be taken to enforce them wherever necessary.

Infractions of medical ethics by the few reflect on the whole profession in the credulous public mind. The

recent sensational publicity in lay journals and the press on the unethical practice of rebates is a case in point. Unfortunately, the local public does not realize that, here in Philadelphia, the profession is powerless to take any legal action against such practice, because no applicable law exists.

The Public Relations Committee of your county society, working with the State Society and the Better Business Bureau, is drafting a bill outlawing rebates to be presented at the next session of the State Legislature.

If our efforts to have such a law passed prove successful, we shall call for the cooperation of every member in assuring observance of the statute. Physicians aware of gross unethical conduct are not discharging their obligations to the county medical society if they do not take proper steps to rectify the situation by reporting the facts through the proper channels. After this is done, it is up to the county society to investigate the matter promptly and thoroughly and to take the necessary action—*Philadelphia Medicine*, July 3, 1948.

MATERNAL DEATHS BY COUNTIES

On page 52, this issue, will be found a listing of "Deaths from Selected Causes in Pennsylvania, April, 1948." The column "Maternal Deaths" totals 12, divided by counties as follows: Philadelphia, 4; Allegheny, 2; Beaver, Lehigh, Lycoming, Schuylkill, Warren, and Westmoreland, 1 each. It is important that the causes for these deaths were determined and discussed by members of the medical societies in the counties where such deaths occurred.



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Secretary, Pennsylvania Department of Health
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MEDICAL NEWS

Births

TO DR. AND MRS. ROBERT C. DIX, JR., of Milton, a son, October 3.

TO DR. AND MRS. JACOB C. FAIR, of Kittanning, a daughter, May 2.

TO DR. AND MRS. THOMAS FITZ-HUGH, JR., of Wynnwood, a daughter, October 1.

TO DR. AND MRS. PETER L. BONAFEDE, of Harrisburg, a daughter, Josephine, October 5.

Engagements

MISS SALLIE HARWOOD, of East Greenwich, R. I., to Charles M. Norris, M.D., of Philadelphia.

MISS JEAN FLORENCE LYNCH, of Roanoke, Va., to Thompson A. Ferrier, M.D., of Philadelphia.

MISS DORIS HELEN MATTHEWS, of Wayne, to Mr. John Cooke Hirst, 3d, son of Dr. and Mrs. John Cooke Hirst, of Philadelphia.

MISS HENRIETTA STARR MALLOY, of Philadelphia, to Mr. Eugene Adam Jaeger, son of Dr. and Mrs. James Rudolph Jaeger, of Wynnwood.

MISS KATHRYNE ELIZABETH McKEOWN, of Narberth, to Dr. Lawrence Thomas Smyth, son of Dr. and Mrs. Thomas L. Smyth, of Allentown.

MISS NANCY HILLES DEWEES, daughter of Dr. and Mrs. Lovett Dewees, of Glen Mills, to Mr. William Shoemaker Flash, of Port Chester, N. Y.

Marriages

MISS EMILY WILHELMINA FRETZ, daughter of Dr. and Mrs. John E. Fretz, of Easton, to Mr. Fisher Morris Starr, of Bethlehem, September 25.

ELIZABETH McNAUGHTON MAIN, M.D., of Malvern, to Robert Ford Welty, M.D., son of Dr. and Mrs. Emil M. Welty, of Spokane, Wash., October 9.

MISS BARBARA ANN STINE, of Wilmington, Del., to Mr. James Seth Hopkins Cruice, son of Dr. and Mrs. John M. Cruice, of Philadelphia, October 1.

MISS EMILY BORIE MUDD, daughter of Dr. and Mrs. Stuart Mudd, of Haverford, to Mr. William Dewson Chapman, of Ontario, Canada, September 18.

Deaths

Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

○ **Bender Z. Cashman**, Pittsburgh; Johns Hopkins University School of Medicine, Baltimore, 1909; aged 62; died Oct. 7, 1948, following a heart attack two weeks before. Dr. Cashman was professor of gynecology at the University of Pittsburgh School of Medicine and was medical director and chief of staff at Elizabeth Steel Magee Hospital. He was a member of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons and a Fellow of the American College of Surgeons. During World War I, he served with Base Hospital No. 27 of the American Expeditionary Forces as a captain in the Medical Reserve Corps. Surviving are his widow, one son, and two daughters.

○ **Robert A. Gaughan**, Hazleton; University of Pennsylvania School of Medicine, 1913; aged 58; died Sept. 16, 1948, of a heart attack. Dr. Gaughan was chief surgeon of the Hazleton State Hospital. He was a Fellow of the American College of Surgeons, and in

1946 was elected to a fellowship in the International College of Surgeons. He was also a member of the staff of the White Haven Sanatorium of Jefferson Hospital. He was a member of the New York and New England Railway Surgeons Association and the American Academy of Medicine. He is survived by his sister-in-law, with whom he lived, and a niece.

○ **William C. LeCompte**, Bristol; Medico-Chirurgical College of Philadelphia, 1897; aged 73; died Sept. 16, 1948. Dr. LeCompte served four years in the Army Medical Corps before starting private practice in 1902. During World War I, he commanded Base Hospital No. 110 in France, retiring with the rank of lieutenant colonel. Last June he was honored by the State Medical Society for his fifty years' service as a physician. Surviving are his widow, two sons, and two daughters.

○ **Lawton M. Hartman**, York; University of Pennsylvania School of Medicine, 1902; aged 69; died Oct. 6, 1948. Dr. Hartman was chief of the heart service of York Hospital for sixteen years, and was on the visiting staff of the Children's Home in York for many years. He was a Fellow of the American College of Physicians. During World War I, he was a captain in the medical corps of the U. S. Army. His widow survives.

○ **August Trapold**, Wilkes-Barre; Medico-Chirurgical College of Philadelphia, 1891; aged 81; died Sept. 16, 1948, of complications that developed from a fractured vertebra sustained in an accident last Thanksgiving Day. A Fellow of the American College of Surgeons, Dr. Trapold performed the first operation in Mercy Hospital, Wilkes-Barre. He is survived by a son, August Trapold, Jr., M.D., of Ohio, and two daughters.

○ **Wayne S. Regar**, Ephrata; Medico-Chirurgical College of Philadelphia, 1907; aged 77; died Oct. 3, 1948, following a head-on collision with another car containing eight occupants, all of whom were injured, some seriously. Dr. Regar, traveling alone, was attempting to pass another car when he hit the car coming from the opposite direction.

○ **Jeremiah F. Lutz**, Glen Rock; College of Physicians and Surgeons, Baltimore, Md., 1894; aged 76; died Sept. 11, 1948. Dr. Lutz was a Fellow of the American College of Physicians and a member of the Radiological Society of North America and the American College of Radiology.

Benjamin S. Davis, Plymouth; Jefferson Medical College of Philadelphia, 1917; aged 55; died Oct. 10, 1948. He was a member of the Wyoming Valley Homeopathic Hospital staff and Plymouth health officer for many years. Surviving are his widow, three sons, and two daughters.

○ **Newton E. Bitzer**, Lancaster; University of Pennsylvania School of Medicine, 1898; aged 75; died Aug. 15, 1948. He was a Fellow of the American College of Surgeons.

Milton E. Wagner, McClure; Medico-Chirurgical College of Philadelphia, 1906; aged 68; died Sept. 2, 1948. He is survived by his widow, a son, and a daughter.

○ **Willard D. Kline**, Allentown; Jefferson Medical College of Philadelphia, 1901; aged 71; died Aug. 9, 1948. He was a Fellow of the American College of Physicians.

○ **Lewis H. Sterner**, Hanover; Hahnemann Medical College and Hospital of Philadelphia, 1889; aged 84; died Aug. 27, 1948.

○ **W. Sturgis Frankenburger**, Carmichaels; Jefferson Medical College of Philadelphia, 1911; aged 62; died June 1, 1948.

○ **Maurice E. Harwood**, Pittsburgh; University of Pittsburgh School of Medicine, 1936; aged 44; died July 17, 1948. He is survived by his widow and three sons.

○ **Charles H. Carroll**, Pittsburgh; University of Pittsburgh School of Medicine, 1906; aged 71; died Sept. 5, 1948. Dr. Carroll was on the staff of Allegheny General Hospital. He is survived by his widow, a daughter, and a grandchild.

Miscellaneous

HENRY C. SCHNEIDER, M.D., chief of the proctology department of Northeastern Hospital, Philadelphia, has been named medical director of the institution.

LOUIS J. KOWALSKI, M.D., of Philadelphia, has been appointed to the newly created post of assistant director of mental health in the State Welfare Department. The position carries an annual salary of \$7,500.

RUTH E. MILLER, M.D., professor of bacteriology at the Woman's Medical College, Philadelphia, was elected president of the Alumni Association of the Philadelphia College of Pharmacy and Science at its annual meeting on May 15.

WARREN F. DRAPER, M.D., for many years a member of the House of Delegates of the American Medical Association representing the United States Public Health Service, from which he has recently retired, has been appointed executive officer of the United Mine Workers Medical and Hospitalization Service.

PASCAL F. LUCCHESI, M.D., superintendent and medical director of the Philadelphia General Hospital, was given the Dr. I. P. Strittmatter Award for 1947 at a meeting of the Philadelphia County Medical Society on the evening of September 22. He was honored for achievements in public health and hospital administration. The award, consisting of a gold medal and scroll, was established in 1923.

THE ANNUAL MEETING OF THE AMERICAN OTORHINOLOGIC SOCIETY for the Advancement of Plastic and Reconstructive Surgery will be held at the Hotel Waldorf-Astoria, New York City, November 4. A testimonial dinner will be held at 6 p.m. for Samuel Fomon, M.D., honorary president. Dr. Fomon will present the paper of the evening entitled "Recent Development in Rhinoplastic Surgery Based on New Physiologic Concepts."

THE WOMAN'S MEDICAL COLLEGE, Philadelphia, has been named beneficiary for three legacies: under the will of Dr. Margaret J. Delmore, class of 1899, Uniontown, Pa., in the amount of \$47,000, the income of which is to be used for scholarships; in the amount of \$17,000 under the will of Dr. Grace W. Sherwood, class of 1904, St. Albans, Vt., also for scholarship purposes; and the amount of \$5,000 from a trust under the will of Redwood F. Warner, an outright gift.

AT A REGULAR MONTHLY MEETING OF THE PENNSYLVANIA ACADEMY OF PHYSICAL MEDICINE, September 16, at the Philadelphia County Medical Society Building, a symposium on peripheral vascular disorders was presented by David W. Kramer, M.D., who spoke on "Newer Trends in the Treatment of Peripheral Vascular Disorders," Edwin Mendelssohn, M.D., who discussed "The Role of the Surgeon in the Treatment of Peripheral Vascular Disorders," and Albert A. Martucci, M.D., who spoke on "Physical Medicine and Rehabilitation in Peripheral Vascular Problems."

THE TWENTY-EIGHTH CONVENTION OF THE NATIONAL SOCIETY FOR CRIPPLED CHILDREN & ADULTS, INC., will be held at the La Salle Hotel, Chicago, November 15-17. Many outstanding speakers in the fields of medicine, health, and education will be on hand to present facts on progress in work with the handicapped during the past year. The convention will be attended by physicians, therapists, educators, workers with the handicapped, and representatives of the National Society's more than 2000 state and local units throughout the United States, Canada, Alaska, and Hawaii.

THE FOLLOWING APPOINTMENTS HAVE BEEN ANNOUNCED by the board of directors of the Mercy-Douglass Hospital, Philadelphia: Wilbur H. Strickland, M.D., medical director; Lewis C. Manges, M.D., chief of surgery; Helen O. Dickens, M.D., chief of obstetrics and gynecology; Edward E. Holloway, M.D., chief of medicine; Russell F. Minton, M.D., chief of x-ray; Henry L. Gowens, Jr., M.D., chief of ophthalmology. All are members of their respective boards. In addition, Chauncey M. Harlee, M.D., was made chief of pediatrics, and Lances McKnight, M.D., and Cornelius G. Wooding, M.D., co-chiefs of pathology.

FOUR PENNSYLVANIA PHYSICIANS SAILED FOR RIO DE JANEIRO, September 24, to attend the Pan-American Medical Congress held from October 5 to 18. The meeting was sponsored by the Brazilian government and was expected to attract more than 500 delegates from the Western Hemisphere. Those attending from Pennsylvania included Dr. and Mrs. James D. Schofield, of Wynnewood; Raymond E. Seidel, M.D., associate professor of pharmacology at Hahnemann Med-

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ical College and Hospital; Ralph Bohn, M.D., of Lansdowne; and Paul S. Schantz, M.D., of Ephrata. Dr. Seidel was to lecture on radioactive medication.

THE FIFTH SERIES OF PUBLIC MENTAL HYGIENE LECTURES being presented by the Philadelphia County Medical Society started Monday, October 11, at 8:30 o'clock in the society's headquarters, S. E. Corner, 21st and Spruce Streets. During the three following Monday evenings the topics discussed were "The Development of Anxiety," "The Meaning of Hostility," "The Immature Person in Society," "Emotional Immaturity," "The Unhappy World We Live In," and "Psychiatry's Contribution to Better Living."

The speakers include Drs. Manuel M. Pearson, Theodore L. Dehne, Herbert Freed, Edward A. Streckler, George S. Sprague, Leon J. Saul, Eleanor A. Steele, Kenneth E. Appel, and Robert A. Matthews. There is no admission fee. A question and answer period follows each lecture.

UNDER A GRANT FROM THE NATIONAL ADVISORY CANCER COUNCIL, a Department of Oncology has been established at the Woman's Medical College of Pennsylvania. Isabella H. Perry, M.D., is director of oncology, and Mildred Pfeiffer, M.D., is assistant director.

Integration of the present clinical work will be emphasized. The Advisory Cancer Committee represents the faculty. Sections of fourth-year students will attend the weekly General Tumor Conference where a Tumor Board, representing the various departments and specialties, will confer on the problems presented by the cases referred to the General Tumor Conference. There will also be a Tumor Diagnostic Clinic, a question hour for students, and a monthly cancer research seminar.

The Division of Cancer Control, Department of Health, Commonwealth of Pennsylvania, has granted three fellowships in oncology to the following: Drs. Cornelia Motley, Mary B. Dratman, and Janet Hampton. Sophie A. Brenner, M.D., is also working in the Department of Oncology under a State grant.

ALLERGY AND COAL SMOKE

From the standpoint of the public I would say that the most prolific source of annoyance among allergic individuals is coal smoke. As far as we know this effect is a non-specific one, but it is not improbable that some day a specific allergen may be discovered in such smoke. Although the large city railway stations and loading platforms are chiefly responsible, the surrounding territory and the passengers on the trains are not free from this hazard.

It is common for allergic persons to experience an attack of asthma or a sneezing fit in these environments, particularly in the sheds on the way to boarding trains, when the engines are belching acrid fumes. I venture to say that it is not unlikely that a great deal of the asthma and rhinitis which people experience in the city is due to the coal smoke from the railway industries and, of course, other industries. I believe that the time is not far off when this problem will have to be solved.—SAMUEL M. FEINBERG, M.D., in *Industrial Medicine*.



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Location Wanted.—Urologist, eligible American Board of Urology. Completes residency in eastern university hospital in June, 1949. Desires association with urologist, group, or opportunity for independent practice. Write HOWARD Z. FRETZ, M.D., Graduate Hospital, University of Pennsylvania, Philadelphia, Pa.

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Wanted.—General practitioner for Protestant community of McClure, Snyder County. Population of 1,000 in town and 3,000 in surrounding area. Living quarters and office available. For further information, contact Mr. PAUL MARSHALL, Chamber of Commerce, McClure, Pa. Telephone—Beaver Springs, 19R4.

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INCOME TAX REVENUE ACT

The new Income Tax Revenue Act of 1948 was enacted into law over the veto of the President in April. Generally speaking, it contains a reduction in income taxes for physicians of approximately 30 per cent. This reduction is largely the result of three changes in the law:

1. The amount allowable as a personal exemption was raised from \$500 to \$600. The credit for each dependent was likewise increased to \$600.

2. The same tentative normal and surtax rates as used in 1946 and 1947 were retained, but the 5 per cent reduction was eliminated and greater credit on the total tentative tax liability allowed on the following scale:

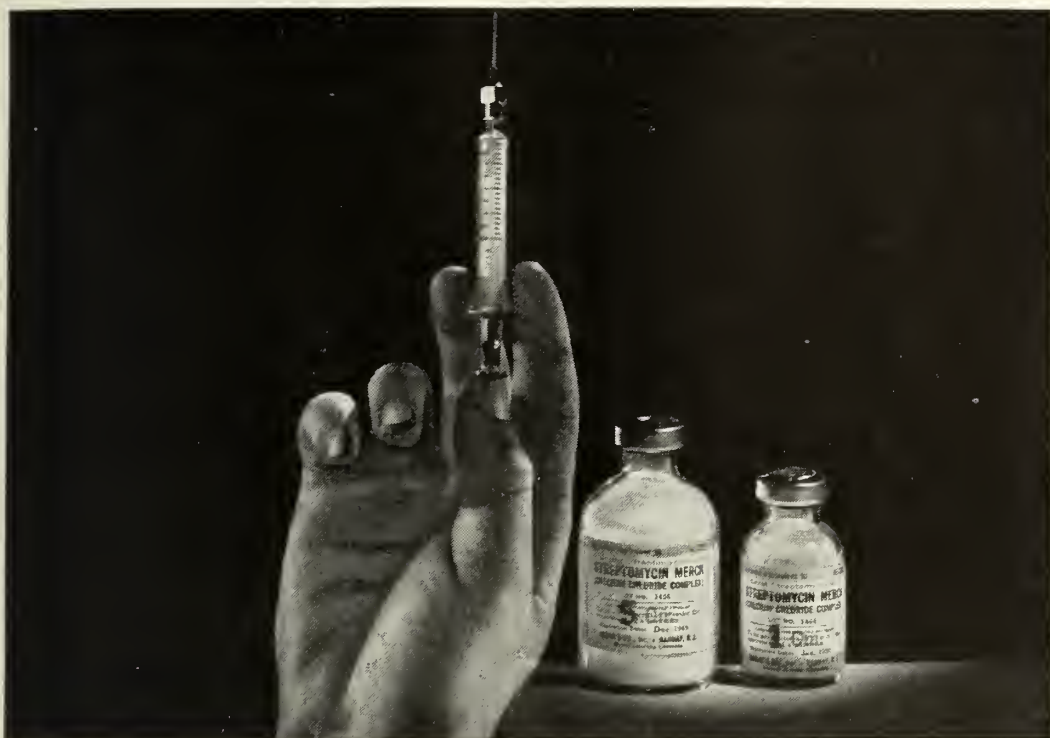
- a. If total tentative tax liability is not over \$400, reduction is 17 per cent of the total.

- b. Over \$400 but not over \$100,000, \$68 plus 12 per cent of excess over \$400.

- c. Over \$100,000, \$12,020 plus 9.75 per cent of excess over \$100,000.

3. Husbands and wives will be permitted to file a joint return and to divide the combined taxable income by two. The tax will be computed on one segment of the divided income and multiplied by two. This enables the family to compute its tax in a lower bracket.

Individuals 65 years of age or over will receive an additional credit of \$600 over their personal exemption. If the spouse has attained that age, an additional \$600 credit is also in order. A credit of \$600 is also for a blind individual and/or the spouse.—*New York Medicine*, July 20, 1948.



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Deaths from Selected Causes in Pennsylvania, May, 1948

County	All Causes, Excluding Stillbirths	Still- births	Infant Deaths	Maternal Deaths	Cancer	Heart Disease	Intra- cranial Lesions of Vascular Origin	Nephritis	Pneu- monia	Tuber- culosis
Adams	32	0	5	0	2	8	4	2	4	0
Allegheny *	1216	63	72	4	170	427	111	79	48	26
Armstrong	53	5	4	0	9	22	2	3	0	6
Beaver	103	7	9	0	15	37	10	7	4	4
Bedford	38	2	1	1	5	11	5	9	1	0
Berks *	229	7	11	0	36	77	22	7	3	12
Blair *	118	11	9	1	25	36	12	8	5	0
Bradford	59	3	2	0	6	25	5	3	2	1
Bucks	96	2	6	0	12	42	7	4	2	0
Butler *	61	1	4	0	6	21	10	5	1	0
Cambria *	174	17	17	1	17	69	8	8	9	6
Cameron	2	0	0	0	0	1	0	0	0	0
Carbon	47	0	2	0	5	18	4	0	1	2
Centre	44	1	1	0	10	13	6	3	1	1
Chester *	127	4	8	0	15	40	17	15	8	0
Clarion	26	0	0	0	2	12	2	1	0	0
Clearfield	74	3	5	0	5	27	9	3	2	0
Clinton	29	1	2	0	2	10	2	5	1	1
Columbia	38	2	0	0	6	17	4	0	1	1
Crawford	58	4	4	0	7	19	9	0	2	0
Cumberland	68	5	4	0	11	25	11	5	2	2
Dauphin *	164	7	9	0	19	61	13	15	1	5
Delaware	274	11	12	0	34	116	23	15	4	2
Elk	27	3	8	0	5	6	2	3	0	0
Erie	189	7	15	1	28	61	18	5	10	3
Fayette	159	14	13	0	23	48	9	10	6	3
Forest	4	0	0	0	1	1	1	0	1	1
Franklin *	61	3	4	1	5	23	5	4	1	0
Fulton	5	0	1	0	2	0	1	0	0	0
Greene	28	2	2	0	4	7	6	1	1	1
Huntingdon	34	4	1	0	3	10	4	2	1	1
Indiana	46	3	6	0	7	16	1	3	0	0
Jefferson	28	2	1	0	6	7	5	4	0	0
Juniata	11	0	0	0	0	5	1	3	1	0
Lackawanna	250	14	14	1	42	101	21	14	6	2
Lancaster	204	9	11	0	21	76	26	12	8	6
Lawrence	98	4	8	0	15	33	7	6	4	2
Lebanon *	61	2	4	0	6	26	4	9	3	0
Lehigh *	196	12	12	1	27	57	15	10	9	3
Luzerne	318	13	27	1	38	114	19	21	11	7
Lycoming	98	3	8	1	23	30	13	3	1	1
McKean	46	2	4	0	9	8	7	0	0	1
Mercer	100	8	11	0	9	35	12	4	6	3
Millin	27	1	7	0	0	8	0	1	1	0
Monroe	33	3	2	0	5	8	2	1	0	0
Montgomery *	281	11	12	1	42	110	17	18	4	11
Montour *	24	0	1	0	5	6	2	1	1	0
Northampton	143	1	9	0	23	53	11	15	3	5
Northumberland	116	4	13	0	11	37	11	9	2	1
Perry	15	0	2	0	1	5	0	2	0	0
Philadelphia *	1946	44	98	1	316	733	125	127	48	75
Pike	5	0	0	0	0	5	0	0	0	0
Potter	14	2	2	0	2	7	0	0	0	0
Schuylkill	188	16	4	0	25	81	15	14	2	2
Snyder	12	0	0	0	0	4	3	1	0	0
Somerset *	80	0	7	1	8	27	9	7	2	0
Sullivan	6	0	0	0	0	5	1	0	0	0
Susquehanna	23	0	2	0	1	8	2	3	1	0
Tioga	27	1	1	0	5	10	4	1	0	1
Union	28	2	3	0	1	13	3	1	0	1
Venango *	54	0	2	0	3	26	7	3	3	0
Warren *	26	0	2	0	3	10	3	0	0	1
Washington	170	6	10	0	24	60	21	8	5	3
Wayne *	25	0	0	0	2	11	3	0	2	0
Westmoreland *	192	8	13	0	24	84	17	12	7	4
Wyoming	17	1	1	0	5	5	1	1	0	0
York	196	5	10	0	31	68	29	13	7	2
State and Federal Institutions	271	0	1	0	31	63	20	9	14	60
State totals	9912	366	539	16	1261	3245	779	558	273	263

* Exclusive of deaths in State and Federal institutions except general hospitals.

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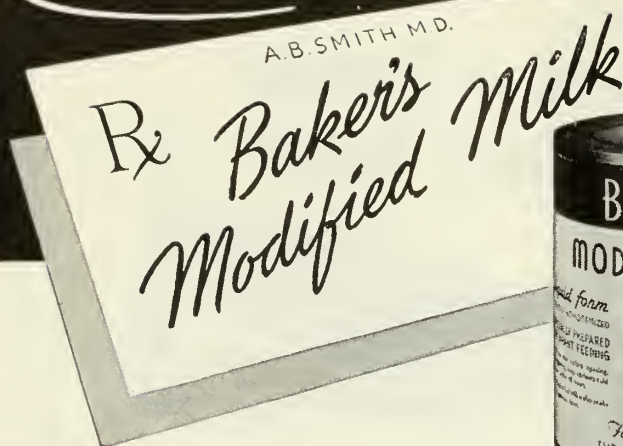
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BOOK REVIEWS

TREATMENT BY DIET. By CLIFFORD J. BARBORKA, M.D., D.Sc., F.A.C.P., Assistant Professor of Medicine, Northwestern University Medical School, Chicago; Attending Physician, Passavant Memorial Hospital; Consultant in Gastro-enterology and Gastroscopy, Diagnostic Center, Hines Veterans Hospital; formerly Consulting Physician, The Mayo Clinic. Fifth edition. 784 pages with 14 colored plates. Philadelphia: J. B. Lippincott Company, 1948. Price, \$10.00.

With the publication of this fifth edition, Dr. Barborka has endeavored to bring our knowledge of diet therapy up to date. However, some of the older concepts are retained, there are several errors in the diet lists, and some statements are contradictory. For instance, under the discussion of vitamin A, the use of mineral oil is opposed, although in the appendix a recipe for mineral oil salad dressing is included. On the whole, Part I, concerning diet in health, is a useful compendium on the nature and functions of the various nutrients. In the sections on application of diet therapy and diet in disease, it is regretted that more attention is not given to individual eating patterns. The author says, "It is not intended that these diets be used as a stock or printed list for a particular disease and applied to all patients afflicted with the disease, irrespective of particular needs. The greatest fault of dietetics today is the attempt to use a standard list for each disease for all patients." If this statement was backed up by information on dietary histories, food habits, and the psychology of diet therapy, which is requisite for optimal nutritional rehabilitation, the practical value of the book would be enhanced considerably.

PERIPHERAL VASCULAR DISEASES. Diagnosis and Treatment. By DAVID W. KRAMER, M.D., F.A.C.P., Associate Professor of Medicine, Jefferson Medical College; Assistant Physician, Jefferson Hospital; Chief Clinical Assistant, Vascular Clinic, Jefferson Hospital; Visiting Physician, Medical Division, Philadelphia General Hospital; Consultant on Peripheral Vascular Disorders, Philadelphia General Hospital; Attending Physician, Metabolic Division, and Chief of Diabetic Clinic, Jewish Hospital; Attending Physician and in charge of Department of Metabolic and Peripheral Vascular Disorders, St. Luke's and Children's Medical Center; Metabolist to Eagleville Sanatorium. Foreword by Edward L. Bortz, M.D. 157 illustrations with 25 in color. Philadelphia: F. A. Davis Company, 1948. Price, \$8.00.

The author's objective in writing this book is twofold. First, he has drawn from his extensive experience in the field of peripheral vascular disease and as a teacher to offer students and practicing physicians a comprehensive and practical text. Second, he was urged by the increased frequency of these conditions and the definite need for funneling into one treatise the information of various articles from any journals.

The material is very well organized and takes the reader through the basic phases of history, symptoms,

physical signs, and circulation function tests and into diagnosis and treatment. To further understanding and to suggest possibilities, salient findings are stressed and linked with factors of differential diagnosis. Then again, the necessity one frequently encounters for translating textbook teaching into clinical concepts is lessened by the many case studies which clarify diagnostic and therapeutic points. In addition, step-by-step explanations of the various tests are presented, and full attention is given to the newer procedures in diagnosis, such as the tropidore test for reflex vasodilatation, the fluorescein test, and aortography.

In the discussion of treatment not only is the correct agent mentioned but also why it is right among a legion of possibilities. The anticoagulants play an important rôle in peripheral vascular disease and their use is covered in detail. In like manner the antibiotics and such new agents as diethyl oxide, histidine monohydrochloride, and tetra-ethyl-ammonium are reviewed. To make the monograph complete, a final chapter is devoted to the lymphatic system.

All in all this book is unreservedly recommended for its clarity and completeness and will make a practical addition to one's reference library.

RECONSTRUCTIVE AND REPARATIVE SURGERY. By HANS MAY, M.D., F.A.C.S., Assistant professor of Surgery, Graduate School of Medicine, University of Pennsylvania; Associate Surgeon, Lankenau Hospital, Children's Hospital of the Mary J. Drexel Home, and Chestnut Hill Hospital; Surgeon, Germantown Hospital; Consulting Plastic Surgeon, Abington Memorial Hospital, Nazareth Hospital, and St. Christopher's Hospital for Children. Foreword by James Barrett Brown, M.D., F.A.C.S. 996 pages with 963 illustrations, 17 in color. Philadelphia: F. A. Davis Company, 1947. Price, \$15.00.

This book is intended to make general plastic and reconstructive surgery better known to the general surgeon. As such, this textbook accomplishes its purpose, for the author's concept of reconstructive surgery falls into many fields.

By a unique arrangement the book has five divisions: (1) general principles of technique, grafting of tissue, transportation of flaps, treatment of burns, wounds, and scars; (2) the head and neck; (3) the trunk; (4) the extremities other than the hand and foot, and hand and foot; in these sections the chapters have been subdivided, whenever possible, under the headings of defects and deformities (or dysfunctions); (5) illustrative cases, 126 in number.

The reconstructive surgeon who has limited himself to a single field may find some of the sections comparatively superficial. Certainly the illustrations of rhinoplastic procedures do not demonstrate the results that refinements of technique of the past few years have produced.

The text is usually clear and the illustrations good. Printing and paper are fine. There is both an index of illustrations and an index of subjects.

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Because this book combines in one volume attributes of various reconstructive specialties, it is considered to be an adequate reference to the general surgeon.

NEURO-ANATOMY. By FRED A. METTLER, A.M., M.D., Ph.D., Associate Professor of Anatomy, College of Physicians and Surgeons, Columbia University, New York. Second edition. 357 illustrations including 33 in color. St. Louis: The C. V. Mosby Company, 1948. Price, \$10.00.

This textbook offers the student considerably more than the title implies. The first section is devoted to gross neuro-anatomy and the second section to microscopic anatomy. The author has correlated the anatomy with neurophysiology and clinical neurology, thus stimulating the student's interest. The author's method of terminology is to be commended; no new terms are employed without having first been defined. The text can be well recommended to all interested in the study of the nervous system.

ESSENTIALS OF FEVERS. By GERALD E. BREEN, M.D., B.C.H. (N.U.I., Dub.), D.P.H., D.O.M.S. (R.C.P., Lond., R.C.S., Eng.), Temporary Divisional Medical Officer, Hospitals Division, the London County Council; Late Municipal Medical Representative and Deputy Sector Hospital Officer, E.M.S.; formerly Deputy Medical Superintendent, the L.C.C. Infectious Hospitals Service; Examiner in Fevers to the General Nursing Council of England and Wales. Second edition. Baltimore: The Williams & Wilkins Company, 1948. Price, \$4.50.

It is unusual to find a book for which one can say there is a definite need, in these days of prolific publica-

tion. But here is a really good book, one which the reviewer enjoyed reading.

The style is most informal and "clinical" in the sense that the reader feels he is in the presence of an author with deep experience together with that rare ability to teach what he has learned. This is not a textbook with serialized formality of presentation. Rather it is more like a group of well-organized clinics on the contagious diseases.

Each page is meaty with clinical facts stemming from experience rather than from abstracting other textbooks.

The introductory chapters deal with the fundamentals of infection—bacteriology, immunology, and epidemiology. Chapter 4 dealing with diagnosis and treatment of febrile patients is a gem. The description and definition of rashes is most lucid and will benefit the student more than many pages of textbook material read in an effort to cull the fundamentals of diagnosis of skin manifestations in contagious diseases. The section on streptococcic diseases is meaty. The chapter on diphtheria is excellent. Practical points in the management of diphtheria patients are emphasized. For example, the reader is cautioned to put rubber shoes on the patient convalescing from diphtheria when first ambulatory because of the danger of accidents produced by the ataxia at this time. The description of tracheotomy is almost as educational as doing this procedure.

There are chapters on typhoid and paratyphoid fever, gastro-enteritis, dysentery, and all are equally replete with clinical facts gathered from handling patients with these diseases. There are many fine color illustrations of rashes and throats which, although somewhat diagrammatic, are more impressive than colored photographs.



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The materials for prophylaxis of some diseases are given in English terminology since this book was published in Britain. There are a few omissions in the realm of diseases characterized by fever, but, as stated before, this is not a textbook, so does not purport to cover all infectious diseases. It might be added that the therapeutics of pertussis does not cover the unquestioned value of human immune serum. However, this is a relatively recent development and will probably be included in a later edition.

This book is highly recommended to all students, interns, and practicing physicians who would like to enjoy reading a real "teaching book" on the subject of fevers and contagious diseases.

TEXTBOOK OF PUBLIC HEALTH. By W. M. FRAZER, O.B.E., M.D., Ch.B., M.Sc., D.P.H., Barrister-at-Law, Gray's Inn, Medical Officer of Health, City and Port of Liverpool, and Medical Officer to the Liverpool Education Committee; Professor of Hygiene, University of Liverpool; and C. O. STALLYBRASS, M.D. (State Medicine), Ch.B., D.P.H., M.R.C.S., L.R.C.P., Order of St. Sava, Deputy Medical Officer of Health, City and Port of Liverpool; Lecturer on Public Health Administration, University of Liverpool, and Lecturer in Vital Statistics and Epidemiology, Liverpool School of Tropical Medicine. Twelfth edition. Baltimore: The Williams & Wilkins Company, 1948. Price, \$6.50.

The twelfth edition of this book consisting of 23 chapters of 551 pages of reading matter and 18 pages of index is an excellently compiled volume on public health. Unfortunately, however, the introductory chapter on public health administration is discouraging to the reader, since it deals with many acts of Parliament on public health legislation applicable only to England, Scotland, and Wales. It is my impression that too much space is given to laws, rules and regulations, but this was probably done, as explained by the authors, "to cover the ground for the certificate and the diploma in public health under the Chief Medical Council's new rules," etc. However, the chapters dealing with science of sanitation are very well done and should be of great

help to the health officer and students of sanitary science and industrial hygiene.

The chapters of extreme interest to the average physician and health worker are those dealing with epidemiology, infective diseases, and maternal and child health. These chapters state in a clear and decisive way the basic principles of epidemiology, communicable diseases, prenatal, natal, and school health services.

There are several terms, such as "ambulance box" and "health visitor," with which I am not acquainted and which should be explained.

In general, this book is worthy of reading and should be of interest to health officers, students of public health, economists, and social workers. It would make a valuable addition to the library of the health officer.

TREATMENT OF HEART DISEASE. By WILLIAM A. BRAMS, M.S., M.D., Ph.D., Associate Professor of Medicine, Northwestern University Medical School, and Attending Physician, Michael Reese Hospital, Chicago. First edition. 195 pages including index. Illustrated. Philadelphia and London: W. B. Saunders Company, 1948. Price, \$3.50.

This book is a well written and easily read manual on the treatment of heart disease. Essentially, the book is in two parts, the first of which deals with the pharmacology of the cardiac drugs, and the second with their application to cardiac disease states. Logically, considerable space is devoted to a discussion of the use of digitalis in therapy, but, in view of their widespread use, much more consideration could be given to the use of the glucosides of digitalis. The section on sub-acute bacterial endocarditis does not mention penicillin prophylaxis in cases of congenital or acquired heart disease where minor surgical procedures, such as tooth extraction, are indicated. This means of preventing sub-acute bacterial endocarditis deserves mention.

The book is a handy reference volume dealing rather thoroughly with the pharmacology of the standard drugs as used in heart disease and deals at some length with congestive heart failure and coronary disease. The remainder of the book is sketchy, but contains a liberal bibliography which should facilitate collateral reading.



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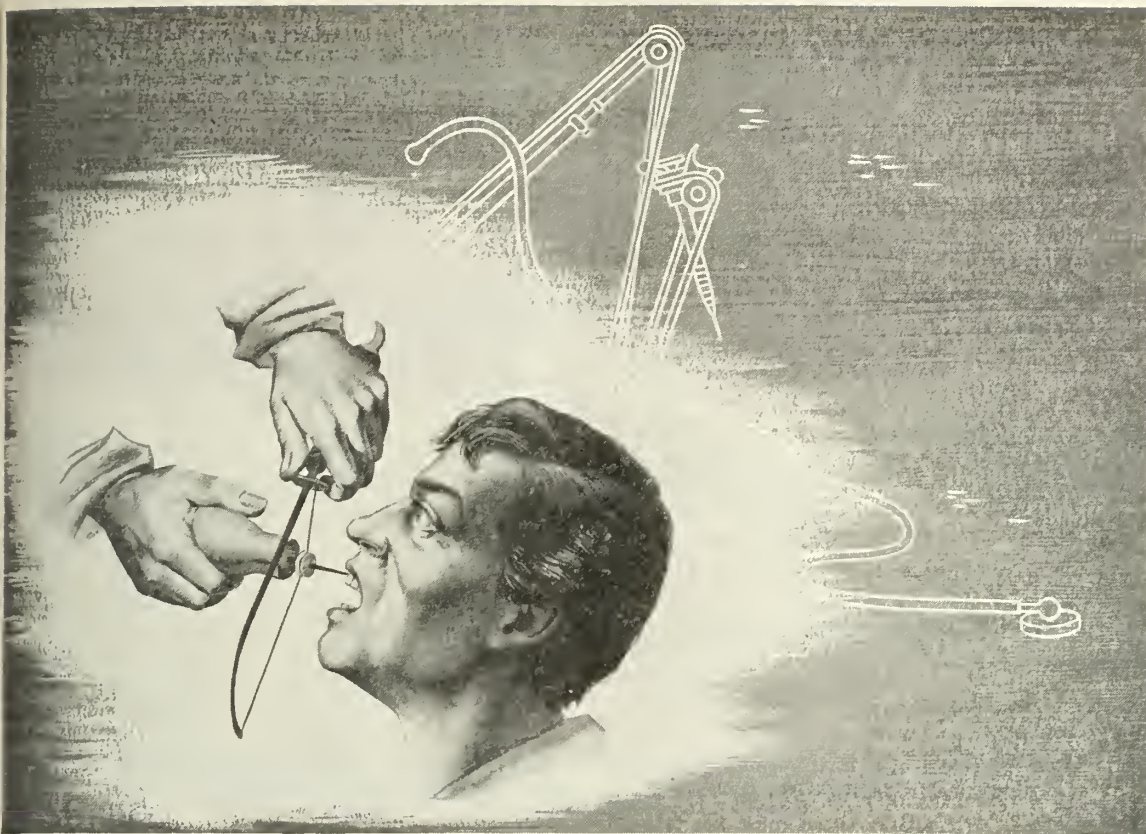
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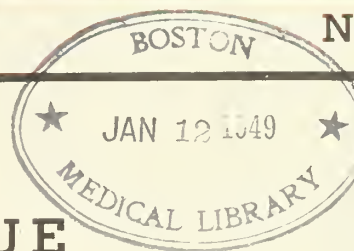
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An Editorial



ONCE IN A HUNDRED YEARS

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MR. EWING'S REPORT ON THE NATION'S HEALTH

Officers' Department

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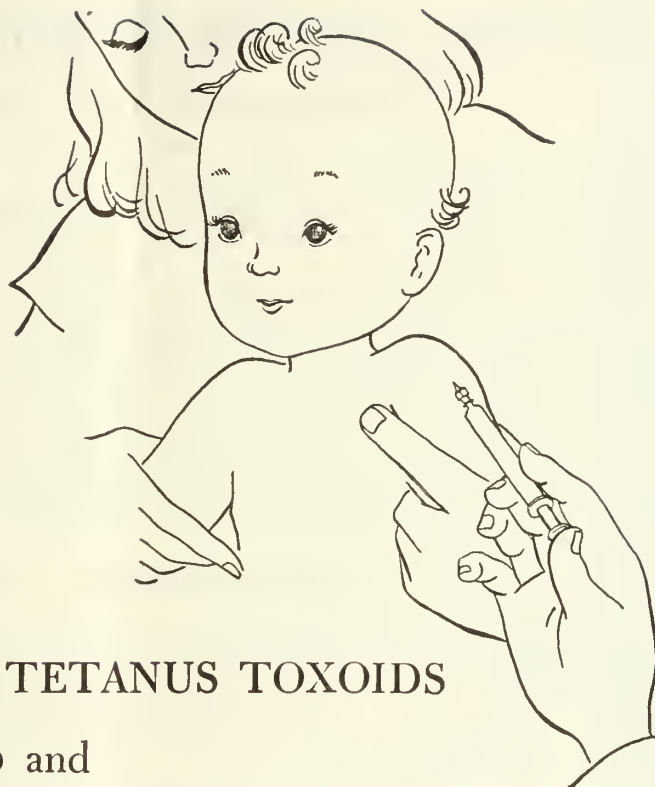
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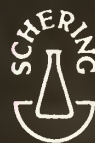
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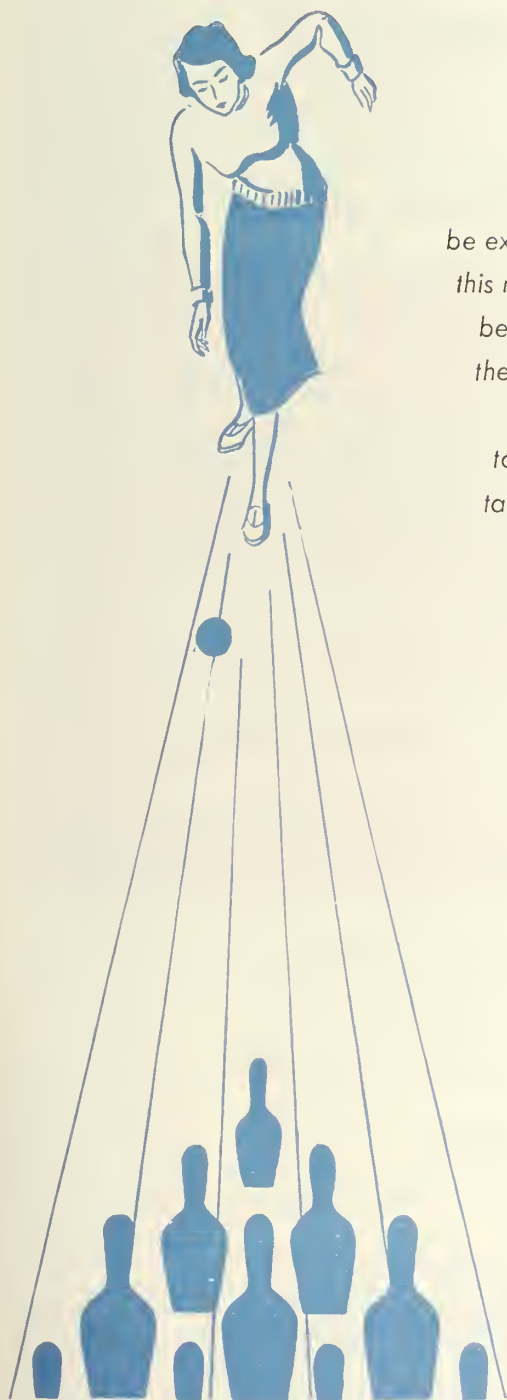
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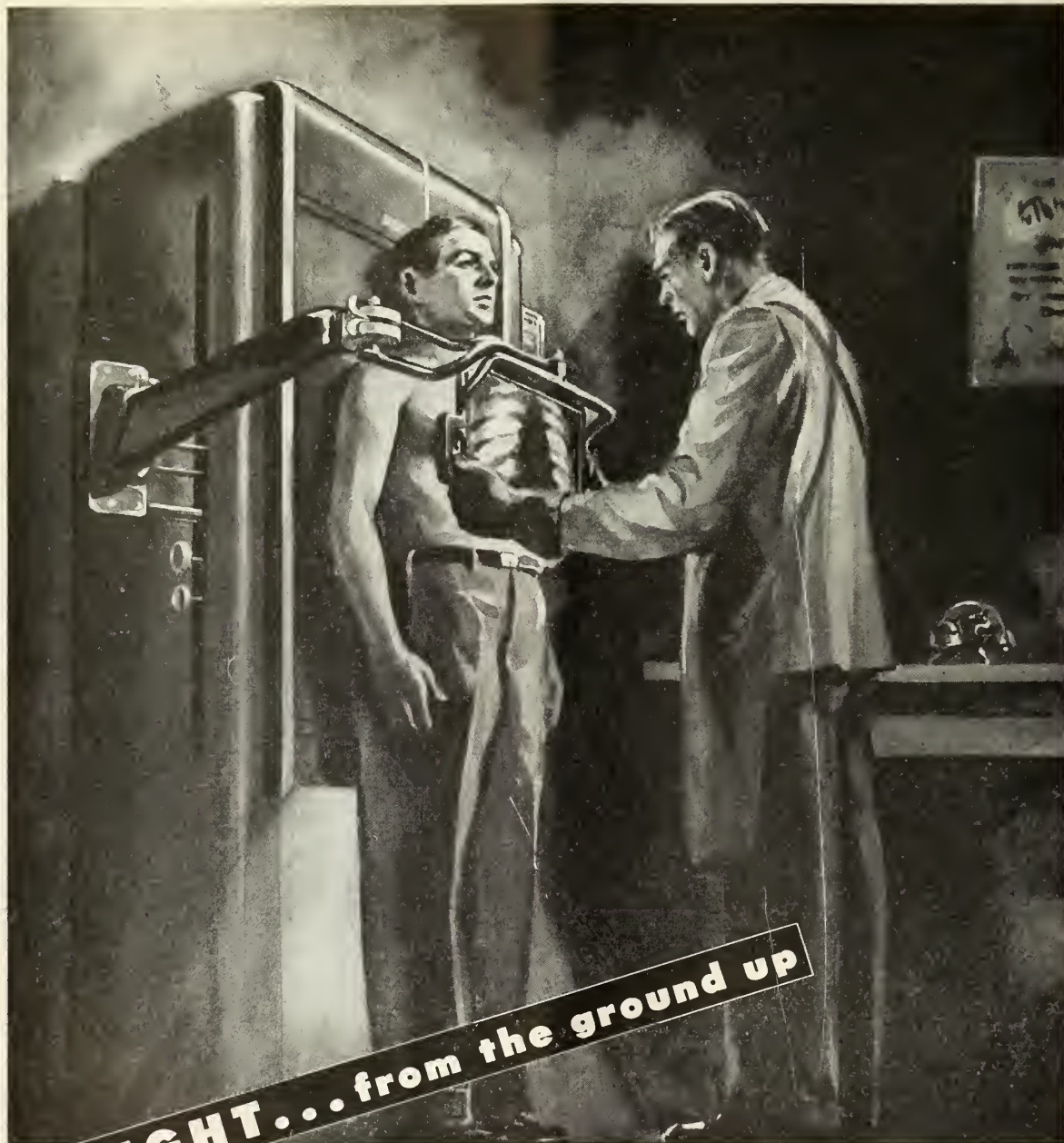
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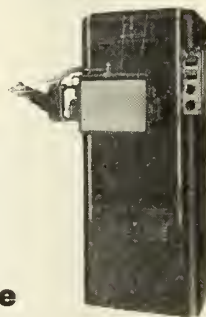
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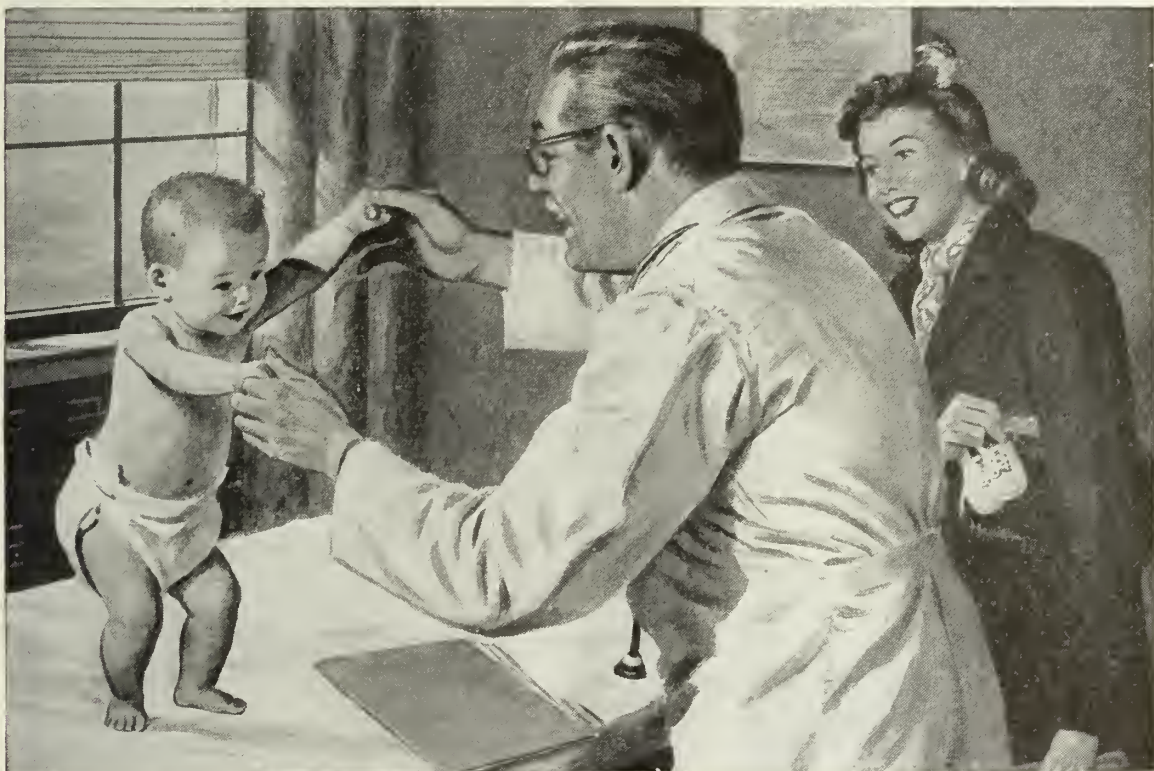
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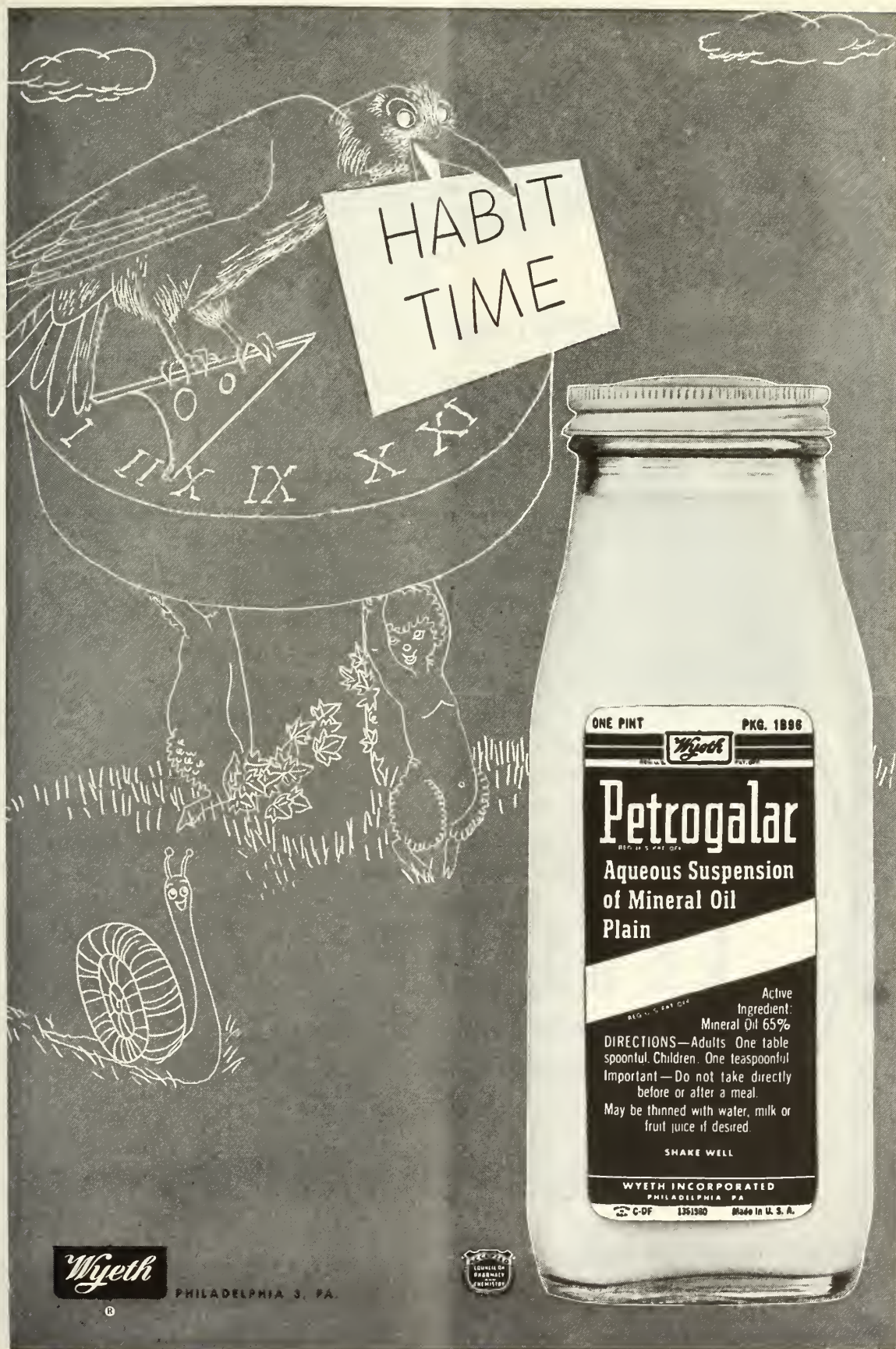
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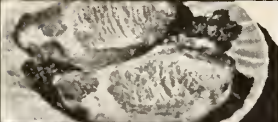
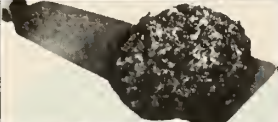
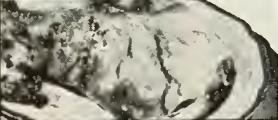
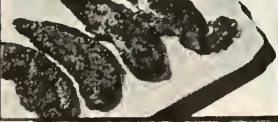
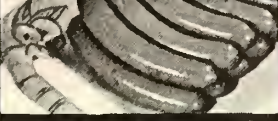
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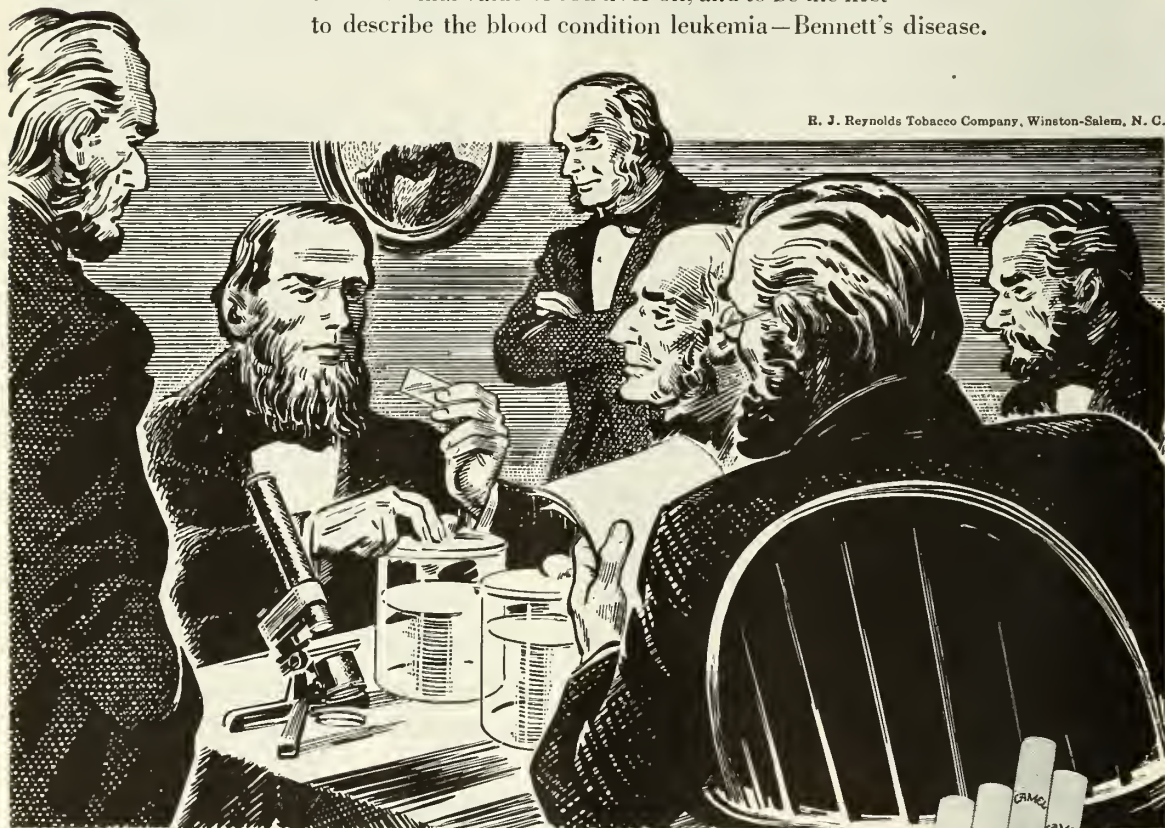
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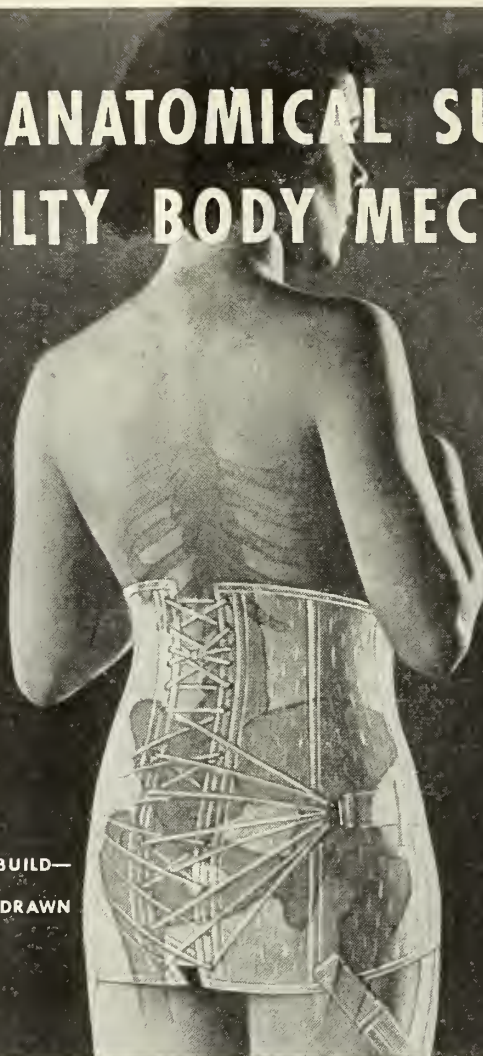
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Present-Day Concept of the Treatment of Thrombosis and Embolism

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DURING the past decade, there has been a real effort on the part of physicians and surgeons in many parts of the world to reduce the morbidity and mortality from venous thrombosis and pulmonary embolism. Although the process of thrombosis in the veins was made clear by William H. Welch, the pathologist, and the mechanism of clotting of the blood clarified by Howell¹ many years ago, little progress has been made in the clinical application of this basic knowledge until recently.

Thrombophlebitis, commonly called "phlegmasia alba dolens" by the profession and "milk-leg" by the laity, was well understood as a serious complication of trauma, parturition, illness, and postoperative convalescence, but little could be done to prevent it. Normal recovery eventually took place in the majority of cases, but a high percentage of these individuals had residual sequelae in the form of persistent swelling and ulceration of the involved extremities. Pulmonary embolism in its non-fatal form was often considered and treated as pleurisy, pneumonia, or heart trouble. Although many con-

valescents died suddenly of massive pulmonary embolism, these were in most instances not related to the previously diagnosed thrombophlebitis. Actually, it was not until recently that Hampton and Castleman² demonstrated that 95 per cent of all pulmonary emboli arise from the deep veins of the legs. Previous to this time, massive embolism was thought to arise more often in the large abdominal and pelvic veins as well as from the heart.

Since the majority of fatal emboli came without warning, it became obvious to Homans³ and to Ochsner and DeBakey⁴ that this phenomenon was due to a non-inflammatory type of thrombus which was loose within the vein. If it developed to sufficient length and was carried to the lungs by the blood stream en masse, death within a few minutes was the rule. Homans used the term "bland thrombosis" and Ochsner and DeBakey "phlebothrombosis" to distinguish this type from the commonly recognized thrombophlebitis. Although the inflammatory thrombus, held within the vein by the reaction in and around it, seldom breaks free in sufficient amounts at one time to cause sudden death, the sequelae of this lesion are often disabling. In many instances of phlebothrombosis, we have observed a slow but progressive change in the process that results finally in thrombophlebitis. The rapidity with which the typical thrombophlebitis develops makes us feel that most of such cases are not preceded by

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phlebothrombosis. Therefore, although all gradations of these diseases are seen, it is our opinion at this time that there are two distinct entities—one being dangerous from the standpoint of sudden death and the other from its disabling sequelae in the legs.

Thrombophlebitis usually comes on suddenly with pain, fever, and swelling of the leg. The diagnosis is easily made and if the patient is treated conservatively the convalescence is a slow process. Often when one leg begins to improve, usually in ten to twenty days, the other leg becomes acutely involved. If there is marked infection, the propagating thrombi break off and cause septic infarcts in the lungs. This may lead to a fatal outcome after repeated episodes over a period of weeks. Based to some degree on the severity, extent, and duration of the process, many of the survivors are permanently handicapped. The chronic lymphedema and superficial varicosities are in themselves often disabling. The chronic stasis and lack of proper oxygenation of the tissues often bring about eczema and chronic or recurring ulcerations. In the past, most of our endeavors have been directed towards the alleviation of these lesions.

Massive pulmonary embolism with its so frequent fatal outcome often occurs in a patient who appears at the time to be making a normal convalescence. There has been no previous pain or swelling in the legs and there has been no elevation of temperature. Although it has been known for years that this was due to venous clotting, rarely, if at all, has there been any consideration given to the possibility that the chief source was the long deep veins of the legs. Bland thrombosis and phlebothrombosis are new terms. The fact that massive emboli came without warning led the profession to look upon them as an "act of God" over which it had no control.

Statistical data concerning the incidence of thrombophlebitis and of fatal pulmonary embolism have been collected from various clinics in many parts of the world for more than a quarter of a century. It was established that certain types of individuals with certain kinds of lesions were more prone to succumb to pulmonary embolism than the average run of patients. Such conditions as obesity, low blood pressure, infections (particularly within the pelvis or abdomen), abdominal and pelvic malignancy, cardiac decompensation, pneumonia, burns, and fractures of the lower extremities appeared to be conducive to this complication. It was not uncommon following parturition and surgical procedures, and it was particularly common follow-

ing prostatic resection and fractures about the hip joint.

It soon became obvious to some that conditions preventing activity of the extremities, particularly those that enhanced venous stasis by immobilization, the sitting position in bed, pressure on the popliteal region, and tight abdominal and inguinal dressings, were conducive to venous thrombosis. Pool⁵ and others recommended passive exercises of the extremities, deep breathing periodically, and frequent changes of position in bed to reduce the incidence of thrombosis. To this has been added active exercises, the elimination of tight dressings, the use of bandages from toes to groin (particularly when varicosities are present), elevation of the foot of the bed, and early postoperative walking. That such general measures are beneficial to convalescence has been generally accepted and they are usually carried out whenever possible. It would be difficult to prove to what degree such methods are effective since so often they are done incorrectly and inadequately. It is our opinion, however, that it is the duty of every doctor to make a serious effort along these lines and take the time to properly instruct his assistants, his nurses, and the patient in the rationale of these maneuvers. Venous stasis and the resulting thrombosis may be avoided, thus reducing the chances of thrombophlebitis and phlebothrombosis with subsequent pulmonary embolism. Even if one does not believe that this purpose is served, it must be obvious to all that continuous exercise during convalescence is of tremendous economic value because thereby the normal responsibilities of life can be resumed in a shorter period of time.

In more recent years, certain specific measures have been developed to prevent thrombosis of the veins and to treat the condition after it occurs. These contributions have led to some basic facts that are important. Laboratory and clinical research have clarified the problem considerably. It became obvious that the degree of atherosclerosis existing in a patient was an important factor in the development of venous thrombosis. This was soon interpreted on the basis of age, since it was easy to show that the older the patient the greater the likelihood of this complication. Furthermore, it appears that climate has a bearing on the incidence of the disease since the lowest ratio is observed in the summer and the highest in the winter months in New England.⁶ Ochsner and DeBakey⁷ have demonstrated that vasospasm was conducive to the development of venous thrombosis and this we believe explains these climatic variations. It also became obvious

that clinics admitting a high percentage of aged patients with serious lesions were more acutely aware of these complications than were the average hospitals throughout the country. Serious thought may not be given the matter in some localities until a catastrophe occurs.

McLean,⁸ working in Howell's laboratory, brought out the fact that extracts of certain organs had an anticoagulant effect on the blood. Later, Howell¹ named this substance heparin and suggested that if it could be purified it might be utilized clinically. Charles and Scott⁹ did purify heparin and soon Murray, Jaques, Perrett, and Best¹⁰ in Toronto and Crafoord and Jorpes¹¹ in Sweden demonstrated that heparin would lower the expected death rate in non-lethal pulmonary embolism. Heparin was also observed to shorten the course of thrombophlebitis. Although heparin did not resolve an old thrombus, it did prevent the formation of the so-called propagating thrombi that usually spread from the original site and were the cause of the most serious complications. This method of treatment was widely adopted in the treatment of thrombophlebitis. Modifications of its use as a prophylactic measure were instituted by Crafoord and Jorpes, Borgstrom,¹² and others in Scandinavia as well as by Loewe,¹³ et al., in America. The latter have demonstrated its effectiveness when suspended in Pitkin's menstruum. The slower absorption of this material eliminates the need of the tedious constant intravenous method used ordinarily. Bauer¹⁴ feels that by constant vigilance one can determine the onset of thrombophlebitis and use heparin in repeated concentrated intravenous doses with excellent results. The clotting time of the blood must be carefully followed during the administration of this drug. If bleeding tendencies occur, whole blood transfusions and the use of protamine are indicated.¹⁵

Link¹⁶ discovered that spoiled sweet clover was the cause of the black water fever in cattle and isolated the active chemical that was responsible. This has become known as dicumarol and it will effectively reduce the existing clotting mechanism of the blood. The action is different from that of heparin in that it increases the prothrombin time. While heparin is almost immediately effective in elevating the clotting time, dicumarol requires from twenty-four to forty-eight hours to bring about a measurable effect on the prothrombin time. Dicumarol has the advantages of being utilizable by the oral route and its low cost. The drug should never be given empirically and must be used with intelligence. Daily prothrombin time determinations are im-

perative until the patients' reactions to it are determined. Some people are very sensitive to the drug while others are quite resistant. Dicumarol has an accumulative action and, even after daily prothrombin levels have given a good idea how much of the drug is needed daily, or every other day to maintain a satisfactory elevation of the prothrombin time, frequent laboratory observations are necessary. Hemorrhagic manifestations that may develop during the use of dicumarol are best treated by massive doses (60 mg.) of synthetic vitamin K. Important contributions have been made on the therapeutic and prophylactic use of this drug by E. V. Allen¹⁷ and co-workers of the Mayo Clinic, Evans and Dee¹⁸ of the Lahey Clinic, Smith and Mulligan¹⁹ of Boston, Wright²⁰ of New York, Bruzelius²¹ of Lund, Sweden, and others.

Following Quick and Leu's²² contribution on the prothrombin time, Chargaff, Bancroft, and Stanley-Brown²³ studied the patients under their care in relationship to the prothrombin time and the development of postoperative thrombophlebitis. They found that all patients under observation who developed this complication were in the group showing a lowered prothrombin time. Although not all of this group developed thrombophlebitis, they felt that these patients required extra precautions. With these data in mind, Mahoney and Rice²⁴ have somewhat simplified the technique of prothrombin determinations and have carried out this test routinely in the vulnerable patients at the Strong Memorial Hospital in Rochester, N. Y. They appear to be able by this routine to predict within the first postoperative week the pending development of thrombosis and prevent its occurrence by the use of properly instituted anticoagulant therapy. This, we believe, is a great advance in the management of this syndrome. It remains to be shown that prothrombin determinations can be accurately carried out routinely in all hospitals. Also, further evidence is needed to support the reliability and feasibility of this method. It is without doubt the proper line of reasoning for investigators in this field and is much more logical than the routine measures heretofore recommended, including our own.

Many members of the staff of the Massachusetts General Hospital have interested themselves in the thrombo-embolic syndrome for more than a quarter of a century. Davis²⁵ found that three of every 1000 patients subjected to major surgical procedures in the decade of the 1920's would succumb to pulmonary embolism. Miller and Rogers,²⁶ in 1929, demonstrated in animals that without venous stasis experimental

thrombosis was very difficult to bring about *in vivo*. They further found in an analysis of all patients who developed clinical thrombophlebitis that 2.5 per cent of these would die of embolism. Welch and Faxon²⁷ showed that during the first decade when active exercises, frequent change in position, deep breathing, and elevation of the foot of the bed were utilized, the incidence of fatal postoperative embolism was reduced to about 1 in 800. Hampton and Castleman² demonstrated not only the ease of roentgen-ray diagnosis of pulmonary infarct but the fact that 95 per cent of all emboli came from the deep veins of the legs. In the past decade, we^{28, 29, 30, 31} have reported the results obtained by phlebotomy, thrombectomy, and femoral vein interruption. Also, we have established that dicumarol was an excellent prophylactic drug in the prevention of thrombophlebitis.

Roe and Goldthwait³² have reviewed our autopsy records and find that there is approximately the same ratio of deaths from pulmonary embolism now as was the case in the previous decade. This outcome is to be expected since now patients seldom die of shock, infection, pneumonia, and hemorrhage. They therefore live long enough postoperatively to develop thrombosis and embolism. The death rate from all causes is tremendously lower, the percentage of autopsies is higher, and the average age of all patients admitted is greatly increased.

A brief review of our data on the subject seems in order. Up to Sept. 1, 1948, we have had 3073 patients under observation for treatment of or prevention of the thrombo-embolic syndrome. Our first efforts were directed towards the use of heparin in well-established thrombophlebitis with or without embolism. It soon became apparent to us that this method left much to be desired. One death from embolism occurred during treatment, and recurrence in another patient with fatal embolism occurred forty-eight hours after an apparent success of fourteen days of treatment. About this time, Homans³³ brought to light the possibility of interruption of the deep veins of the legs as a means of preventing repeated sublethal infarcts in low-grade thrombosis. The use of this method was begun with great caution and, in addition to interruption of the veins, we removed by suction the thrombi above and below the point of vein division. This proved so spectacularly successful that we soon had confidence in it and proved that it could be done without harm to the patient. Having the knowledge that the fatal embolus had come from the apparently uninvolved extremity following interruption of the femoral vein that

was obviously thrombosed by sudden death and postmortem proof thrust upon us, we soon began bilateral femoral vein interruption. Observations of the negligible swelling and discomfort following the interruption of the normal superficial vein gave us courage to try this procedure as a prophylactic measure in a series of highly vulnerable cases. It soon became obvious to us that interruption of the common femoral vein was followed by greater edema and of a more persistent character. Also, in one instance, an alarming engorgement of the extremity took place similar to that experienced by Dennis.³⁴ Because the results appeared so good and the sequelae so slight, we rapidly came to the conclusion that the routine site of femoral vein interruption should be immediately distal to the profunda femoris vein.

Ochsner and DeBakey's⁷ contribution on the effect of vasospasm on thrombophlebitis led us to adopt their recommendation of repeated lumbar sympathetic blocks. This procedure was used exclusively in certain patients, but we found that in our climate the relief was transient and often had to be repeated over a long period of time. We still use this important aid in the treatment of persistent painful swelling following femoral vein interruption.

In an analysis of our patients, we found that fatal embolism rarely occurred under the age of thirty. Usually patients below this age were easily activated, had less serious lesions and, when thrombosis did occur, there was sufficient warning to institute specific treatment before serious embolism occurred. In those patients over 65 years of age, we preferred not to use anticoagulant therapy since our medical service had encountered too frequent cerebral hemorrhages in this age group treated with heparin for subacute bacterial endocarditis. For this age group, we felt that selected cases with lesions known to be conducive to thrombosis and embolism should have prophylactic femoral vein interruption. This was done at the time bedrest was instituted, at the time of the major surgical procedure, or within seventy-two hours afterwards. In the interim age group, it seemed practical to carry out a controlled study on the prophylactic use of dicumarol. Since we have two identical surgical services, we used dicumarol on one and not on the other until we could learn how best to employ it.

We have performed phlebotomy, thrombectomy, and femoral vein interruption on 1369 patients after the diagnosis of thrombosis was obvious or strongly suspected. Our first series showed that approximately half of these were on

the basis of pulmonary infarct and the remainder on the signs of thrombosis by examination of the legs. Later, we came to have reliance on the concomitant slight rise in temperature, pulse, and respiration as recorded on the clinical chart. When this occurs at the same reading on a patient otherwise doing well, one can be sure that phlebothrombosis is present and that there has been a painless infarct. If the legs of a patient are carefully observed twice daily, it is often possible to see the early signs of venous thrombosis. One sign may be a slight tenderness on palpation of the foot, the calf, the popliteal space, or the groin. There may be a slight dilatation of the superficial veins of the foot. The dorsiflexion sign of Homans is present only in well-established thrombosis and is not an early manifestation of disease. In spite of these careful observations, the first warning is often a pain in the chest. One must not rely on the absence of cough or bloody sputum or on an immediate negative roentgenogram. Infarcts are usually more easily manifest by x-ray examination twenty-four hours after their occurrence. In severe chest pain without leg signs, one must bear in mind the possibility of coronary occlusion. With the electrocardiogram, the cardiologist can often differentiate infarct in the lungs from infarct in the heart. In the above group of 1369 patients, 6 succumbed to further emboli. All of these had had sublethal embolism before operation and all but one were over 65 years of age. On the basis of previous experience, we could have anticipated 54 deaths from embolism in this group.

By this method of treatment, we are impressed by the short duration of thrombophlebitis symptoms. These patients are made ambulatory as soon as their original condition permits. If the inflammatory process does not abate rapidly and swelling and pain persist, lumbar sympathetic procaine blocks are used. Heparin and dicumarol are given if the process is extensive or if infarcts continue. In spite of the above measures, rarely have continued infarcts called for vena cava interruption. Only 15 patients have been subjected to this procedure in our clinic. The sequelae are quite disabling in some instances following vena cava ligation and we feel that such a procedure should not be used except in the unusual circumstance of repeated septic infarcts from the pelvic veins or in those whose thrombotic process is not arrested by the less radical methods described above.

During this same period, we have subjected 984 patients to superficial femoral vein interruption as a prophylactic measure. Almost all of

these have been beyond the age of 60, and all have had lesions or conditions that made them particularly prone to develop thrombosis and embolism. Veal³⁵ has demonstrated that patients requiring low thigh amputation, particularly for arteriosclerotic or diabetic gangrene, have a high incidence of massive pulmonary embolism. Golodner,³⁶ et al., pointed out that patients with fractures about the hip joint were also likely to develop thrombosis and that a high percentage of them died of pulmonary embolism during convalescence. Bauer¹⁴ brings out the fact that patients with leg injuries, particularly fractures of the long bone, have a high incidence of thrombophlebitis. We have definitely confirmed these reports in an analysis of our own patients. In addition to these, we have shown that malignancy of any of the pelvic or abdominal organs increased the hazard of thrombosis and embolism. Acute intestinal obstruction, peritonitis, prostatic resections, and obesity, all have shown a high incidence of this complication. The age factor alone is important because it matters little for what cause an elderly patient is made bed-fast; a certain percentage of them will die of pulmonary embolism.

In this group of 984 vulnerable patients treated by prophylactic superficial femoral vein interruption, there were four who died of pulmonary embolism. These were known to arise in the profunda femoris in two instances and from the iliacs in the other two. If no prophylactic treatment had been instituted in these 984 cases, we would have expected 37 deaths from embolism. This determination is based on the examination of the counterpart record as regards age, sex, lesion, and hospital service. They are a mixture of patients from the wards and private pavilions. Although the majority of them were surgical patients, a considerable number were medical with a high percentage of cardiacs.

The congestion of the pelvic veins following femoral vein interruption makes this procedure a handicap if done before or at the time of pelvic dissection. For this reason, we advocate a delay of forty-eight hours when such an operation is done.

Having demonstrated in our controlled studies that small doses of dicumarol would protect 80 per cent of the patients from thrombophlebitis, we have now used this drug on 720 patients. This does not include patients with coronary occlusion treated by the medical service. Although we have advocated the use of this drug in the middle-aged group, we have on occasion given it to patients under 30 and to those over 65. We have tried to avoid its use in hypertension, liver

disease, old age, arthritics taking aspirin, multiple-stage operations, and other situations where hemorrhagic tendencies were above the average. In surgical procedures that leave a large denuded surface such as combined abdomino-perineal operations or many of the thoracic lesions, it seems best to withhold it. Without doubt, its use increases the amount of oozing in dead spaces. In spite of our warnings and caution, we have had two hemorrhagic fatalities in this group of patients. One was a hypertensive who developed subarachnoid hemorrhages. The other was an 82-year-old man who had a transurethral prostatic resection followed a few days later by repair of an incarcerated sliding hernia. He was given 200 mg. of dicumarol in error and had a series of massive hemorrhages from the prostatic bed. Three weeks later, he died of uremia while still in the hospital. Neither of these patients should have received the drug.

There were a considerable number of non-fatal hemorrhagic complications in the dicumarol-treated group. Two patients bled massively from the anastomosis following right colectomy. Two instances of major bleeding occurred in the pelvis—one following total hysterectomy and one following a combined abdomino-perineal operation for cancer of the rectum. Another patient, age 49, recovering satisfactorily from closure of acute perforation of a duodenal ulcer, bled massively on the eighth postoperative day. He had received 400 mg. of dicumarol in divided doses.

Summary and Conclusions

1. Thrombosis of the deep veins of the legs is of two distinct types.
2. Thrombophlebitis is inflammatory in nature and the thrombus is not as likely to be detached en masse to produce fatal pulmonary embolism. The sequelae of untreated thrombophlebitis are severe and disabling. These may be eliminated by early femoral vein interruption, lumbar sympathetic procaine blocks, and anticoagulant therapy.
3. Phlebothrombosis is bland in nature and may cause such minimal signs in the legs that it is entirely overlooked and unthought of until pulmonary embolism occurs. The majority of pulmonary embolic deaths are from this type of thrombosis because the loose clot often becomes detached and is carried to the pulmonary arteries en masse.
4. Phlebectomy, thrombectomy, and bilateral superficial femoral vein interruption will prevent phlebothrombosis from developing into thrombo-

phlebitis and also prevent fatal embolism in most instances.

5. Prophylactic bilateral superficial femoral vein interruption is a safe and logical procedure in certain types of highly vulnerable patients. This does prevent thrombophlebitis and pulmonary embolism in nearly all of such patients.
6. No patient out of 2353 subjected to femoral vein interruption at the Massachusetts General Hospital has lost his limb or his life as a result of this procedure.
7. Heparin and dicumarol are effective in preventing thrombosis of the veins and in the treatment of thrombophlebitis and sublethal pulmonary embolism.
8. Safer drugs for this purpose are needed.
9. Simpler laboratory control methods are also necessary.

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VACATIONS

Prescription for a busy doctor: one vacation twice yearly—take as desired for relief of jitters, restlessness, difficulty in thinking, and assorted headaches.

We order patients to get away and see in them numerous benefits of similar prescription. Current thinking approves vacations. They are acceptable to the U. S. Government, to the Civil Service, to the United Mine Workers, and to most corporations. In principle every one admits a vacation is desirable. Creative work in design, music, science, writing, medicine, law, teaching, and administration demands longer and more effective vacations than do the tasks which require less imaginative effort. Farmers, especially those who love the soil, have told me, "I don't need a vacation" and then explain the pleasures of their work and daily living a gratification in achievement which is truly satisfying. Few physicians can so well balance the day's energy output with rest and recreation so that each day ends profitably in terms of energy. Most physicians get too little exercise, too long hours, irregularity of living habits, and have too little recreation in terms of hobbies or fun activities at home. As a result of intense application, a variety of fatigue or staleness appears even if the doctor is still young and even if he is in good health.

The individual should be privileged to take his vacations as he needs them. Perhaps a long week-end timed properly can put a man in good enough shape to carry on for a time. In older men longer vacations are more to be desired. Summer holidays are the choice of younger men, particularly with children, whereas older men often prefer a winter vacation in the South. Such decisions are highly individual and often dictated by reasons of health in the doctor or his immediate family. The common aim is *escape* (without pharmacologic assistance) from fatigue, boredom, responsibility, and routine. A vacation is not intended to correct an involuntary psychosis or to cure any undiagnosed ailments. The greatest benefits of a vacation go to those in good health. It is hygienic, not curative.

Doctors have many ways of paying office expenses while on vacation. Partnerships and clinics plan for vacations for their professional men and usually plan generously, utilizing the "slack season." Individual physicians may be able to shut the office entirely and give the office help some time off also. A friend may keep office hours if the practice requires it. The hospital or exchange can direct your calls to a man of your choosing. In most communities some capable physician can

be had as your relief man. How you repay him is for you to decide. No honest method would be criticized. Local customs differ, but are still dependent on personal agreements and on good-humored friendliness. Smith will gladly look out for Dr. Jones during his absence because that will get a vacation for Smith some day.

Note on Income Tax.—At present a significant part of our annual income goes to the government. The lower our income the lower the tax. The higher the income the greater the tax. Therefore, on a lifetime income of \$400,000, the longer the period over which it spreads the lower the tax. The nearest approach to a loophole in the income tax system is organization as an educational institution; but a strong man can do something for himself by maintaining some income through the sixties and often enough in the seventies. Perhaps the prescription of one vacation twice yearly as desired may help you reduce your lifetime taxes by spreading them over four or more decades.

For advice as to what to do on vacation, we suggest consultation with—your wife—she probably needs it worse than you do.—*Illinois Medical Journal*, August, 1948.

THE GENERAL PRACTITIONER

Before any physician can be a competent specialist, he should be a good doctor and should be well acquainted with all of the diseases of the human body. It, therefore, might be well to urge that the specialty boards require that each applicant have at least three years' experience in general practice before specializing, and that hospitals reserve a major portion of their resident training positions for men with such experience. The specialty training program then could be lessened, because out of his own experiences the physician would have acquired unusual training that especially fitted him for any type of medical practice.

The general practitioner is a vital part of our system of medical care. He should not be denied the proper use of available hospital facilities. There are certain intricate procedures that must be limited to specialists in that field, and the competent general practitioner will recognize his limitations. Our present system of medical care is very complicated, and no one can cover the whole field. The specialist and the general practitioner are equally necessary.—CLEON A. NAFE, M.D., *Journal of Indiana State Medical Association*.

PHYSICIAN, HEAL THYSELF!

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THE proverb which Christ quoted, "Physician, heal thyself," is peculiarly apt as we consider tonight the history and the destiny of the profession of medicine. As we recall the accomplishments of the last hundred years we are acutely aware of the progress of medicine. Even a layman reading of medicine one hundred years ago, of the methods used, of the limited knowledge, of the primitive facilities, is awed by the progress which has been made in the knowledge and practice of medicine. But we are not celebrating one hundred years of medicine. We are celebrating one hundred years of The Medical Society of the State of Pennsylvania. Therefore, we must consider on this occasion not medicine but the medical profession as typified by this distinguished society.

There is a marked difference between a profession and a trade association. There are some trades and trade groups which designate themselves as professions but which can never be such. There is a distinct content to that word and appellation. It is to the credit of the medical profession that some of the finest content of that word has been put into it for all of us by the medical profession.

The first characteristic of a profession is insistence upon the highest possible standard of educational preparation and qualification for admission. Here medicine in Pennsylvania has been pre-eminent. The high standards attained in this regard have been facilitated by the very expense and difficulty of medical education. It is not easy to train medical men by half-way measures as is the temptation to do in the legal profession and in the ministry. But above and beyond this inherent stimulus to high quality preparation, there has been the unwavering insistence of this Society and of those in other states that the standard of attainment for admission shall be ever higher.

The second element of a true profession is an ethical standard of professional conduct which is uncompromising. Here again the medical profession has set a high standard. The ethics of medical practice are clearly enunciated. They are reiterated from the first year of medical school through every stage of education and every stage of advanced practice. There are those who deviate from these standards, but the ethical standards of medicine are so clearly enunciated that these deviations are known by the offender, recognized by his colleagues, understood by the public, universally condemned and reasonably well enforced by the weight of the medical profession and by the pressure of society.

The third element of a true profession is startling in this mercenary age, but medicine has sustained it. This element is that a profession is not officially or organically concerned with mercenary objectives. In view of the large income of many medical men and the presently high cost of medical service to the people, this seems strange. In our day of measuring everything by wage or profit, this professional ideal might be assailed. But that no such attack on this ideal may be made in this Society without your clear understanding of the issue, I emphasize it in passing. A profession is not and cannot be concerned with its financial remuneration in any major or fundamental way. A profession must be devoted to some great human service, quite regardless of remuneration. This service must go on, pay or no pay. Many members of any true profession are, always have been, and always will be, underpaid. There will be no economic reorganization of society by which this will be changed—communism, socialism, or anything else. And when a profession gives precedence to the financial return of its members over and above imperative service to humanity, it then ceases to be a profession.

Here is one of the grave dangers of this age which emphasizes pay, wage, profits, and security. Here is the point at which some associations are at the parting of the ways. When and if the ministry of the church attains perfect security,

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when men giving their lives to preaching of the gospel of Christ are assured through their ecclesiastical organizations that they need have no financial worry, that they will be guaranteed a living wage, that the risk is gone, that theirs need not be a financial adventure, in that day the ministry will sink from a great profession to a kind of ecclesiastical trade-union.

This danger now threatens my own teaching profession. As an organized profession or association, it is verging further and further toward a primary emphasis on teachers' salaries, pension plans, sickness benefits, and high wages. These are all good, and they are indeed essential. But teaching is only a profession so long as men "gladly teach," to use the words of Chaucer—teach because they cannot help it, teach because they have a passion that men may know the truth, teach because humanity must know the truth of God, teach whether they are paid or not. And, if they hold to that supreme motive, it may well be that they—like the profession of the Christian ministry—will be always underpaid.

This is the issue which I feel threatens the destiny of what can yet be a nursing "profession." My statement of this danger recently in York has been very disturbing to the nurses. I think they should be paid more for their wonderful ministry, but I am alarmed for the future of that association if its leaders shall succeed in making wage, hours, and working conditions the primary function of their organization and their thinking. You cannot translate the supreme task of the relief of human suffering into economic terms any more than you can the preaching of the gospel of Jesus Christ or the teaching of truth to little children.

Despite the fact that just now the physician, the surgeon, and the specialist seem to be "in the money," I think there is ample evidence that many are underpaid and that financial remuneration has not pre-empted first place in the organized objectives of the medical profession. With comparatively few exceptions, medical men are still serving quite regardless of the patients' ability to pay. Physicians are still notably inept at keeping accounts of their services. They are notorious for their inability to send bills. They still drive their paying clients mad with bills which are six months to ten years late and which sometimes never come. Many pretend to keep accounts; they still succeed in dying as did my father and my wife's father with a fortune on the books which they never tried to collect. When they do get some money, they still lead our sucker lists in getting rid of it. They rank way up at the top in recklessly abandoning them-

selves to the challenge to save life and bring healing without counting the cost and without collecting the reward.

But the medical profession is being tempted in this age. It is being tempted to organize and correct this situation and see to it that any qualified man entering the profession shall have a living wage assured him and shall have complete economic security. A voice crying out from an economic jungle—I plead now in the name of the mendicants of all ages, in the name of threadbare priests and payless ministers, in the name of missionaries serving with a bare subsistence, in the name of penniless and often homeless teachers, in the name of the country doctor who gave his life without material reward, in the name of the always underpaid professions of service—that you resist this savor of the fleshpots and the clinking of silver, and as a true profession maintain the saving of human life, the alleviation of suffering, and the healing of mankind as the one and, if possible, the only objective of the medical profession and of The Medical Society of the State of Pennsylvania on its one hundredth anniversary.

Now, having given what you might call a good bill of health to medicine as being a true profession and entitled to all of the rights and privileges thereunto appertaining, I want to raise the great question with which you will be confronted in the next one hundred years. This question applies with equal force to other associations—to Lafayette College, to the church, to the bar association, to the nursing association, to the labor unions, to the grange, to the stock exchange, to industry. It is very fundamental. This is it: granted that you have done a good job up to this point, are you going to make the changes which a fluid social order requires for the future? Are you going to make those changes yourselves or are you going to let society do it for you?

This question does not arise only from the defects and problems within a profession. For example, no matter how good a job Lafayette College is doing up to now, and quite regardless of what we are accomplishing, there are certain changes going on in society about us which change drastically what we should be doing and the methods by which we are operating. We haven't gone wrong in our ivory tower. But many things go wrong outside the ivory tower. Our impact on society must be changed to meet these external circumstances. Will we do it or will we let the boys outside do it for us? To our trustees, a few days ago, I named three such conditions that we must face and solve within

our field of responsibility. If we do not, someone else will do it for us. That will hurt us.

I could give you many illustrations of this problem. Do you recall the drastic reformation of the stock exchange that was put in by forces who knew little of finance and proved it? No one can tell us that the able and fine men in the stock exchange lacked either the financial acumen, the social responsibility, or the moral judgment to correct those conditions. They just did not do it within their association. Somebody else had to do it for them. Last week I was guest of honor at a dinner with some of my labor friends who turned out to be rabid Democrats and wildly opposed to the Taft-Hartley Law. I listened fascinated to their attacks on that corrective law. Admitting for the moment their arguments, I still could not forget that when the vicious and unjust Wagner Act prevailed these same labor unions refused to do anything to correct the evils involved in their own law. They refused to correct certain evils within their own associations, nor would they adapt their workings to social changes which were going on all about them. Society had to do it. If it was done ineptly in the Taft-Hartley Law, which I doubt, but, if it was, it simply illustrates that societies and professions must correct themselves to meet changing social conditions and do it the right way, or someone else will do it and do it the wrong way.

Now, I am not a medical authority in any sense, but I suspect that there are certain changes in society to which the medical profession will have to adapt its whole method and impact. These external changes may be wrong or right. It makes no difference. They are objective facts. I cannot say with authority what they are, but I believe that, if your Society is to look forward to another hundred years of progress, you had better find out what these changes are.

I suggest that one is the new circumstance of our economic life involving an approach to socialism, subjecting society to expropriation of their earnings and savings in order to support an ever-increasing bureaucracy—an inflation of values due to unbridled government loaning and spending, and a consequent lack of personal financial resources. Our margins of safety are gone. Many of us are desavers. The result is that there must be some adaptation of the economics of prolonged illness and costly surgery to these conditions. On this something has been done, but thus far it is timid, limited, and inadequate. You have started with the ball. You had better carry it over the goal before someone steals it out of your arms.

A second factor is the dearth of medical service in comparison to the increase of our population. On this I have done some study. I am convinced that we need more first-class medical training in Pennsylvania. Assuming that I am right, are you going to solve that, or are you going to wait and let some demagogic politician solve it for society?

A third factor seems to me to be an appalling dearth of medical service in rural areas and a concentration of medicine in the large urban areas. Not only is this true but in 1946 there were figures indicating that 43.7 per cent of rural doctors were over sixty years of age. The question is not what are we going to do about it. The question I ask is, who is going to do it? Are you going to solve this in Pennsylvania in the next hundred years, or are you going to let some political "planner" do it?

A fourth condition which confronts us is the lack of medical training for negroes and the lack of medical care for negroes. Today there is one white doctor for every 850 white population. But today there is one colored doctor for every 4400 colored people. Who will solve this in Pennsylvania—you or the politicians?

A fifth factor which emerges today is the demand of the people for preventative medicine. To this the profession gives lip service, but you know the facts. Go in without a pain or an ache or a broken neck and try to get a thorough examination. See how far you get in one of your colleagues' offices. It is not their fault. They have to save the dying and to do that they must let the living die. On the larger scale, observe that one-third of the counties of America have no full-time health officer. In the balance, 3.4 per cent of the people are served by health departments which meet the minimum standards of the medical profession. This is not easy. It is a great new problem for the medical profession. The question is—are you going to solve this thing or are you going to let the state legislatures do it. If they do it, I warn you, you won't like it. We won't like it!

Finally, I would mention a new condition which is appalling. Medicine has made a mighty appeal for research as a basis for medical progress and treatment. It's been a great job. Everyone who dies now leaves his estate or foundation for medical research. But you forgot that we have to have researchers. No one thought of that. As a result, there has been no corresponding provision for the training of researchers. The colleges and the graduate schools can get little from these foundations because they are

pledged to research, not researchers. Hence, we cannot train the men who must do the research. Research has come to a serious impasse. I do not know the answer to this great medical problem, but, believe you me, I would rather have you solve it than anyone else in the social order. The question is will you do it in your second hundred years?

Gentlemen of the Pennsylvania Medical So-

ciety, these and other medical problems are yours. They are your cancers, your infections, your broken bones. You did not cause them. But somebody is going to treat them—you or somebody else. For the second hundred years in The Medical Society of the State of Pennsylvania, I suggest that you adopt an ancient admonition which was old when Christ quoted it—Physician, heal thyself!

FAMILY DOCTOR IN MAGAZINE ARTICLES

The October 9 issue of the *Saturday Evening Post* contained an article on the general practitioner by Steven M. Spencer, associate editor of the *Post*. Using a Texas general practitioner, a member of the American Academy of General Practice, as the theme of his piece, Mr. Spencer told of the satisfaction to be enjoyed by a competent doctor who serves the health needs of his families without limiting his practice to a single narrow specialty.

Full information concerning the American Academy of General Practice was furnished to Mr. Spencer by the executive secretary during the preparation of his article. Considerable correspondence has also been carried on between the headquarters office and other writers who have done or are doing articles for popular magazines of wide circulation.

Life magazine, in its issue of September 20, carried an interesting story concerning a general practitioner, Dr. Ernest G. Ceriani, of Kremmling, Colorado. Dr. Ceriani took up practice in this town of 1000 after the retirement there of Dr. Chester A. Sudan, an honorary member of the American Academy of General Practice and recipient of last year's award for the outstanding general practitioner of the year presented by the American Medical Association.

Life closed its pictorial narrative with a provocative editorial under the title "General Practice vs. Specialization." It referred to the rebellion against "the rigid protocol of specialization" and the "politics in which many doctors, in order to succeed in a big city, must indulge."

Speaking of the need for more and better general practitioners, *Life's* editor offered two solutions: "a reformation on the part of the schools, which as a rule present specialization as a glamorous occupation and general practice as the thankless chore of a drudge, and an effort on the part of small communities to attract general practitioners by following the example of Kremmling."

The *Woman's Home Companion* recently purchased full-page advertisements in a number of metropolitan newspapers to carry its message decrying the tendency to freeze competent physicians out of hospitals. Under the title, "Give Young Doctors a Break," the magazine's editors declared that "physicians do have the power to squelch potentially dangerous competition—by denying hospital staff appointments." Although the text of the *Woman's Home Companion* advertisement, like most of the similar ones they have been running in a series for

more than a year, is badly garbled, somewhat intemperate, and full of distorted facts, it nevertheless points a public finger at the evil of monopolistic hospital practices.

The increasing number of favorable articles about the indispensable general practitioner appearing in the popular press reveals two very interesting facts: First, the creation of a national organization for general practitioners has focused attention upon the general practitioner and has won for him consideration that was not enjoyed before; second, the establishment of a headquarters office has given writers a source of information for the accurate facts they require in the preparation of such articles.—*General Practice News*, October, 1948.

PSYCHIATRIC THERAPEUTIC DEVELOPMENTS

Pennsylvania's program of mental hospital construction emphasizing treatment facilities furthers the challenge to those engaged or about to engage in institutional psychiatric practice.

While many problems in the treatment of psychiatric disabilities still remain unsolved, therapeutic weapons are now available which were unknown in the none too remote past. The introduction and development of insulin shock therapy has appreciably altered certain types of dementia praecox, while electric shock has benefited forms of dementia praecox and manic depressive psychosis as well as the involutional psychosis. The advent of shock therapy has decreased the median institutional confinement by months and correspondingly increased the number of discharges in the improved and recovered categories.

Additional developments in the field of epilepsy, alcoholism, electro-encephalography, and more recently, the operation of prefrontal lobotomy provide applicable advances in therapy that will promote a more assured and optimistic approach to the problem of treatment of so-called nervous or mental disease. Furthermore, the application of direct, tangible methods of treatment has helped to break down the traditional sharp distinction between physical and mental disease and tended to stimulate investigation of the causes of mental illness as well as encouraged removal of the stigma formerly associated with such disorders.—*Mental Health Bulletin*.

STUDIES ON THE RH HAPTEN

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THE late Karl Landsteiner² used the term "haptén" to distinguish from complete antigens their specifically reacting fractions. Thus a hapten will combine with antibody *in vivo* and in the test tube, but alone it will not produce antibody when injected into the experimental animal. Since the identification of the Rh factor in 1940, many investigators have felt that the Rh hapten, should it be isolated, would offer great promise, both clinically and in laboratory investigation. It is possible to obtain Rh hapten through the use of relatively simple methods and this active material lends itself to research, both in laboratory tests and directly in relation to Rh sensitization.

The methods for preparation of the Rh hapten are as follows:

(1) Pool the cells of outdated bank blood from which the plasma has been removed. This blood may be of any group and may be of any Rh type except Rh negative. If possible, the pool should include all sub-types of Rh. The pooling of a large quantity tends to insure this.

(2) At least one liter of this pool is laked by mixing with half its volume of distilled water, i.e., one liter of pooled red cells requires 500 cc. of water. The cells are not washed because comparison of results with washed and unwashed cells revealed no detectable difference.

(3) Five volumes of 95 per cent alcohol (for one liter of pooled cells plus 500 cc. of water, use six liters of alcohol) are added slowly with shaking and the entire mixture is shaken thoroughly for ten minutes. This gives a dark red precipitated mass, which is covered and allowed to stand at 4 C. overnight.

(4) Filter through a Buchner funnel with suction, pulling air through the dark red powder until the powder is friable.

(5) Add to this powder five volumes by weight of 50 per cent alcohol. Shake for ten minutes.

(6) Filter with suction through a Buchner funnel. When the powder is friable, add to it in a flask five volumes by weight of 25 per cent alcohol and shake thoroughly for ten minutes.

(7) Filter through a Buchner funnel. When the powder is friable, add to it in a flask five volumes by weight of anesthesia grade ether. Shake thoroughly. Allow this to stand for five days at 4 C., with a ten-minute shaking period each day.

(8) Filter through Buchner funnel with suction. Retain the filtrate. Discard the powder.

(9) The ethereal filtrate is evaporated in a hood by repeated fillings of the same crystallization dish. The evaporation is hastened by use of an electric fan.

(10) When most of the liquid is gone, the remainder of the drying may be carried out in a desiccator under vacuum in the presence of phosphoric anhydride. The yellow to white waxy residue contains the active fraction. It is dissolved in 95 per cent or absolute alcohol and bottled.

The purpose of successive washings of the pooled cells with descending concentrations of alcohol is the elimination of superfluous material, notably the group-specific substances.

Assay of the Rh hapten makes use of several serologic methods. Determination of its potency depends on its behavior as an incomplete antigen in relation to *in vitro* tests. The most usable method involves complement fixation. The complement fixation procedures are similar to those used by John A. Kolmer¹ in the serodiagnosis of syphilis. In determining the activity of a specific lot of Rh hapten, a 1 per cent solution of Rh hapten in 95 per cent alcohol is diluted with four volumes of 0.85 per cent saline to produce a 1:500 dilution. Similar dilutions are made to provide concentrations of hapten of 1:1000, 1:1500, and 1:2000. Dilutions may be carried further if the activity of the particular lot of hapten warrants it. The suspension of hapten in saline gives a milky, opalescent liquid.

For each of these concentrations, two 13 x 100 mm. tubes are set up in serologic racks. Control

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tubes for antigen (haptén), hemolysin, and sheep red cells, as well as a serum control for each serum used, are included also. In the four tubes for testing haptén, place 0.2 cc. anti-Rho (anti-D) serum diluted so that its titration end point is 1:32. In the four remaining tubes, put 0.2 cc. normal male serum. To each of the eight tubes, add 0.5 cc. of the appropriate dilution of haptén. Thus each haptén dilution will be added to two tubes, one containing anti-Rh serum, the other containing normal serum. The controls are treated exactly as in a Kolmer complement fixation test for syphilis. After the tubes have stood for fifteen minutes, 1 cc. of saline containing two full units of complement (units are determined by previous titration) is added to each tube except the sheep cell control. The tests remain for eighteen hours at 4 C., when they are removed from the refrigerator, warmed in the 37 C. water bath, and hemolysin is added in concentration determined by previous titration and followed by the 2 per cent sheep cell suspension. Readings are made when the controls are completely clear after incubation in the water bath. The test for complement fixation with haptén is a very satisfactory method of assay which is suitable for use with any type of Rh antibody.

A second method for assay of Rh haptén uses specific inhibition of agglutination by the haptén. A series of concentrations of haptén in 95 per cent alcohol are mixed with equal volumes of normal saline. Equal parts of the suspensions so produced are incubated with equal volumes of an agglutinating anti-Rho (anti-D) serum for fifteen minutes in a 37 C. water bath. Then two drops of each of these mixtures are placed in the bottom of each of a series of 11 x 75 mm. tubes, two drops of a 2 per cent suspension of Group O, Rh positive cells are added, the mixtures are shaken and allowed to incubate for forty-five minutes at body temperature. Controls are set up similarly, except that in place of solutions of haptén, a solution of 50 per cent alcohol in saline is used.

This is a very satisfactory method of assay when high-titered, avid anti-Rh serums are available, but with mediocre serum the controls are apt to be negative, also since the 50 per cent alcohol may have some inhibiting effect on such a serum. Also, the relative suitability of agglutinating serum for the demonstration of inhibition by Rh haptén is variable. Those serums which agglutinate suspensions of Rho cells in salt solution directly are the most usable. Such serums which have, in addition, agglutinins of high titer demonstrable in an albumin medium do not lend themselves readily to inhibition demonstrations.

It seems desirable to establish a standard for measuring the activity of Rh haptén. With this standard, a unit may be defined as the least quantity of Rh haptén required to fix two full units of complement in the presence of an anti-Rho (anti-D) serum possessing an antibody titer of 32 units under the conditions of the test. The titer of 32 units is the lowest titer indicated as acceptable for Rh testing by the National Institute of Health.

The Rh haptén is apparently a lipid substance. It is insoluble in water and soluble in warm 95 per cent alcohol, in ether, chloroform, and acetone. Probably either or both cholesterol and another unsaturated sterol are present, since the fraction gives a positive Liebermann-Burchard reaction. Saponification yields approximately 50 per cent non-saponifiable material. While most of the activity is lost in the process, what is left is found in the non-saponifiable fraction. The haptén contains approximately 2 per cent nitrogen and 0.5 to 1 per cent phosphorus. In the finished preparation, both the biuret test and the Molisch test are negative.

The failure of this substance to produce antibodies when injected into 96 guinea pigs indicates its haptén nature. It will produce antibodies in the experimental animal only when coupled with an antigenic protein such as egg albumin. As described, the haptén will inhibit agglutination by Rh antibody in the test tube and will fix complement in its presence. That a similar combination of Rh haptén with antibody will occur in vivo seems demonstrable; a fall in antibody titer after injections of haptén has been observed repeatedly. A rough assay of haptén activity may be made by measurement of fall in antibody titer after injection of the haptén into previously immunized guinea pigs.

The Rh haptén in the form ready for use can be kept at room temperature. Controlled experiments indicate that it will resist heating at 56 C. for four hours and after that time fall in activity proceeds slowly. Finished Rh haptén preparations have remained constant in activity for at least three months and some lots have retained their strength for indefinite periods. In the early stages of haptén preparation the use of heat is unsatisfactory. It is probable that activity loss occurs more readily when the haptén is still in protein combination.

The Rh haptén has been used clinically in relation to both active and passive Rh sensitization. Preliminary observations should be interpreted conservatively. From 500 to 1500 units of Rh haptén have been introduced intramuscularly at one time in the treatment of Rh negative mothers

whose blood contains Rh antibodies. The initial injection may be followed by others in from one to two weeks and at intervals throughout pregnancy. Consecutive titrations of serum drawn from the treated sensitized woman have shown the expected falls in titer in all but two out of thirty cases treated to date. Treatment is begun preferably as soon as pregnancy is established in known cases of Rh sensitization and as soon as sensitization is revealed in Rh negative women who are pregnant, but who have no previous history of difficulties due to the Rh factor. To date, there have been no untoward reactions, either systemic or local, from the administration of Rh hapten and there is no evidence that the hapten has any antigenicity in human beings.

Babies delivered from treated women have been normal so far in all but two cases. These two cases have involved mothers who had lost erythroblastotic babies previously and who were severely sensitized. Neither woman was treated until the fifth month of pregnancy and each delivered a macerated fetus at the seventh month.

Erythroblastotic babies, i.e., those born of untreated, Rh sensitized mothers, have been given from 1000 to 6000 units of Rh hapten at a time. The injections of Rh hapten suspended in sterile normal saline are given intramuscularly. The practice to date in both Rh sensitized mothers and erythroblastotic infants is modeled after the work of Dr. Joseph Loughrey. Of twenty-five babies treated with Rh hapten so far, nineteen have recovered and are living and well, with normal development. Six babies died, but in five of these cases the physicians felt that the cause of death was not erythroblastosis. This series includes only severe cases. Those babies which showed obvious promise of spontaneous recovery have not been treated with hapten.

A typical case which involves the treatment of an Rh negative woman sensitized to the Rh factor is that of Mrs. L. She is Group A, Rh negative. Her husband is homozygous for the Rh factor. Mrs. L. received three transfusions of blood when she was 12 years old, this, of course, before the Rh factor was recognized. Mrs. L. has one living child, a daughter, 6 years old, who is Group A, Rh positive. She has lost two children: one, the first, after two days of life with severe jaundice; the second was a macerated fetus born at the eighth month. She was seen first at two months in her fourth pregnancy. At that time she was given 1000 units of Rh hapten, since her titer was already 1:320 with blocking antibodies. The first injection did not affect the titer, but a second inoculation in two weeks, again of 1000 units, caused the titer to fall to

1:20. Further injections of Rh hapten at bi-weekly intervals brought the titer down to 1:3. Thereafter there was one instance in which the titer rose again to 1:20, but it came down rapidly and at seven months of pregnancy Mrs. L. showed no demonstrable antibodies. The child was born at term, in excellent condition, apparently normal in every way. The hapten inoculations were not abandoned when the maternal serum became normal, but were continued to term. The maternal titer remained normal from seven months until delivery.

Baby S. is typical of erythroblastotic babies treated with Rh hapten. Baby S. was the fourth child of an Rh negative, Group B mother. The first child is living and well. The second child died on the fourth day with severe jaundice, neurologic signs, and a red cell count of 1,850,000. The third child was badly jaundiced and had a low red cell count, but was treated by replacement transfusion and survived. Baby S. on the first day of life had 300 nucleated red cells per 100 white cells, a red cell count of 2,050,000, palpable liver and spleen, and the icterus index was 500. Immediately after delivery Baby S. received 4000 units of Rh hapten. On the second day, another 4000 units were given. On the third day the nucleated red cells had disappeared from the circulation, but since the count was still low, Baby S. was given 2000 units of hapten. The red cell count climbed gradually, with the help of 5 mg. folic acid given daily by mouth, and the child was discharged from the hospital at the end of three weeks with a red cell count of 4,580,000.

The mechanism of the action of Rh hapten can only be guessed. Whether it neutralizes antibody or whether it satisfies antibody receptors, only further investigation will determine. Preliminary observation seems to show that, in cases of passive Rh sensitization, the effect of antibody is blunted by the presence of Rh hapten. In active sensitization, the maternal titer will fall in response to treatment with Rh hapten.

Some studies have been made on the day-to-day effect of hapten injections. If a woman who is sensitized to Rh is injected with Rh hapten in sufficient quantity to produce an effect, the result can be seen in titrations on the day following the inoculation. On the second day, the titer will rise again, sometimes to a point above that found with the initial titration before inoculation. On the fourth day, the titer is approximately what it was before inoculation with hapten. On the fifth day, the titer has fallen to the low point seen on the second day and will persist there for several days to weeks, depending

on the individual. These results are suggestive only, since only a few individuals (five) have lent themselves for study to date.

The use of the complement fixation reaction may shed some light on the mechanism of the hapten-antibody reaction. Use of complement fixation with the hapten as antigen will demonstrate maternal Rh sensitization in cases in which the condition is not yet demonstrable by ordinary methods, such as agglutination of Rh positive red cells by maternal serum in the presence of albumin diluent. This use of the reaction came to light by accident when a presumably

normal serum used as a control proved to be one from an Rh₂ patient who had been sensitized to Rh₁ blood by repeated transfusions.

In summary, the methods of preparation, the characteristics, and the assay of Rh hapten have been considered, along with a preliminary evaluation of clinical significance. The mechanism of effect of Rh hapten on antibody has been conjectured and suggestion has been made for further study of this problem.

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TOOTHBRUSHES

Four out of five of the toothbrushes now in use in American families are so badly worn or in such an unsanitary condition that they are no longer useful for oral hygiene, according to a survey reported upon in the September issue of the *Journal of the American Dental Association*.

The study, conducted through a group of families representing a cross section of the American population, revealed that 80.7 per cent of the toothbrushes in use by family members were in need of replacement because they could no longer be effective implements in mouth hygiene or because their use might injure dental tissues.

Approximately three-fourths of the unsatisfactory brushes were found to have bent, broken, or matted bristles. The remaining one-quarter of the unsatisfactory toothbrushes, or one out of each five examined, were found to be unsanitary.

Examination of the toothbrushes, collected from housewives and members of their families from coast to coast, was conducted by two staff members of the American Dental Association—Dr. Allen O. Gruebbel, executive secretary of the Council on Dental Health, and Dr. J. M. Wisan, director of the Division of Dental Health Education. They reported:

"The study provides adequate evidence that only a small percentage of the American public follows the oral hygiene practices which the dental profession believes are important in maintaining dental health. The remedy for this situation can be found only in an aggressive campaign to inform every individual of the value of the frequent use and renewal of the toothbrush."

A total of 8176 toothbrushes, submitted by 1929 families, was examined by Drs. Gruebbel and Wisan. Of these, only 1580 were judged to be in satisfactory condition. The rest—6596 brushes—were found to be unsuitable, with 2444 rejected because of bent and broken bristles, 1435 because of matted bristles, the balance because of their unsanitary condition or because of a combination of all these reasons.

Representation on the panel, which covered 48 states, was selected in proportion to the population, the size of the community, and rural or urban residency. Fam-

ilies were also selected proportionately by income and age of housewife. Because of this controlled distribution the families included in the study represented a cross section of the general population.

DR. PARRAN TO HEAD NEW SCHOOL OF PUBLIC HEALTH

A new graduate school of public health is being set up at the University of Pittsburgh through a \$13,600,000 grant from the A. W. Mellon Educational and Charitable Trust. The first dean of the new school will be Dr. Thomas Parran, former Surgeon General of the United States. The school will emphasize occupational and industrial health and hygiene and do basic research in all phases of public health.

It is expected that the school will begin operation by the fall of 1949. An initial \$4,000,000 will enable the university to obtain an adequate faculty and facilities for teaching, and \$1,600,000 will be given during the first five years for operating and equipment expenses and for development. A \$5,000,000 building to house the school will be erected as soon as the school is accredited and the university is able to integrate its medical schools and hospitals in the medical center. The final \$3,000,000 will be paid within five years, when the school has developed "into a successful undertaking."

Dr. Parran is a graduate of Georgetown University School of Medicine, Washington, D. C. He joined the public health service in 1917 and in 1936 began the first of three terms as Surgeon General. From 1930 to 1936 he was commissioner of health for New York State. Since early in 1948 he has served as chief of a mission to the Far East for the United Nations International Children's Emergency Fund. His most recent assignment was chairman of the U. S. delegation to the first World Health Organization meeting in Geneva, Switzerland, June-July, 1948.—*Pittsburgh Medical Bulletin*, Oct. 16, 1948.

The Social and Economic Aspects of the Practice of Medicine

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THE fundamental philosophy of the practice of medicine, as you and I understand it, is more seriously threatened today than ever before. Despite wishful thinking and optimism on the political horizon, it remains essential to become better informed in regard to changing socio-economic trends and their relationship to the general health and welfare of the people. There is no doubt that we, as physicians, would prefer to practice medicine and let others deal with political and economic questions. Whether we like it or not, medicine, today, is so intricately associated with economics that we are finally compelled to study and analyze the underlying reasons for this apparent trend of the basic change of medical practice.

There is a vast amount of printed data available to those who really desire factual information. It is discouraging to note the lack of interest by the physicians in this problem. It is unfortunate and obviously bad public relations when physicians say that there is no problem. Such remarks merely confirm the public's opinion that the medical profession has no sympathy with the economic state of illness. We know that this is not true. Our job is to sell the public on the type of practice we think provides for optimum quality of medical care. It is not healthy when a statement is made that not one doctor in twenty has an adequate understanding of the present threat to medicine.

The physician must develop an awareness of the constantly changing social order of the economy of the people. The impact of any serious economic upheaval is promptly manifested in the individual physician's income. This type of economics is readily understood, but the present philosophy of those groups who are thinking in terms of social security is an entirely new concept and is not as simple of solution.

It is obvious that only the highlights of this problem can be mentioned. One can hardly refer

to the social and economic aspects of a special branch of medicine without consideration of the problem as a whole. No definite conclusions can be made because the entire question is in a state of flux. That is the reason why it is so important to maintain your contacts with your county medical society. Organized medicine must insist upon a systematic, periodic study of its relations with government—federal, state, and county legislators and public health officials; employer and employee groups—the manufacturers and labor unions; educators, teachers, social and welfare agencies. For many years these groups have discussed health problems, the majority without the aid of the medical profession. Thus they have arrived at concepts of medical practice with which the greater number of us disagree.

It is incumbent on us that the health of the people becomes the business of the medical profession. The President of the United States is in favor of compulsory health insurance because he says it affords the only remedy for good health for all the people. He compares compulsory insurance to the Federal Reserve Bank system, stating that the Federal Reserve Bank has not taken away local bank autonomy or initiative. This is the type of thinking which the medical profession must combat.

Another important trend in social thinking is presented by the large corporations and labor unions. If 1¼ per cent of employers in this country employ 55 per cent of the labor, their expression of the medical and health problem becomes a major concern of the medical profession. The United Auto Workers are expected to put their main emphasis in contract talks next year on Social Security protection. This means, exclusive of pensions and death benefits, that their new standards will include income maintenance during occupational sickness or accident disability; hospitalization protection (the union wants insurance that will cover the full payment of all hospital costs for a period of at least seventy-two days); and medical and surgical protection. As

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minimum standards, the union seeks full payment of the costs of physicians' services to the worker and his family; eventually, the union wants a system of clinics financed on a prepayment basis.

There is every indication that management will give considerable thought to these demands and obviously their conclusions will have a direct effect on the physicians. It is interesting to note that insurance counsels are now advising health coverage on a national level rather than on a regional or sectional basis for hospital and medical services. This is indeed far from what we are thinking and yet close to the idea of national insurance, if not on a voluntary basis, then the only alternative, compulsory health insurance. This comes from the larger corporations, possibly coerced by the labor unions. Therefore, our problem remains static, in spite of the national political complexion.

How can we effectively prevent the change of our present pattern of medical practice? Dr. Paul R. Hawley states: "How much government medicine we get depends almost entirely on how much progress we make in coming months toward extending adequate medical care to more people."

We come, then, to the proposition of voluntary or prepayment health plans. It is obvious that we, as a practicing specialty, must be familiar with these plans. The Medical Service Association of Pennsylvania has approximately 250,000 subscribers. The enrollment will increase—it must of necessity, otherwise there will be some form of State or Federal subsidy, or compulsory insurance. It is to our advantage to be informed on prepayment health insurance plans because our own economy is directly dependent on this knowledge. Dr. Gilson Colby Engel, our state president, says: "The encouraging growth of the State Society-sponsored organization and its wide acceptance by the public obliges the medical profession to become thoroughly informed on the Blue Shield Plan of prepaid medical care. There is no doubt that the future success of this 'doctors' plan' depends upon the physicians of Pennsylvania."

Recently, at the meeting of the American Hospital Association, Dr. Hawley asserted, in a discussion on service benefits versus indemnity in Blue Cross plans, "Indemnity is a dangerous trend—its extension will mean ruination of Blue

Cross and the trend in Blue Cross must be towards complete service without any limitations at all." (The additional cost to individuals would be 50 cents a month; to a family, \$1.00 a month.) One may readily appreciate the fact that if Blue Cross takes up such a service contract, the next question will be standardization of fees. No service contract can be written unless such standardization is agreed upon by the doctors.

Another symposium presented at the recent annual meeting of the American Hospital Association was titled "Relationship of Specialty Fees to Hospital Finances." Subtitles were listed as follows: Statement of the Problem; Patient's Interest in the Problem; Physician's Interest in the Problem, and finally, Hospital Interest in the Problem. All participants were noted hospital administrators in large populated areas. This fact is significant.

What does all this mean to the practice of any specialty? Is it that we may be offered employment by the larger hospitals of densely populated areas? It will be not only necessary but essential that the doctors be constantly on guard or some form of contract for service will be placed before us.

It is particularly important that the specialties have their representatives on hand in any group where such discussions may be held, otherwise regulations and fees will be set and decided upon without consultation with the specialty group.

We must be aware of the problem, keep informed, be as wary as the business man, develop an acumen in economics, and convince the public that it will be better served by individual participation than by contractual agreements, either voluntary or compulsory.

Finally, it is hoped that all of you will give this great problem serious study. Organized medicine must be prepared to meet any emergency that may be thrust upon it. We, in turn, must be able to support our leaders by constructive thinking and a positive offense, and inform our patients and friends of the real basic fundamental issues. It seems to me that a discussion of this kind is not only timely but highly informative and desirable.

The lesson should be constantly enforced that, although the people support the Government, the Government should not support the people.

Urethrograms and Cystograms in the Diagnosis of Lower Urinary Tract Disease

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AMONG the various branches of medicine, urology has occasionally been referred to as the most exact science of them all. This, the workers in other fields are quick to point out, is because virtually all of the organs with which urologists deal may either be visually inspected or delineated by x-ray. It would be unfair to imply that the urologists have been backward about appreciating this advantage, but one gathers that not all urologists are forward about exploiting it. The ease with which the urethra and bladder may be visually inspected endoscopically seems to have left many physicians apathetic about their x-ray visualization. No great use of urethrography, for example, was made between Cunningham's demonstration in 1910, using 50 per cent argyrol, and 1921, when Haudek and Priegl first showed that in order to demonstrate the posterior urethra the films had to be exposed during the injection of the contrast medium. In 1936 Kerr and Gillies were still deploring the general neglect of cysto-urethrography. And today the same conviction is being voiced, namely, that cysto-urethrography can make a great contribution to diagnostic exactitude, and that by and large it is ignored or inadequately utilized.

It should be stressed that there are a multitude of techniques by which the urethra and bladder may be shown in x-rays; that each technique or combination of techniques has something to recommend it; and that x-ray visualization of the lower tract can no more be standardized than can the treatment of the lesions in question. There has been a tendency in publications on the subject to advocate a "routine" series of films. In the work done by Flocks, and by Kerr and Gillies, a routine is prescribed consisting of a flat anteroposterior scout film, an anteroposterior sodium iodide cystogram, an air cystogram, and a stereo 45 degree oblique contrast urethrogram with an air-filled bladder. More

recently, Draper and Sicheluff have proposed a routine consisting of an air cystogram, an exposure while voiding contrast medium, an exposure while voiding is interrupted, one while voiding against an obstructing penis clamp, and a film at the completion of voiding to show residual urine. In practical, everyday urology such routines are frequently uninformative to the urologist and unnecessarily expensive to the patient. The investigator must know what he is looking for and must choose the means of visualization best calculated to yield the desired information. Here is the unparalleled field for co-operation between the urologist and the radiologist. It is not usual for the radiologist to intrude in the cystoscopic clinic and express views on urologic matters, but rare indeed is the urologist who does not fancy himself an expert in urography. If, by so flattering himself, he is deprived of the radiologic assistance that may be his in matters of technique, positioning, and choice of media, both he and his patient are being short-changed.

To too many of us cystography means only the introduction of sodium iodide through a catheter, and urethrography calls only for the injection of the medium through the meatus. It is the purpose of this presentation to suggest the wide variety of procedures which are easily available, and to indicate some of the virtues of each.

It would seem that full advantage of excretory urography is often missed. The patient is usually dehydrated in preparation for this procedure, and the bladder may not be well filled in an hour. A delayed film taken when the patient feels the desire to void is often of value, and a film taken after voiding may give excellent visualization of the amount of residual urine, especially when taken in the erect position.

Positioning for cystography is oftentimes important. Fig. 1-A shows a routine sodium iodide cystogram made in the anteroposterior position. There is evidence of intravesical prostatic in-

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trusion causing deviation of the catheter, and there is a large irregular diverticulum with an extension into a hernial sac. Fig. 1-B presents an oblique view of the same patient, angled at 30 degrees, to show a better picture of the prostatic enlargement and to demonstrate perfectly the narrow neck of the diverticulum. The degree of obliquity necessary to show things best must sometimes be selected with care. A routine 45 degree oblique film is often unsatisfactory. Fig. 1-C shows the ordinary sodium iodide cystogram in the case of a Navy veteran who came to us complaining that when he had intercourse there was no ejaculum. He said that he had been an episodic bed-wetter, and in the Navy they had done an operation on him with an instrument through the penis. This picture shows the post-resection conical character of the vesical neck, plus the fact that a non-obstructive nodule of tissue remains. Cystoscopy had shown trabeculation of the vesical vault and either a deep cellule or diverticulum. Fig. 1-D shows the dramatic way in which air-contrast cystography can demonstrate such a diverticulum. After routine

filling of the bladder, the dye is allowed to drain out quickly, and when the flow stops, the bladder is inflated with air and a second picture is taken.

A word may also be said about the density of the contrast medium. When soft tissue shadows are to be studied, it may be desirable to decrease the density of the medium. This is especially true in demonstrating the extent of bladder tumors.

A useful air-contrast technique is one in which the bladder is first filled with air through a catheter, and then a viscid opaque medium is injected through the urethra. A lipiodol-tragacanth jelly is usually quite satisfactory. Fig. 2-A shows such a film made in a case of vesical neck contracture. One can clearly see the verumontanum in this case. Fig. 2-B shows a similar film which was of especial interest since it showed an early neurogenic dilatation of the vesical neck in a patient who went on to develop all the symptoms of a fulminating and fatal case of Landry's paralysis.

The method of retrograde injection is often valuable in studying the vesical neck after pros-

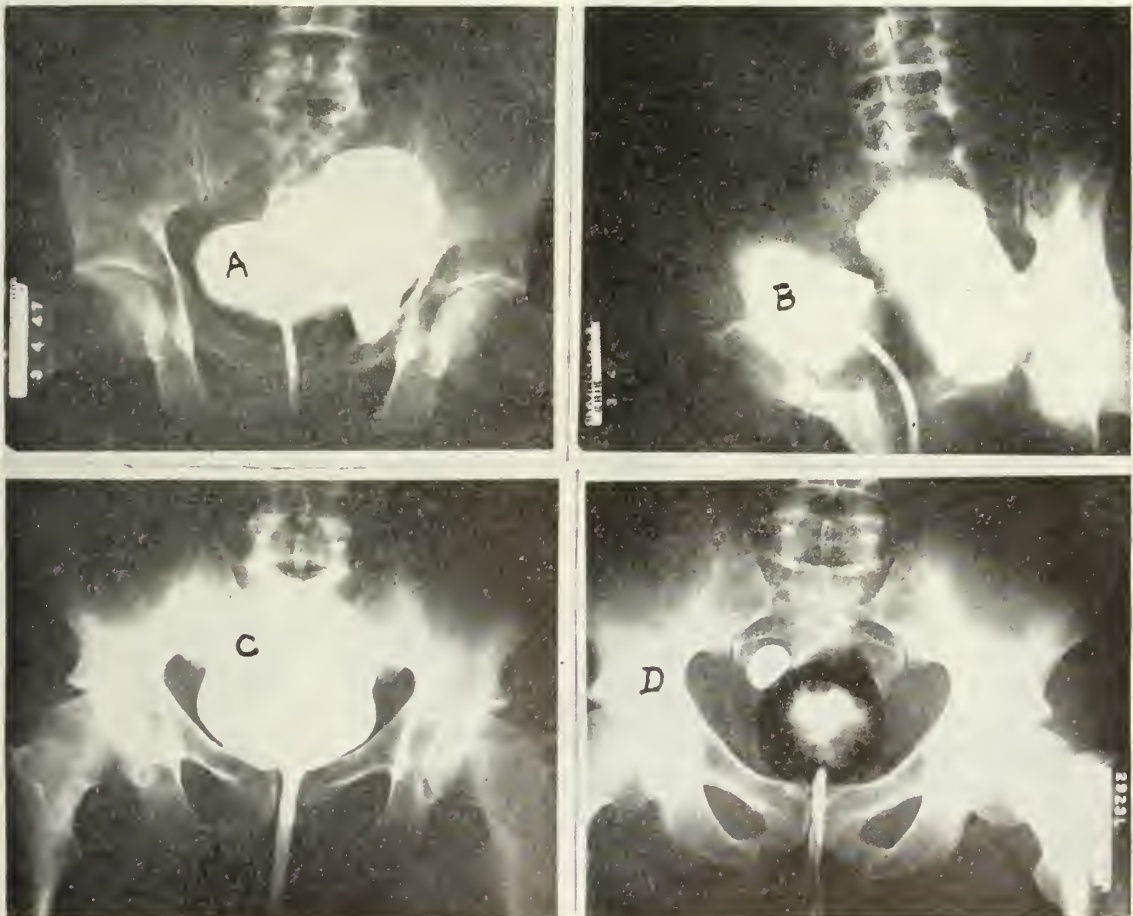


Fig. 1



Fig. 2

tatic surgery. Fig. 3-A shows clearly that an inadequate transurethral resection had been performed on this patient, in addition to which ureteral reflux is evident. Fig. 3-B shows how a viscid material such as visco-rayopake will aid in clear visualization of the problems presented by a urethral stricture. Here the lesion extends the full length of the anterior urethra, thus helping in the selection of proper management. Fig. 3-C shows a different problem due to a short stricture with filling of dilated prostatic ducts and old abscess cavities.

The use of the voiding urethrogram seems to have been almost discarded, or perhaps it has never been justly popularized. After opaque liquid has been introduced into the bladder, much may be learned in certain cases by exposing a film while the patient is voiding, or attempting to do so.

Fig. 4-A shows a urethrogram made while dye was being injected. This shows a diverticulum of the urethra, but Fig. 4-B made with the patient attempting to void shows more clearly the site of the obstruction and the cause of the

diverticulum. Similarly, Fig. 4-C shows a retrograde injection of the urethra with filling of prostatic abscess cavities and distortion of the vesical neck. One might conclude that the current voiding difficulties of which this patient complained were due to obstruction distal to the prostatic cavities. A voiding urethrogram, Fig. 4-D, shows that such is not the case, and that actually urine cannot be forced past the swelling of the prostatic abscess which was the acutely obstructing factor.

An outstanding example of the virtue of voiding urethrography is presented by Fig. 5-A, B and C. This patient was a young man who had had a ruptured urethra secondary to a fractured pelvis. He had a suprapubic cystostomy at the time of the accident, followed by a second suprapubic approach to allow attempts at reconstituting the urethra. This was followed by weekly dilatations for two years, then a third suprapubic operation for the removal of several calculi. At intervals after this, he had a perineal exploration and excision of scar tissue, two transurethral resections of the vesical neck, and an excision of a

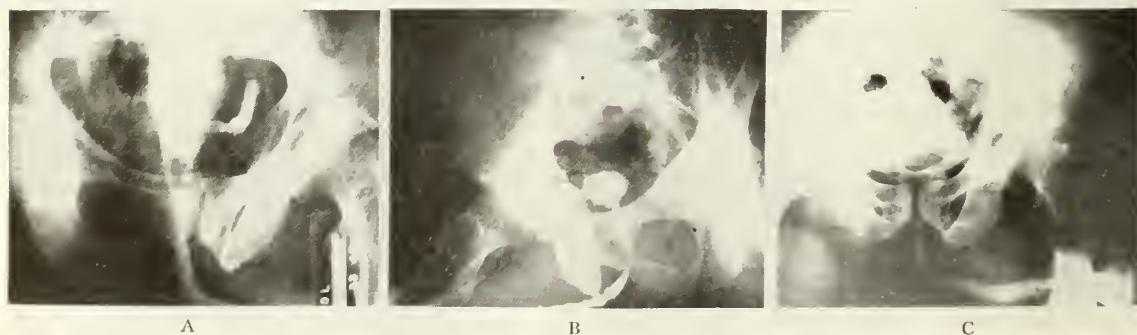


Fig. 3

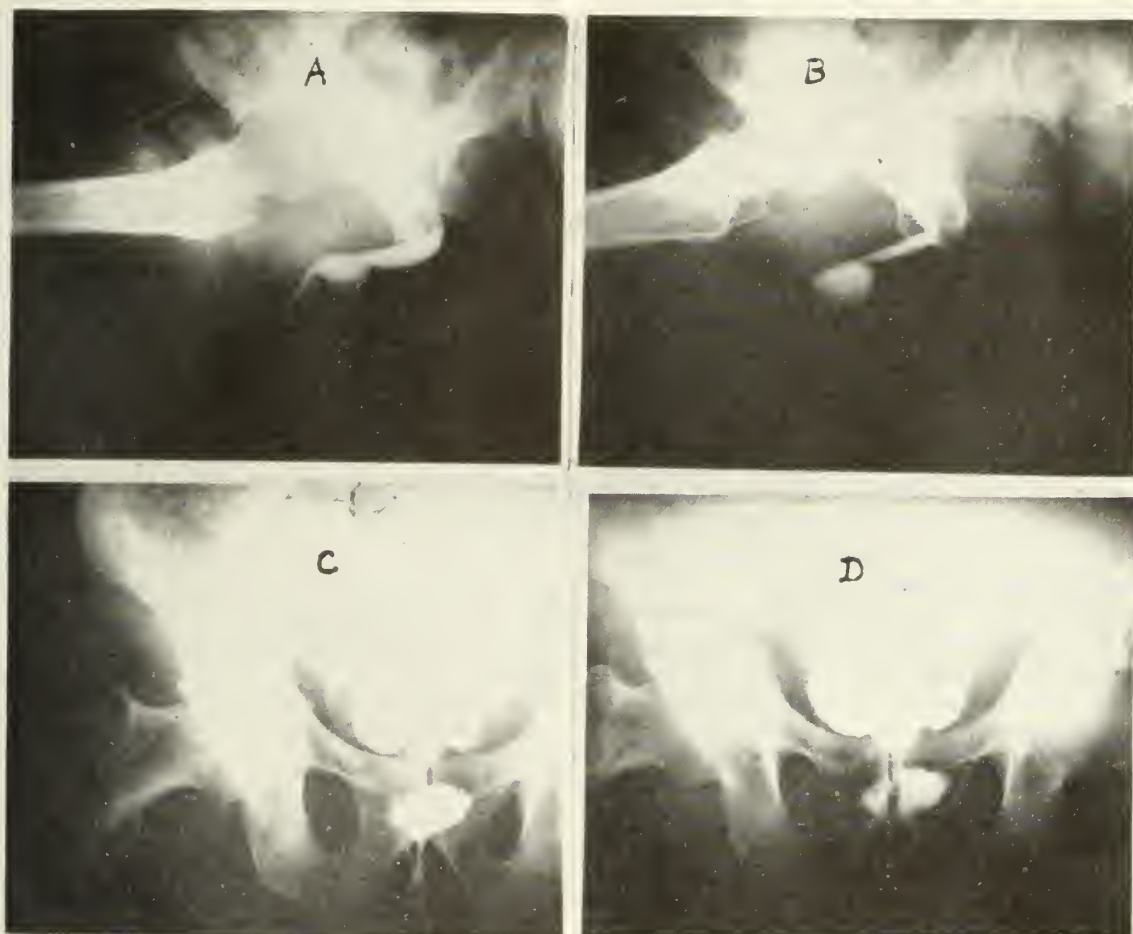


Fig. 4

diverticulum of the anterior urethra. When he came to us, he was still in retention and was catheterizing himself without difficulty. He dilated easily to 24 F., but could not void. In Fig. 5-A, an injected retrograde urethrogram, we can see an anterior urethral stricture, the incompletely removed stump of the diverticulum, and what appears to be a vesical neck contracture despite previous resections. Because of the ease in dilating the stricture, one might be tempted to focus

attention on the vesical neck and do more resecting. Fig. 5-B, however, shows a voiding urethrogram. Here, it is clearly shown that the obstruction is at the level of the stump of the diverticulum. With this information, we were able to resect two cubic centimeters of urethra at the proper point, with an end-to-end anastomosis. Fig. 5-C shows a postoperative voiding film. At this time (September, 1948) the patient has gone nearly two years without trouble, and is



Fig. 5

now being dilated once every six months as a precautionary measure.

Summary

In summary, then, there are at least eight useful variations in technique in respect to the use of air and contrast media, and combinations of the two: excretory urograms, contrast cystograms, contrast urethrograms, air cystograms, air urethrograms, air-contrast cystograms, voiding urethrograms, and evacuation cystograms. There is a wide choice of media, including sodium iodide in varying strengths, the newer visco-rayopake, the various intravenous preparations, opaque jellies such as the lipiodol-tragacanth jelly popularized by Flocks, and air. Various degrees of obliquity may often be indicated, and we are now working on the occasional substitution of postero-anterior films in place of the usual anteroposterior type to eliminate undue magnification of the urethra.

In addition, certain pathologic conditions which obstruct the free outflow of urine do not impede the free inflow of injected media through the urethra. Here the voided urethrogram may give evidence otherwise unobtainable. In certain neurogenic vesical neck dysfunctions, in posterior urethral valves, strictures, and diverticula the voided urethrogram has much diagnostic value. This technique has had many advocates in the past, but has fallen into general disuse. Its revival is recommended. In short, if the art of diagnosis is to be fully practiced, the physician must be willing and able to employ a diversity of techniques.

ABSTRACT OF DISCUSSION

EMANUEL LUBIN (Philadelphia): I am quite pleased to have the opportunity to discuss Dr. Roth's excellent paper. He has presented things to us which we ordinarily don't think about because the occasions do not arise frequently. However, I wish to submit that the actual business of cysto-urethrography can be greatly overdone. I take exception to its routine use as adopted in several clinics. Being an Iowa alumnus myself, I am acquainted with the work done by Flocks, Kerr and Gillies, and am aware that the reason they embarked upon it was to enable them to keep permanent objective records of their cases of prostatic enlargement, pre- and postoperatively, so that they could have a potent argument in favor of transurethral resection.

At the Jefferson Medical College Hospital we have employed the various techniques so ably outlined by Dr. Roth, but we have employed them primarily to provide objective evidence to show our medical students when they are unable to be present at the time of endoscopic examination or at the time of operation. For practical purposes, when we are actually concerned with obtaining information which will enable us to treat the patient better, we feel that there are perhaps four prime places for the use of cysto-urethrograms.

In my own mind, the most important use of this aid in diagnosis is to determine whether the patient with

obstructive lower tract disease has reflux up the ureters. It is a well-known fact that most preventable deaths following prostatic surgery are due to the old bugbear—urosepsis. It has been shown that, in the absence of dilated ureters, urosepsis is less likely to occur. Consequently, it behooves us to know whether or not a patient has dilated ureters before proceeding with prostatic surgery. Should we find dilatation, then it is wise to give the patient a lengthy period of drainage, regardless of what his renal function might be at that particular time.

Consequently, we have employed cystograms on many occasions to determine reflux when an intravenous urogram failed to outline the ureters or when renal function was so low that the urinary tract remained completely invisible.

Another place where cystograms are of great value is in diverticula of the bladder. On that point, I wish to say that while we can determine by endoscopy whether a diverticulum is present, we cannot determine whether that diverticulum is emptying completely. By taking a post-evacuation film of a cystogram, that is, emptying the bladder by means of a catheter after the dye has been instilled, we can find out whether the patient's diverticulum is emptying or not. We find that very useful in deciding whether a patient needs a diverticulectomy or whether the diverticulum is a benign process after the primary obstruction has been relieved.

A third place in which cysto-urethrography is of value is in traumatic rupture of the urethra or bladder, where it is of great assistance in establishing an early diagnosis and enabling us to proceed with treatment as soon as possible.

A fourth place in which urethrography is useful is in the "watering-pot" perineum. By injecting iodo-chlorol or lipiodol or one of the lipiodol-tragacanth jellies, we can outline the various sinus tracts and get an idea of how extensive the excision must be. But that is really more of theoretical interest than practical value because during such an excision it behooves us to take out everything that looks in the least bit scarred, regardless of what the films might show.

So, while it is interesting to see these films and nice to know that a bladder tumor can be visualized in a cystogram, it is, to my mind, of very little value, particularly since, in such cases, with a cystoscope or pan-endoscope we are able to evaluate thoroughly the prostatic urethra, the anterior urethra, and the bladder. It seems rather a waste of money, energy, and materials to subject the patient and ourselves to the process of securing films unless we do it fully cognizant of the fact that what we desire is a permanent record rather than information regarding the particular case.

Furthermore, in regard to bladder tumors, I think that perhaps cystograms may be deceptive. We may see a filling defect, it is true; but beyond that, we know nothing without an endoscopic examination, biopsy of the tumor mass, and bimanual examination of the bladder to determine the extent of the tumor. Merely to say that a bladder tumor is present is of little value in its treatment.

In closing, I would like to show four films of the type that we have employed at Jefferson Hospital. They represent the principal purposes for which I believe cysto-urethrography is of value.

DAVID M. DAVIS (Philadelphia): One remark made by Dr. Roth meets with my most enthusiastic approval, namely, that the institution of an elaborate and expensive routine is a thing we should all fight against. It is not only expensive to the patient but it takes up the

time of the hospital staff and the money of the hospital, and, worst of all, it tends to atrophy our own minds. We will never be good doctors unless we use such minds as we have in the individual consideration of each case.

Further than that, I would say that there is only one other type of case in which, in my opinion, urethrography is of the greatest value. That is in cases of injury to the lower part of the urinary tract—not the acute cases seen immediately after the accident, which Dr. Lubin has mentioned, but cases which have gone on for a long time and perhaps have been inadequately treated. Oftentimes the analysis of exactly what is wrong with these cases is very difficult. There may be abscesses and sinuses running in directions that cannot be explored with any kind of instrument. In these cases, cysto-urethrography is of the greatest value.

DR. ROTH (in closing): I simply want to thank Dr. Lubin and Dr. Davis for their remarks and to point out that the particular value of the voided urethrogram to me is that in obstructive lesions of the lower tract, many of which are in essence valve-like, there may be no obstruction to the free inflow of an injected medium. The same thing applies to the inflow of water through a cystoscope; in order to see through any urethroscope and endoscope that I know of, the water current must be running in. Posterior urethral valves, flap-like affairs, as in the last series of films, simply do not appear in their obstructive light. It takes the physiologic process of water or urine flowing from the inside out to demonstrate the obstructive character, and cysto-urethrography or voided urethrography will demonstrate that where instrumental examinations will not always do so.

HIPPOCRATIC OATH AMENDMENT

A rather unique procedure took place at the meeting of the World Medical Association held in New York recently. It was an amendment to the Hippocratic Oath, which was approved by the Association. It is the first amendment to this honored document in two thousand years.

The object of the proposed amendment is to prevent medical crimes in the event of another war, such as using human beings for experiments, permitting mass killings and deliberate starvation. In recent trials some German physicians were guilty of these crimes in World War II.

The new oath, which supplements the Hippocratic Oath, reads as follows:

"My first duty, above all other duties written or unwritten, shall be to care to the best of my ability for any person who is entrusted or entrusts himself to me, to respect his moral liberty, to resist any ill treatment that may be inflicted on him, and in this connection, refuse my consent to any authority that requires me to ill-treat him. Whether my patient be my friend or my enemy, even in time of war or in internal disturbances, and whatever may be his opinions, his race, his party, his social class, his country, or his religion, my treatment and my respect for his human dignity shall be unaffected by such factors."—*New York Medicine*, Oct. 5, 1948.

public health implications, apparently, have been under consideration for a number of years. Recently the Joint Committee on Railway Sanitation of the Association of American Railroads has tuned in on the problem and, in March and December, 1947, issued a technical and a supplementary report.

Research was carried out on the heavily traveled New York to Washington run of the Pennsylvania Railroad, and in the course of the investigation "the toilet habits of 2000 persons were studied over a total of 6201 passenger hours and 320,000 passenger miles." Since such a project of necessity covered a considerable area, in the interests of accuracy the wastes were collected in sealed containers carried underneath the cars.

Certain estimates were possible. Approximately 276,000 pounds (dry weight) of the material under discussion was spread per year along 226 miles of roadbed, or 0.694 pounds per linear yard. Found in the collection, although not included in the statistical analysis, were orange peelings, cigars and cigarette butts, cigarette packages, miniature whisky bottles, beer bottles, men's handkerchiefs, and women's handbags.

Whether epidemic disease has actually resulted from this impartial and not inconsiderable contamination of roadbeds is problematical; certainly the possibilities are present. Perhaps the advice of the popular song, not originally intended for mixed company, should be reversed and passengers exhorted to use the station toilets and spare the rolling landscape.—*New England Journal of Medicine*, Sept. 30, 1948.

"PASSENGERS WILL PLEASE REFRAIN—"

The *Journal of the American Medical Association** has made editorial comment on a potential health hazard that must have occurred as a possibility to many persons, without necessarily stimulating any number of them to a crusading pitch of activity. This hazard is the impartial distribution of toilet wastes along railroad lines—except, usually, in stations.

The practical difficulty of attaching a swiftly moving train to any permanent sewage system is obvious; the

"MUST" READING FOR EVERY DOCTOR

The brief article on "Social and Economic Aspects of the Practice of Medicine" in this issue should be read and reread by all JOURNAL readers, and they in turn should bring it to the attention of even the occasional member who may fatuously boast that he never opens his state society's JOURNAL. Dr. Fetter is the current president of the Philadelphia County Medical Society.

* Current Comment. Railroad toilet wastes, *J. A. M. A.*, 137: 1134, 1948.

THE ABUSED DIAGNOSIS OF SINUSITIS

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IT IS not the purpose of this discussion to present new data but rather to call attention to the widespread misuse of well-known facts and fancies relative to the diagnosis of sinusitis.

The term sinusitis should be used to designate infection with inflammation of the sinus mucous membrane lining. Unfortunately it is wrongly applied to many cases merely because they have some of the symptoms and physical signs commonly associated with this disease.

At least 75 per cent of the patients who come to the laryngologist with a firm conviction that they have sinusitis and are doomed to a lifetime of a dread malady do not have the disease.

Some of these individuals have made their own diagnosis from information gained from friends or popular health columns, but since many of them have been told by their doctors that they have sinusitis, this subject is brought to your attention.

Many of these patients become mentally depressed, due to the constant thought that they have an infection that will always be with them and eventually lead to serious complications. Some of them are so convinced that they have sinusitis and that ill-advised, long-continued, expensive treatment has failed to cure their symptoms that they become discouraged, neglect to seek further medical advice, and thus fail to discover some much more serious underlying systemic condition of which the so-called sinus symptoms are but secondary manifestations.

The tendency to use this diagnosis arises when the patient complains of things that we all know can be due to either acute or chronic disturbances in the sinuses and perhaps his doctor lacks the special training, equipment, or experience necessary to thoroughly examine this part of the body or to correctly evaluate and differentiate his symptoms and physical signs.

The symptoms that most often lead to an erroneous opinion that sinusitis is present are: (1) headache, particularly frontal pains, (2) facial pains, (3) the presence of excessive nasal

or postnasal discharge, and (4) nasal obstruction.

Headache.—The causes of headache are numerous and often difficult to discover, even by the most experienced practitioner.

Intranasal pressure and obstruction to ventilation and drainage of the sinuses are probably the most common cause for the headache. The middle turbinate is a structure that can become enlarged either by acute or chronic thickening of the mucous membrane portion or by cystic changes in the bone. It is so situated high in the narrow part of the nose that in some cases even slight enlargement causes it to serve as a wedge. As the swelling increases the wedge-like effect becomes greater, until pressure between septum, turbinate and lateral wall produces pain that varies in intensity from an annoying headache to one of great intensity, particularly in the frontal area. This pain can be relieved by shrinking solutions applied to the turbinate or in persistent cases by a turbinectomy.

If the middle turbinate presses so firmly against the lateral nasal wall that swelling of the mucosa causes obstruction to the sinus ostia, air is prevented from entering the sinus. At once the blood begins to exhaust the trapped air from the sinus cavity and a vacuum is created. There is then a negative pull upon the sensitive lining and pain exactly like and just as intense as a true sinusitis quickly results and is maintained until ventilation of the sinus is restored.

Recent articles tend to cast doubt upon the sensitivity of the sinus linings, but it is still true that severe pain is experienced in the sinuses when air is exhausted from these cavities by a suction pump to thus create a vacuum. It can be stated, too, that the introduction of fluid into a sinus after paracentesis, thus avoiding the ostium, as is often done in dealing with the maxillary sinus, will cause severe pain in that sinus if the ostium is partly or completely obstructed. The pain is felt in the anterior and infra-orbital walls as well as in the supposedly more sensitive medial wall near the ostium.

There are numerous causes for sinus-like headache, but the reason most of them cause pain

Read before the Section on Eye, Ear, Nose and Throat Diseases at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 6, 1948.

is that they bring about irritation, congestion, and sufficient swelling of the nasal mucosa to produce intranasal pressure or obstruction to ventilation of the sinuses. Some of the conditions responsible for these symptoms are allergy, circulatory disturbances, gastro-intestinal disorders, industrial irritants, acute upper respiratory infections, alcohol and endocrine disturbances, particularly of the ovary and thyroid. Proetz¹ and Coachman² have made interesting observations regarding the role played by the thyroid in nasal disturbances. Headaches associated with the menstrual period, sexual excitement and emotions are probably due in large measure to the action of the endocrine glands. In many women, for instance, there is a congestion of the nasal mucosa prior to menstruation and during pregnancy, due possibly to an alteration of estrogen balance. Changes in atmospheric conditions, such as excessive humidity on one hand and extreme dryness on the other, can cause nasal congestion. Sudden and frequent changes from warm to cold air such as experienced by butchers, dairymen, and cold storage workers give a similar reaction. Other causes for headache include eye disorders, migraine, histamine imbalance, and other circulatory changes, particularly intracranial, such as vascular sclerosis, dilatation, and distention—the latter so ably discussed by Wolff, Goodell and their co-workers.³

The pain in the afore-mentioned cases often starts in one frontal area on the side where there is a deviated nasal septum or large middle turbinate. It may extend to include both frontal areas and occipital region. It is not unusual to have post-cervical or suboccipital headache when there is inflammation of even rather mild types in the nasopharynx. In these cases one can invariably find disturbances in the nose or sinuses. The pain usually occurs at irregular times of day or may be fairly constant. It starts as a dull feeling of pressure and may progress to a throbbing or expansive pain that is increased by sudden motions or jarring.

Facial Pains.—Pain in the face or antral regions may be of dental origin, neuritis, or inflammation of the turbinate and lateral nasal wall.

The dental cases often have a history of a bad tooth. X-ray plus a dental consultation solves this problem.

The pains of neuritic type are most often caused by disturbances in the branches of the second division of the trigeminal nerve. At times the infra-orbital or superior alveolar branches are at fault, but occasionally the source of trouble

can be found in the sphenopalatine ganglion. The supra-orbital branch of the first division of the fifth cranial nerve may cause severe frontal neuralgia.

It is not an uncommon thing to find that facial pain is due to an inflamed turbinate and the adjacent area on the lateral nasal wall. A cellulitis of the vestibule or soft tissues higher in the nasal cavity will give severe pain, redness, swelling, and tenderness of the antral region.

An interesting type of frontal headache is that sometimes present in cases with marked atrophic rhinitis. The nasal mucosa is dry, pale, and thin. This causes the sinus ostia to be unusually patulous. It is quite possible that the excessive flow of air, especially if it is cold or contaminated, is responsible for painful reactions of the sensitive sinus linings; or perhaps contraction of the fibrous linings can also cause pain.

Nasal and postnasal discharges are often wrongly considered as an indication of sinus infection.

In all acute or chronic rhinitis, except in atrophic cases, there is an excessive amount of nasal secretion produced, due either to irritation by bacteria, circulatory disturbances, or irritants that stimulate the mucous glands. When bacteria are the cause of either acute or chronic irritation, there will be a mucopurulent or purulent discharge.

It is well established that aside from these local factors there are many, more remote, causes for congestion and therefore excessive secretory activity by the nasal mucous glands. Included are circulatory changes, endocrine disorders, toxins, allergins, and emotional states.

Emotions and nervous reactions have been more thoroughly studied during and since the late war. Post⁴ observed among fliers that neuroses, attendant to their work, were a frequent cause for primary hyperesthetic rhinitis and nasal blocking with resultant headaches and secondary infections. The sympathetic nervous system controls the vascular tonus in the nose, and it is not strange that it should be disrupted when anxiety, fear, and tension exert an unusually powerful influence upon the individual, possibly by sudden or prolonged shock to the ductless glands. A very thorough investigation by Wolff, Holmes, Goodell, and S. Wolf⁵ adds to the evidence that emotional states have much to do with nasal disturbances that are often wrongly thought to be of sinus origin.

Study of the psychosomatic nervous system has thoroughly established that the upper respiratory tract is as greatly affected by disturbances of this system as are all other parts of the body.

These extraneous conditions all cause an excessive amount of mucus to be present in the nose and nasopharynx. The mucus may vary from a very thin, clear type, as seen in hay fever, to the thick whitish secretion so often ascribed to catarrhal states. It is only when bacterial irritation is pronounced enough to cause the leukocytes to concentrate in defense of the mucosa that the secretion assumes the mucopurulent or purulent characteristic color. Except in the very early serous stage, the nasal discharge in acute sinusitis is mucopurulent and then purulent, just as in any bacterial infection. It is not true, however, that the presence of pus in the nose or pharynx necessarily means that there is a sinusitis because, as previously stated, bacterial activity in the nose itself can produce a similar discharge.

Allergy is probably the most common cause for excessive nasal and postnasal discharge, with or without obstruction to breathing, and since the mucosa is thickened, there can be headache due to intranasal pressure or obstruction of the sinus ostia. In allergy the discharge is mucous in type and varies in consistency. The presence of purulent elements in it should not lead us to assert that sinusitis exists because, as stated before, the pus may be produced in the nose itself.

It is easy to see why allergy is so often responsible for a mistaken diagnosis of sinusitis, since its symptoms and signs include those popularly ascribed to sinusitis by the lay person and the doctor. Severe allergic reactions, with a pale boggy mucosa and profuse clear mucous discharge, such as occur in hay fever, are usually correctly diagnosed, as are the cases that develop urticaria or systemic reactions. The mild allergies to dust, feathers, foods, and many other things with a red slightly thickened mucosa and a moderate amount of mucus are liable to be regarded as frequent colds and remain undiagnosed. They cause intermittent or constant nasal obstruction with resultant intranasal pressure or vacuum type headaches. These conditions, and certainly their combinations, are often wrongly taken as sufficient evidence that they are the result of infected sinuses.

Nasal obstruction is often considered as an indication of sinusitis, but its presence alone is not so liable to be construed as an indication of sinusitis as are the other three symptoms. It is quite generally recognized that septal deviations and hypertrophied lower turbinates can cause obstruction. It is important to recognize also that the congested state of the mucosa lining the nose and covering the turbinates may be caused

by other than sinus infection with an irritating purulent discharge. Any intranasal irritation or deflection of the air currents, atmospheric changes, allergy, alcohol, emotional excesses, endocrine imbalance, circulatory changes, or other systemic conditions already mentioned as causing increased nasal secretion can bring about obstruction to nasal breathing.

It is important to point out that many times transillumination and x-ray study of the sinuses will show a clouding of one or all of the sinuses when there is absolutely no infection in any of them. Time and again this x-ray finding is due to a swelling of the sinus linings that occurs in allergy, emotional states, or during an acute rhinitis. In cases of these types the x-ray shadows will vary in succeeding studies. Occasionally, repeated transilluminations and x-ray films will show a non-infected sinus to have constantly thick linings. This is usually due to a fibrosis resulting from a healed sinusitis or to postoperative scar tissue.

Conclusions

It is the purpose of this discussion to point out, first, that the diagnosis of sinusitis is much too often erroneously made by both the general practitioner and the otolaryngologist; second, that many of the symptoms and some of the physical findings in cases with sinus infections are also often present in patients whose sinuses are absolutely free from infection.

To this great group could well be applied the term "phantom" or "pseudo-sinusitis."

Only by a careful history, consideration of the symptoms, intranasal and special physical examinations by those who are thoroughly trained and experienced in evaluating them, can a proper differential diagnosis be made.

In order to reduce the too casual use of the term sinusitis, it should be kept in mind that patients who have frequent or persistent headache, facial pains, excessive nasal or postnasal discharge, and nasal obstruction, in various combinations, are sufficiently distressed, and may present a diagnostic problem difficult enough to justify the combined skills of the internist, roentgenologist, and otolaryngologist.

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ABSTRACT OF DISCUSSION

DANIEL S. DESTIO (Pittsburgh): This subject is so vast that in the few minutes allowed to me I shall discuss only one specific phase which, in my opinion, is of extremely great importance. Dr. Fox has spoken of it and I wish to re-emphasize it; that is the role which nasal allergy plays in the abused diagnosis of sinusitis.

Most of the patients who come to my office with the complaint of nasal obstruction, postnasal discharge, with or without face pains, think they have chronic sinusitis. In my experience the majority of these patients do not have chronic sinusitis but have primarily a nasal and sinus allergy. They are not going to be improved by treating them on an infectious basis. The underlying allergic state must be properly treated before the patient will be permanently benefited, even though some degree of secondary infection of the sinus mucosa has taken place.

Dr. Fox has called attention to the manner in which pressure of an enlarged or swollen turbinate may cause head or face pains. Nasal allergy is a very common cause of enlarged turbinates. Since so many of these sinus symptoms are due to nasal allergy, it behooves us to establish the proper diagnosis. The history is the most important factor in the diagnosis of nasal and sinus allergy. Allergic attacks are frequently mistaken for repeated colds. A positive family history of allergy or other allergic manifestations such as urticaria, eczema, asthma, or hay fever, is strongly suggestive of nasal allergy. It is needless to emphasize that a thorough knowledge of the possible etiologic factors of allergy is also necessary.

The rhinoscopic examination should be correlated with the allergic history. In typical cases of nasal allergy the mucosa appears wet, pale, grayish, boggy or

swollen. Sometimes, however, the color may be fairly normal and at times it may even be slightly reddened, thus making diagnosis more difficult. A posterior rhinoscopic examination should always be made. I cannot too strongly emphasize the importance of this procedure because the posterior tips of the lower turbinates may show the characteristic allergic changes, but the anterior two-thirds of the nose may appear fairly normal. The presence of nasal polyps, especially in both nasal cavities, is almost presumptive evidence of nasal allergy until proven otherwise. Let us not be influenced too much against a diagnosis of nasal allergy if the nasal and postnasal discharges are thick or mucopurulent, thinking that allergic discharges are only clear and watery, because this is not true. It is sometimes impossible to tell the difference between the nasal discharge of infection and that of allergy, macroscopically.

The conclusive step in the diagnosis of nasal allergy is the study of the cytologic picture of the nasal secretion under the microscope. In uncomplicated allergy the cytologic picture is one of a pure eosinophilia. The preparation of nasal secretion smears and the technique of staining is so simple and so little time-consuming, requiring only one minute, that it should be a routine office practice to study the nasal secretions on every patient having nasal symptoms in which allergy could be an etiologic factor.

In conclusion, what is to be done with the patient who has nasal and sinus symptoms which are primarily of allergic origin? I believe it is the rhinologist's duty to familiarize himself with the allergic management of this type of patient. No one is better qualified than he to study the patient's nose and sinuses and determine what part is played by allergy, by infection, or by structural abnormality, in the patient's nasal complaints and correct each one as it becomes necessary.

PEDIATRICIANS PLAYING WITH FIRE

The American Academy of Pediatrics has proposed that Congress appropriate \$5,000,000 to provide for grants-in-aid by the Federal Security Agency in support of pediatric education. This proposal was made to the Health Subcommittee on the basis that it is more important to train pediatricians than to inaugurate a nationwide school health program.

This is the way the Academy of Pediatrics proposed that the \$5,000,000 be spent:

1. Two million five hundred thousand dollars to be allocated to medical schools approved by the AMA, such sums to be used as the several heads of departments of pediatrics think best.

Each of the approved medical schools having residencies in pediatrics—there are 170 of these—would receive a minimum of \$20,000.

The remainder of the \$2,500,000 would be divided among the schools on the basis of needs and student enrollments.

2. One million five hundred thousand dollars allocated for the following purposes: (a) scholarships or

fellowships; (b) expenses of pediatric instructors making teaching circuits; (c) support for maintaining high standards of pediatric education; (d) other purposes directly related to pediatric education.

3. Remaining \$1,000,000 to be used for grants-in-aid for graduate fellowships. These would be granted conditionally with the understanding that recipients would return to areas in need of pediatricians in the states receiving the grants.

The proposal of the Academy of Pediatrics opens the door wide for Federal invasion of the sphere of medical education. Once scholarships are granted to medical schools, the Federal government would move in and direct the distribution of these scholarships. It is the identical problem that faces the entire field of education today where large endowment funds have dwindled and the Federal government through tax laws has tapped the sources till they have dropped to a low-water mark. It may be more important to train pediatricians than to inaugurate a nationwide health program such as proposed in S-1290, but why must we have this training done through the largesse of Uncle Sam?—*Connecticut State Medical Journal*.

The Evaluation of the Newer Vasodilators in Peripheral Vascular Disorders

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SINCE peripheral vascular disorders have been accepted as one of the branches of medical science, the treatment of this group of conditions has stimulated considerable interest. More recently, attempts have been made to produce a drug which will give satisfactory results in controlling arteriospasm and inducing vasodilatation. We can only surmise the role that arteriospasm plays in this group of disorders. However, we are safe in assuming that arteriospasm is present in practically all groups of vascular disorders. It certainly exists in the vasospastic conditions and likewise is present in occlusive vascular disorders, such as arteriosclerosis obliterans, thrombo-angiitis obliterans, and other conditions. It may be extensive and intense in embolic occlusion. It is therefore obvious that not only is it essential to control the underlying pathologic condition but the arteriospasm also must be combatted.

Formerly, we had varying success with such vasodilators as the nitrites, papaverine hydrochloride, prostigmine, depropanex (tissue extract), and xanthine products.

In the past few years there have been contributions in the literature offering newer preparations to overcome arteriospasm and to relieve symptoms, such as pain and discomfort, and exert a favorable influence upon the ulcerative lesions.

We cannot discuss all of these newer measures, but will limit our presentation to such products as diethyl oxide (ether), histidine, tetra-ethylammonium chloride (etamon), dibenamine hydrochloride, and priscol.

However, it may be pertinent to comment upon the possible effects of nicotinic acid, papaverine hydrochloride, paravertebral block, and the more recently reported alpha-tocopherol, as vasodilators.

Diethyl oxide (ether) was suggested as an excellent vasodilator in occlusive conditions by Katz¹ in 1946. He stated that "ether produces a vasoconstriction initially, but within twenty minutes this is followed by progressive vasodilatation and an increase of blood flow in the peripheral arteries." In his early investigations, ether was given intramuscularly, but this was too painful; subsequently, it was given intravenously.

The following dosage is recommended: It has been our custom to begin with 10 cc. diluted in 200 cc. normal salt solution intravenously, daily. This is given for three days. The dose is increased to 15 cc. in 250 cc. solution, and then to 20 cc. of ether in 300 cc. solution, for a total series of ten treatments. Any difficulty of miscibility is overcome by chilling the solutions before mixing, and it is also suggested that precautions be taken to keep the container of the solution chilled with ice bags during the intravenous injection. It is recommended that the infusion be given at the rate of 40 drops per minute.

The benefits of this therapy may be attributed to the increased blood flow in the peripheral circulation as evidenced by the increase in skin temperature. Katz mentioned that in many cases there was a prompt favorable effect upon pain. He was likewise impressed with its favorable effect upon gangrene, which in some cases became more or less localized after a series of treatments. After giving as many as 1500 treatments upon patients, ranging in age from 18 to 86 years, he found no untoward effects upon the kidneys, nor upon the diabetes (many of his treated cases were diabetics).

We employed this procedure in various groups of vascular disorders, both in diabetics and non-diabetics, and found that in some cases there was a favorable effect upon the circulation. We did not find that it had any definite influence upon the gangrene that could not be obtained by our other forms of therapy. In our series we did not experience any notable complications with this form of treatment.

Read before the Section on Medicine at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 5, 1948.

From the Department of Medicine, Jefferson Medical College, and Vascular Divisions of Jefferson Hospital, Philadelphia General Hospital, and St. Luke's and Children's Medical Center, Philadelphia.

Histidine-ascorbate therapy was recommended by Wirtschafter and Widmann² in 1947. By injecting this combination, they hoped to produce a histamine substance which would exert the properties of histamine, namely, dilatation of the arterioles, venules, and capillaries.

The following technique was recommended for administration: Patients were first given 500 mg. of sodium ascorbate intravenously. This was followed by intramuscular injections of 5 cc. of 4 per cent aqueous solution of histidine monohydrochloride and, simultaneously, a subcutaneous injection of 100 mg. of sodium ascorbate. The latter two injections should be given in different areas, and should be repeated every four, six, or eight hours according to the severity of the case. It was also recommended that ascorbic acid be administered orally in doses totaling 600 mg. daily.

In their original report, this form of therapy was carried out in a series of 11 cases and encouraging results were mentioned. There was relief of pain, improvement in the peripheral circulation, and a favorable effect upon gangrene.

We observed the treatment outlined above on a series of 8 cases. No untoward effects were noticed in our series. However, we did not find any more favorable effect upon our patients than could have been obtained with our other procedures, which require less frequent injections.

Tetra-ethyl-ammonium chloride (etamon)* is a quarternary ammonium compound, similar in structure to acetylcholine. This preparation showed pharmacologic properties of effectively blocking autonomic ganglia. After experiments upon animals, investigations were carried out upon humans.^{3,4} Subsequently, Berry and his co-workers⁵ made further observations and showed that tetra-ethyl-ammonium could produce the same vasodilatory effect as that produced by nerve block, spinal anesthesia, and sympathectomy.

Etamon may be given intravenously or intramuscularly. It is dispensed in 10 cc. vials. Doses of 1 cc. (100 mg.) to 5 cc. (500 mg.) may be given intravenously. It is given slowly, and the patient's condition should be observed for possible reactions. In our experience, we recommended that the patient remain at rest for approximately one hour after the injection. The same precaution is observed when etamon is given intramuscularly. When the latter method is carried out, the solution is usually given in 8 cc. to 10 cc. doses into the gluteal muscles, one-half dose on each side.

The following effects have been observed with etamon: The patient experiences a metallic taste, numbness and tingling in the extremities, dryness of the skin, a rise in skin temperature of the distal parts, and a fall in blood pressure. These phenomena appear early within five to 15 minutes after the injection, and may last from fifteen to thirty minutes or longer. The drop in blood pressure may be quite marked, and may result in peripheral circulatory collapse. This can be readily controlled by administration of epinephrine, 10 minims of a 1-1000 solution.

We have employed this procedure on a number of our patients with occlusive vascular disease and in phlebitis. In many cases there is a decided improvement in the circulatory status, both subjectively and objectively. In some cases there was a striking relief of pain.

Dibenamine hydrochloride† is chemically known as N, N-dibenzyl beta-chloro-ethyl-amine hydrochloride. It is available in tablet form or in liquid concentration for intravenous use. When given orally, patients may complain of gastric irritability. However, it is preferably given intravenously because by this method the action is more direct and certain.

Pharmacologically, dibenamine is credited with sympatholytic and adrenolytic properties. When given in full therapeutic doses, it produces a complete block of responses of adrenergic receptor cells and the excitatory effects of sympathetic nerve impulses (sympathin E) or of epinephrine. The responses of adrenergic receptor cells to the inhibitory effects of sympathetic nerve impulses (sympathin I) or epinephrine are not influenced. The sympatholytic and adrenolytic blocking influences may continue for twenty-four to ninety-six hours or even longer, and are completely reversible.

Hecht and Anderson⁶ investigated the effects of this preparation on blood pressure and peripheral circulation. They found that in resting individuals there was a slight reduction in the systolic and diastolic arterial pressure, which disappeared within twelve hours as a rule. However, when the patient rose from the supine position, there was a striking fall in blood pressure with dizziness and fainting sensations. It was also noticed that there was a visible effect upon the peripheral circulatory system by flushing of the extremities. This was not a common finding, but was noticed occasionally. In four cases out of nine, there was a significant increase in skin temperature. These changes were temporary.

Dose and clinical application: Dibenamine is

* Etamon was supplied by Abbott Laboratories for our investigative purposes.

† Dibenamine was supplied by Givaudan-Delawanna, Inc., for our studies.

dispensed in 10 cc. ampules, each cc. containing 50 mg. The intravenous method is recommended in doses of 5 to 7 mg. per kg. body weight. A single dose should not exceed 500 mg. It is given in 300 to 500 cc. normal saline solution, and should be given so that the infusion is completed in not less than sixty minutes. At the end of the injection it is advisable to flush the vein with either normal saline or glucose solution.

Dibenamine has been recommended for vasospastic disorders, in occlusive vascular conditions, frost-bite, and in the various causalgias. Our experience with it has not been extensive, but we have seen some favorable influence upon pain, and a rise in skin temperature in cases where the degree of occlusion was not too far advanced.

*Priscol** is one of the most recent preparations, and is now being observed for its vasodilator effects upon the circulation.

The pharmacology of priscol was investigated by Ahlquist and his co-workers.⁷ They reported that it has a blocking effect upon the sympathetic vascular receptors and a direct histamine-like effect upon the smaller blood vessels.

Hendrix and Grimson⁸ observed the action of priscol upon the blood vessels, and found that it does have a definite dilator effect. This action can be produced by oral administration as well as by intravenous or intramuscular injection. They found that the vasodilating effects can be produced by giving 0.05 to 0.10 mg. per kg. In smaller doses, the vasodilating influence can be induced without drastic effect upon the blood pressure. When given in larger doses, 2 to 3 mg. per kg., the drug exerts adrenolytic and sympatholytic properties.

Priscol may be given orally, intramuscularly, or intravenously. For testing purposes, 50 mg. to 100 mg. have been employed, and in some cases, 200 mg. has been used. However, clinically, 50 mg. doses, three or four times a day, have been found to be adequate. The effects of priscol appear promptly. Grimson and Hendrix⁹ observed the influences of priscol in a series of 43 patients and were encouraged with their results, particularly in the vasospastic disorders, and in some of the occlusive vascular cases as well.

Miscellaneous Group of Vasodilators

At this point, we may comment upon some of the preparations and procedures which have been used as vasodilators in the treatment of circulatory disorders.

Nicotinic acid has been used extensively in the management of vascular disturbances. Numerous contributions have appeared in the literature emphasizing its value as a vasodilator. Abramson, et al.,¹⁰ have shown by plethysmographic studies that nicotinic acid produces an increased blood flow in the hands and forearms, and that this effect may last as long as seventy minutes. Similarly, Lowan and his co-workers¹¹ also proved that injection of nicotinic acid intravenously has definite vasodilator properties.

Nicotinic acid may be given orally and intravenously. When given by mouth, 100 mg. three times daily is recommended. It may be given intravenously, 100 mg. daily. Patients usually experience generalized flushing and warmth. Some may be more sensitive, and may complain of discomfort. Nicotinic acid may be useful in the vasospastic disorders, particularly when the upper extremities are predominantly involved. It may be helpful in combatting arteriospasm with occlusive vascular disorders of the lower extremities. In the latter group, it may be considered as an adjunct in the treatment. However, in our experience, we have not found it a satisfactory substitute for the more accepted procedures which are generally employed to improve the circulation.

Papaverine hydrochloride has been used as a vasodilator for a number of years. It first aroused interest when it was administered to patients with embolic occlusion.

Pharmacologically, it is an alkaloid obtained from opium. However, it can be given to patients without the danger of becoming habit-forming. It is said to have mild antispasmodic properties, as well as vasodilating effects upon the vessels. Some investigators have reported that they could not definitely demonstrate the vasodilator properties when using papaverine experimentally in animals. However, when given in adequate doses, we noted that it does produce an increase of blood flow in the distal parts. For proper effect, it should be given in doses of one grain intravenously every four hours, or four times a day. It also may be given orally.

Paravertebral block is recognized as a procedure which will produce vasodilatation of the peripheral vessels. The technique has been fully described in textbooks and various articles, so need not be repeated here.

It is undoubtedly an accepted procedure of blocking the parasympathetic nerves, overcoming the pressor stimuli, and inducing vasodilatation. These are evidenced by dryness of the skin, increased temperature, warmth to the parts, and

* Grateful acknowledgment is made to Ciba Pharmaceutical Products, Inc., for supplying priscol for our studies.

giving comfort as well. However, its action is limited and transitory.

As a diagnostic procedure, it ranks among the most favorable and accepted methods of testing the peripheral circulation. For therapeutic purposes, when a prolonged effect is desired, paravertebral block may be performed and alcohol injected about the parasympathetic ganglia. With this modified procedure, we have seen the desired therapeutic effect last from three to six months. However, this method should not be employed promiscuously, but should be relegated to one who is experienced and familiar with the technique.

Tissue Extracts. Extracts from the pancreas and the muscles have been credited with vasodilator properties. Depropanex (Sharp & Dohme) and padutin (Winthrop-Stearns) are commercially available. Tissue extract is given intramuscularly in 1 to 2 cc. doses daily in severe cases and over longer periods when necessary.

Although some investigators have reported that they are not convinced of the definite vasodilator effect of tissue extracts, others do recognize that they have merit clinically. Roth and Brown¹² reported their observations of the effect of tissue extracts upon claudication time. By giving doses of 3 cc. intramuscularly, they found that claudication time was increased from three to ten minutes in some patients.

Depropanex has been widely used in vasospastic disorders and in occlusive vascular diseases which may be associated with arteriospasm. We have found it a satisfactory adjunct in the treatment, but it should not be considered as a substitute for the more direct forms of therapy.

Alpha-tocopherol (vitamin E) has recently been recommended as an aid in the treatment of peripheral vascular disorders, particularly in chronic leg ulcers. The contribution of Shute and his co-workers¹³ indicated that it brought about a remarkable improvement in the circulation of the distal parts, and had a beneficial influence upon the healing of ulcers.

We have had only slight experience with the clinical application of alpha-tocopherol in chronic ulcers, but in some cases it seems to exert a favorable effect upon these conditions. We have not yet made intensive studies to determine its value as a vasodilator. It may be of interest to await further observations and investigations of this preparation before drawing any conclusions.

Evaluation

In order to properly evaluate the vasodilators, various factors must be taken into consideration.

Does the preparation have proven vasodilator properties? Are the vasodilator effects local or general; transitory or prolonged? Is it feasible for general use? Are there contraindications to its use, and must it be given cautiously?

Diethyl oxide (ether) has vasodilator properties. In some cases the results are good, but it has not been effective in others. It is not practical for office administration, but is readily carried out in hospital cases. In our experience, we have not seen any complications. In the favorable cases the improvement can be prolonged.

Histidine should have a favorable influence if the original pharmacologic objectives can be fulfilled. This fact must be proven. In our short series of cases we have not seen any advantage of this method over the other procedures generally employed in the treatment of peripheral vascular disorders. The frequent multiple injections cause some discomfort to the patient; however, this is not a serious objection. No untoward effects or complications were noticed in our cases.

Etamon (tetra-ethyl-ammonium) causes an effective autonomic blockade, proven pharmacologically and clinically. Its effect is transitory, but in some cases there is a prolonged improvement. It can be given to ambulatory cases and can be classified as an office procedure. However, it should not be given promiscuously and patients should be observed for at least an hour after its administration, because of the marked drop in blood pressure which usually occurs.

Dibenamine, a new preparation, has definite pharmacologic properties. It has a vasodilator effect which is more prolonged than etamon. However, at the present time, it is classified as a hospital procedure when given intravenously, which is the preferred method of administration. It offers some encouragement in dealing with vascular disorders, but further investigations and observations on a larger scale are necessary before a final decision can be given.

Priscol is another new drug which has vasodilator properties evidenced by pharmacologic and clinical studies. It is feasible for office use because it can be given orally and intramuscularly. Although large doses may produce some untoward symptoms, these can be avoided by giving smaller doses and still produce the desired therapeutic effect. Like any new drug, it is necessary to await further studies and observations upon a larger series of cases. However, offhand, the preliminary reports of priscol as an addition to the treatment of peripheral vascular disorders are encouraging.

The relative merits of the miscellaneous group

of vasodilators have been adequately discussed in previous contributions, so further comment upon their evaluation is not necessary.

Summary and Conclusions

The presence of arteriospasm in vasospastic disorders, and its frequency in the occlusive groups as well, obviously emphasizes the necessity of vasodilator drugs in the treatment of circulatory disorders.

The nitrites, nicotinic acid, papaverine hydrochloride, tissue extracts, and other drugs have been used as vasodilators in conjunction with other measures to improve the status of the circulation. Some of these preparations have been accepted, but others have been questioned as to their usefulness. Paravertebral block and alcohol injected into the ganglia has been credited with improving the peripheral circulation.

Efforts are constantly directed to producing a sympatholytic drug which will effectively bring about vasodilatation. It should be well tolerated and preferably one that is available for office and general use. Of the newer preparations, etamon, dibenamine, and priscol have pharmacologic properties which may be helpful in overcoming arteriospasm and improving the status of the peripheral circulation. They evidently have merit, judging from reports that are available, and the outlook for a satisfactory and acceptable sympatholytic agent is encouraging. However, observations upon larger series of cases will permit us to evaluate more definitely their clinical application in circulatory disorders.

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ABSTRACT OF DISCUSSION

HAROLD L. TONKIN (Williamsport): Few of us in private practice have an opportunity to see a sufficient number of patients with peripheral vascular disease to enable us to make an accurate critical appraisal of the various drugs used in its treatment. It has been possible for Dr. Kramer, with his years of experience in this work and his interest in the peripheral vascular clinics of Jefferson Hospital, to present this exceedingly interesting and valuable contribution to the problem based on his observation.

In order to bring to you the opinions of men who are particularly interested in this work and to summarize the results in clinics in several sections of the country, I corresponded with Dr. Irving S. Wright of New York City, Dr. Robert R. Linton of Massachusetts General Hospital in Boston, Dr. Edgar A. Hines, Jr., of the Mayo Clinic, and Dr. Hugh Montgomery in charge of the peripheral vascular clinic at the University of Pennsylvania. I am greatly indebted to these clinicians and to Dr. Linton, a surgeon, for their replies.

The experience with ether has been found unfavorable by Dr. Hines, has been disappointing to Dr. Wright, and the use of the drug has been discontinued by Dr. Montgomery.

The use of histidine and ascorbic acid has not been favorable in the experience of Dr. Hines, has been quite negative in the opinion of Dr. Wright, and Dr. Montgomery feels that it has not been productive of favorable results.

Tetra-ethyl-ammonium chloride has not seemed to aid very greatly in increasing the peripheral circulation nor in relieving the patients' persistent pain in the experience of Dr. Hines. Dr. Wright cannot state that the beneficial effects have been proven beyond doubt. Dr. Montgomery and his associates have found that in doses of 80 to 300 mg. the drug is very useful in diminishing the pain which accompanies many peripheral vascular states and particularly helpful in patients with cold, painful extremities during thrombophlebitis or during post-phlebotic states.

Dibenamine hydrochloride is not considered by Dr. Wright as showing proven beneficial effects, and Dr. Hines has had no experience with the drug. Dr. Montgomery believes that the general effect of the drug decreases its value in peripheral vascular disease.

Priscol has been used in a limited number of cases with not particularly favorable results by Dr. Hines. Dr. Wright has had no experience with the drug. Dr. Montgomery feels that the drug because it appears to be effective by oral route offers considerable promise in the treatment of peripheral vascular disease.

Dr. Linton from Boston states that all of the preparations have been used therapeutically and they have found that none produce any lasting effects. Tetra-ethyl-ammonium chloride and dibenamine hydrochloride were discontinued because of the side effects.

I am certain that Dr. Kramer's paper has stimulated our interest and will tend to focus our attention on future observations on these drugs. We must continue to be critical but always alert for encouraging results by experienced men.

THE PENNSYLVANIA MEDICAL JOURNAL

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EDITORIALS

AMERICA! WHY NOT AN ALTERNATIVE PLAN?

How different might have been the fate of medical and hospital service in England today if its physicians had earlier developed *an alternative plan* to that of socialization which this very year has been consummated under England's labor government.

Surely the sturdy growth and accomplishment of the Medical Service Association of Pennsylvania (MSAP) attests to its sound undergirding by The Medical Society of the State of Pennsylvania. Therefore, should not each and every Pennsylvania physician identify himself before Congress meets again (January, 1949) with MSAP, "*The Doctors' Alternative Plan*" to the plan of the Wagner-Murray-Dingell political coterie?

The above words were distributed to many county medical societies in Pennsylvania ten days before that fateful day, November 2, 1948. If the words "The Doctors' Alternative Plan" meant anything at that time, what do you suppose they mean to all of us today with the incoming new "New Deal" type of Federal Congress convening in January?

Can you think of a better plan as an "alternative" to the *compulsory* sickness insurance plan of the Wagner-Murray-Dingell political type than a combination, for every state of the Union,

of voluntary non-profit insured medical service (Blue Shield) and hospitalization service (Blue Cross)?

Should not the members of the medical profession throughout Pennsylvania and the nation unite in an intensive ninety-day campaign to *acquaint, at the local level*, every professional, social, industrial (management and labor), agricultural, banking and school group with the impressive *contrasts* between the cost and the quality of voluntary and of compulsory sickness and hospital service?

Don't wait for united action—essential as it will be ultimately—but let every doctor proceed realistically to present the health cause of the people as we understand it to his or her friends and neighbors who comprise the several groups in society mentioned above.

Are you at a loss for words? Tell them that Blue Shield and Blue Cross insured services are everywhere available for those able to pay and that they are adaptable to the care of those less fortunate for whom local or state tax funds may pay.

In all our talk about competency in our own professional education, training, experience and service, let us remember that competency has meaning only in relation to the good of the public. With that basic truth well imbedded in our own minds, we may with confidence discuss our

profession's own plans for more and better medical service for everyone with anyone—from our next-door neighbor to our representative in the 81st Congress.

For additional comments favorable to local and state administration of voluntary, non-profit sickness and hospitalization insurance, read in this issue "Very, Very Unwise" (page 148) and "Mr. Ewing's Report on the Nation's Health" (page 153).

ONCE IN A HUNDRED YEARS

Who but the Editor would take the liberty of presenting as a leading editorial in this medical journal a compilation to which he contributes lightly after quoting, under the general caption "Once in a Hundred Years," from certain expressed reactions of others to the programs of public meetings held in October in the name of The Medical Society of the State of Pennsylvania?

We quote in part from comments by Dr. George S. Klump, of Williamsport:

"The tone of the meeting was set by the Religious Hour held Sunday afternoon at Irvine Auditorium. A distinguished musician, Alexander McCurdy, D.Mus., gave an organ recital at 3:45. On the stroke of four Dr. McCurdy's well-trained choir entered to the majestic processional 'God of Our Fathers.' The auditorium was well filled; many of the members and guests were eminent scientists. As they rose and spontaneously joined in the singing, one could sense that here indeed was an example of the humility of mind combined with recognition of spiritual values that is characteristic of the disciples of any true science. Those of us in attendance, physicians and laity alike, had tingles running up and down our spines.

"The State Dinner. The Rt. Rev. Msgr. Cornelius P. Brennan pronounced the invocation. Following excellent food and entertainment, President Elmer Hess introduced the speaker. It was a serious and unusual introduction. Dr. Hess asked God's blessing for the message that was to be given. Ralph Cooper Hutchison, D.D., president of Lafayette College, addressed the assemblage. His topic, 'Physician, Heal Thyself,' was developed in the eloquent masterful style that Dr. Hutchison has made distinctive.

"The Installation Meeting. The wind and the rain that had begun earlier in the day continued Tuesday evening when the Installation Meeting was held at the Academy of Music.

"Retiring President Elmer Hess received the traditional ebony, silver-mounted, inscribed gavel.

"Dr. Gilson Colby Engel was installed as president of The Medical Society of the State of Pennsylvania, Dr. Park A. Deckard received a plaque recognizing his service as a retiring member and chairman of the Board of Trustees, and Secretary-Treasurer Walter F. Donaldson was presented a television-radio set as a token of the esteem and affection in which we hold this

'medical statesman' who this year completed thirty years of service to the Society and to the purpose it serves.

"President Engel's address, beamed to the current election and the stake every citizen has in it, was enthusiastically received. Dr. Engel presented the Benjamin Rush Awards to Alan Magee Scaife of Pittsburgh and to the Rotary Club of Lancaster.

"The musical program under the direction of James Allan Dash, D.Mus., was without doubt the finest our society has ever sponsored. The Bach Festival Chorus and the Baltimore and Ohio Glee Club each had a number during the program outlined above.

"After a short intermission Dr. Dash took over. His inimitable sense of humor combined with great technical skill resulted in an outstanding performance by the vocalists and an unusual musical experience for the audience. The program closed with a soul-stirring rendition of Haydn's 'The Heavens Are Telling' (The Creation) by the chorus, glee club, and soloists."

We also quote Dr. Adolphus Koenig, of Pittsburgh:

"I wish to ask you to transmit to the other appropriate officers of the State Medical Society some personal observations regarding the Centennial Celebration session in Philadelphia. The chairmen of the various convention committees, and Dr. Bortz in particular, deserve the highest praise for their achievements during the convention. I am proud to be a member of the society which carried out the dignified and inspiring ceremonies of Sunday afternoon and of evening programs. The choice of speakers and subject matter presented by the speakers were equally deserving of praise. I hope that future annual meetings may repeat at least some of these features of the Centennial meeting."

Doubtless, JOURNAL readers of the foregoing comments who attended the Centenary Convention will not only approve but wish that they had added to the chorus of praise; and those who read but did not attend will further regret their absence when they read these additional appended comments.

Once in a Hundred Years

Only once in the one hundred years since the birth of The Medical Society of the State of Pennsylvania, at Lancaster, in 1848, has the annual session of the Society been marked by such expansive and expensive plans and preparations as resulted in the unparalleled program of scientific and social events which was smoothly and successfully unrolled, October 3 to 7, 1948, at Philadelphia.

Leaving to the next issue of the JOURNAL the detailed recording of the traditional stories of the presentation of scientific programs, the House of Delegates, and the Installation Meeting of the century as transcribed from the reports of half a dozen stenotypists, the Editor will here touch briefly on unusual features only.

Delightful Interlude: The presentation to The Medical Society of the State of Pennsylvania by the Medical Association of Georgia of a beau-

tifully grained, handsomely turned, silver-mounted gavel bearing the following inscription:

THIS GAVEL MADE OF DOGWOOD GROWN
AT THE BIRTHPLACE OF
CRAWFORD WILLIAMSON LONG, M.D.
PRESENTED TO THE MEDICAL SOCIETY OF
THE STATE OF PENNSYLVANIA
CENTENNIAL CELEBRATION
BY THE
MEDICAL ASSOCIATION OF GEORGIA

This presentation was made during the State Dinner, which was attended by six hundred persons, including guests from a dozen states and several South American countries.

Dr. Edgar H. Greene, president-elect of the Georgia State Medical Association, who brought the gavel to Philadelphia, in memory of the Georgia physician who, in 1842, first used ether as an anesthetic, gallantly permitted his charming soft-voiced wife to hand it over to President Hess with words and manner of speaking in keeping with all that is expected in expressing the characteristic courtesy, charm, and magnanimity of the South.

A Happy Interlude: The presentation, in the Philadelphia Academy of Music, to The Medical Society of the State of Pennsylvania, during the installation of its ninety-ninth president at its Centenary celebration, of one hundred lovely red roses from the 24-year-old Woman's Auxiliary to the century-old Medical Society by the charming, beautiful, and capable Mrs. Rufus M. Bierly, the retiring president of the State Auxiliary.

The registered attendance was indeed unusual and most gratifying, and should thoroughly satisfy the state pride of the most enthusiastic supporter of Philadelphia as the Cradle of American Medicine, and Pennsylvania as having one of the nation's great state medical associations.

Registrations at Philadelphia, October 3-7, 1948, were:

Members of The Medical Society of the State of Pennsylvania,	
from Philadelphia County	1501
from 58 other Pennsylvania counties ..	1302
	—
	2803
Non-member Pennsylvania practitioners ..	118
Non-member out-of-state physicians	247
Hospital interns and residents	429
	—
Total doctors of medicine	3597
Medical students	532
Nurses	252
Technicians, etc.	105
Exhibitors	701

Woman's Auxiliary	491
Miscellaneous	550
	—
Grand total	6228

The names of the official representatives of twelve state medical societies and of physicians in attendance from an equal number of Central and South American countries will appear in the December PENNSYLVANIA MEDICAL JOURNAL.

NOT CONCERNED WITH MERCENARY OBJECTIVES

"But the medical profession is being tempted in this age. It is being tempted to organize and correct this situation and see to it that any qualified man entering the profession shall have a living wage assured him and shall have complete economic security. A voice crying out from an economic jungle—I plead now in the name of the mendicants of all ages, in the name of threadbare priests and payless ministers, in the name of missionaries serving with a bare subsistence, in the name of penniless and often homeless teachers, in the name of the country doctor who gave his life without material reward, in the name of the always underpaid professions of service—that you resist this savor of the fleshpots and the tinkling of silver, and as a true profession maintain the saving of human life, the alleviation of suffering, and the healing of mankind as the one and, if possible, the only objective of the medical profession and of The Medical Society of the State of Pennsylvania on its one hundredth anniversary.

"Now, having given what you might call a good bill of health to medicine as being a true profession and entitled to all of the rights and privileges thereunto appertaining, I want to raise the great question with which you will be confronted in the next one hundred years. This question applies with equal force to other associations—to Lafayette College, to the church, to the bar association, to the nursing association, to the labor unions, to the grange, to the stock exchange, to industry. It is very fundamental. This is it: granted that you have done a good job up to this point, are you going to make the changes which a fluid social order requires for the future? Are you going to make those changes yourselves or are you going to let society do it for you?"

The two paragraphs printed above are lifted from the address (see page 120, this issue) delivered before 600 persons assembled at the State

Dinner connected with our state society's Centennial Celebration in Philadelphia the first week of October.

Ralph Cooper Hutchison, D.D., president of Lafayette College, gave this address. His message was angled at the next century and the part which must be played by the medical profession in the impending fluid social order which will injure our profession or any other concurrent institution or association that remains inflexible in its purposes toward a gradually changing society.

The entire address is well worth reading by any alert and intelligent member of our society.

VETERANS ADMINISTRATION

Washington 25, D. C.

To the Editor:

It has come to my attention that considerable misunderstanding has developed throughout the medical profession concerning the establishment of fees for medical services to be paid private physicians participating in the so-called "Home-Town Medical Care Program for Veterans." It has been contended that the Veterans Administration has arbitrarily established a fee schedule which represents the maximum amount which may be paid for any given service and which is, in effect, a national fee schedule. It has also been contended that the various state medical societies and other interested groups were not consulted when this fee schedule* was adopted.

In order to clear up any misunderstanding regarding this matter, it is desired to emphasize that my predecessor, Dr. Paul R. Hawley, had no intention at any time of establishing a national schedule of fees, nor do I contemplate doing so. However, the fee schedules originally submitted by the various state medical societies, when the "Home-Town Medical Care Program" was inaugurated, varied so widely in format, terminology, and fees for similar or identical services, that it was deemed advisable to establish a uniform Fee Schedule Format and to set up tentative fees which could be used as a guide by the various state medical societies when submitting their proposals for the furnishing of medical care to veterans.

This uniform Fee Schedule Format was formulated by the Professional Group of National Consultants to the Chief Medical Director. This

group, representing the various specialties in medicine and surgery, is composed of eminent physicians from all parts of the country. Tentative fees were set up in the format after a careful analysis of prepaid medical care plans, workmen's compensation and insurance fee schedules, and also the fee schedules in effect in the various states having agreements with the Veterans Administration. As was to be expected, considerable variation occurred in the fee schedules reviewed.

The Professional Group of National Consultants made every effort to arrive at fees that were considered to be within reasonable limits and which would, as nearly as possible, allow a uniform provisional fee schedule for use as a guide in facilitating and expediting the preparation of agreements between state medical societies and the Veterans Administration.

A further attempt was made to provide for elasticity in the charges for certain operations or other services which seemed to evoke more than average contention by listing the minimum and maximum amounts considered equitable. These items bear the notation "AA," which indicates that the fee for the given service is to be determined by arbitration and agreement between the Veterans Administration and the medical society concerned.

May I reiterate that the Veterans Administration Fee Schedule Format is in no sense to be construed as an arbitrary or national fee schedule. Furthermore, it is subject to periodic review and such modification as conditions may indicate.

I would appreciate it very much if you could possibly arrange to publish this as an open letter in the JOURNAL. I should like this to reach all of the physicians throughout Pennsylvania, and I know of no better way to do it than through the JOURNAL.

PAUL B. MAGNUSON, M.D.,
Chief Medical Director.

VERY, VERY UNWISE

Our system of private medicine is not perfect. There are some chiselers and incompetents among physicians as there are among farmers, workers, businessmen, and politicians. Fee-splitting with specialists; the performing of unnecessary operations; the dragging out of treatments—these are unsavory, but not unknown practices.

But by and large our system has worked well. Most doctors are honest and capable. They make allowances for the indigent. Clinics and free hospitals are provided for those who cannot pay. Health insurance programs

EDITOR'S NOTE: A revamped fee schedule mutually satisfactory to the Veterans Administration and The Medical Society of the State of Pennsylvania will be printed in an early issue of THE PENNSYLVANIA MEDICAL JOURNAL.

are available to those who desire them. Under private medicine, America is the healthiest country on earth. That's a pretty good testimonial.

Yet it is now proposed to scrap a system which has proved its value and adopt a compulsory governmental one which, in countries where it has been tried, has failed miserably. Medical men who have studied these foreign systems report that in every case their adoption has reduced the quality of medical practice.

The costs of compulsory medicine are tremendous. Great Britain's system will leave an estimated \$2,000,000,000 hole in the treasury. America, being three times as populous, would presumably have three times the expense.

Under government medicine, as Economist Melchior Palyi points out, the traditional doctor-patient relationship disappears: "A bureaucratic operation of vast dimension is needed to check the doctor and to check the patient—to the dissatisfaction of both."

A serious objection is that physicians must operate an assembly line—a mass treatment of patients. With

a minimum fee system, patients must be rushed through at breakneck speed or the doctors' income will be insufficient. In New Zealand, appointments must sometimes be made four months in advance.

Certainly the physician would have no incentive to pursue additional studies or keep pace with advancing medical techniques. Incompetent and competent medical men would receive the same minimum fees. Moreover, few doctors could stay outside the program, ready to give thorough treatment. They would be forced in by the general public, which would presumably be unwilling to pay for something obtainable free. (Free, that is, until they came to pay their tax bills.)

Physician groups have recognized imperfections in our system and have tried to eliminate them. The general abandonment of rebates on spectacles furnishes a recent example. But to scrap the successes of private medicine and substitute the costly failures of compulsory systems would be folly. It would make us unhealthy, unwealthy, and very, very unwise.—*Chicago Journal of Commerce*, Sept. 23, 1948.

VENEREAL DISEASE NOTES

From the Pennsylvania Department of Health

"Not able to make the test—specimen hemolyzed." No message is more disappointing to the hard-working doctor than the above report received from the laboratory.

An attempt will be made to set down in simple language several of the most poignant factors in the hemolysis of specimens.

Warm weather apparently has a profound effect in the production of this unfortunate condition. This statement is based on the number of "kicks" received from clinicians during the period from April to November each year. Accordingly, it is well during warm weather to subject specimens to moderate refrigeration before placing them in the mail. *But they must not be frozen.*

Dr. Claude P. Brown, ex-director of the State laboratories, reports that recently tests were made to determine the influence of agitation of the blood contained in mailing tubes. The results were amazing. If the tubes were filled to capacity—right up to the cork—hemolysis did not occur after twenty-one hours of mechanical agitation of the tubes. Manifestly, air in the tube has a strong influence in breaking up the corpuscles.

Other factors in the production of hemolysis as reported by the laboratories are:

"Shooting" blood through the needle into the tube, thus breaking the fragile corpuscles.

Water that is left in the syringe or the needle.

Poor timing in mailing specimens to the laboratory. Care should be taken not to permit specimens to lie for hours in the local post office. Neither should they reach the laboratory on a Saturday or a Sunday.

Chemical action by alcohol that too often is used in sterilization of syringes.

In other words, specimens that have been cooled, specimens that have been drawn through dry needles and dry syringes, specimens that have been properly corked and that have been mailed at the proper time are much more likely to reach the laboratory in suitable condition for testing.

Finally, if hemolysis does occur, don't be too hard on the poor laboratory director, but rather on the weather man or possibly on—guess who? Careful observance of these simple rules should go a long way toward preventing the receipt of reports similar to the one at the beginning of this little article.

The value of the serologic test in the therapy of *early* syphilis has increased tremendously since the advent of penicillin.

In the absence of clinical symptoms, the *quantitative* serologic test is the only means that permits the clinician to determine the result of penicillin treatment. If the blood titer rises, and if it continues to rise on repeated testing, a second course of penicillin is required. Therefore, both from the clinical and from the public health standpoint, quantitative serologic testing is of the utmost importance.

It is apparent, therefore, that any care that is given to the preparation of specimens for mailing will be worth many times the trouble that it takes.

EDGAR S. EVERHART, M.D., Chief, Venereal Disease Division.

Deaths from Selected Causes in Pennsylvania, June, 1948

County	All Causes, Excluding Stillbirths	Still- births	Infant Deaths	Maternal Deaths	Cancer	Heart Disease	Intra- cranial Lesions of Vascular Origin	Nephritis	Pneu- monia	Tuber- culosis
Adams	30	0	1	0	4	7	5	3	2	0
Allegheny *	1120	78	69	2	178	356	107	54	34	26
Armstrong	44	1	4	0	2	18	3	7	1	4
Beaver	112	1	7	0	24	29	11	6	0	2
Bedford	30	3	2	0	3	10	1	6	1	5
Berks *	220	5	15	1	30	72	22	12	6	0
Blair	116	4	9	1	18	42	10	9	3	0
Bradford	44	1	1	0	9	15	5	3	0	1
Bucks	77	2	2	2	9	30	10	5	2	0
Butler *	74	4	4	0	12	27	7	4	1	0
Cambria *	148	11	12	1	22	44	17	8	7	0
Cameron	1	0	0	0	0	0	0	1	0	0
Carbon	51	3	3	0	8	21	6	4	2	1
Centre	52	2	5	1	9	13	3	5	1	1
Chester *	128	4	9	0	19	42	11	14	5	3
Clarion	16	0	0	0	1	8	3	2	0	0
Clearfield	69	6	4	0	11	27	2	8	0	1
Clinton	23	1	3	0	3	8	4	0	0	0
Columbia	85	1	4	0	3	17	7	3	0	3
Crawford	72	2	3	0	8	29	8	4	0	0
Cumberland	64	6	5	0	10	26	5	5	1	1
Dauphin *	180	10	5	1	31	68	12	22	2	2
Delaware	229	8	11	0	46	85	18	17	5	6
Elk	23	1	0	0	5	8	1	2	1	1
Erie *	193	6	14	0	30	67	27	12	3	6
Fayette	146	11	14	0	16	50	16	9	1	0
Forest	0	0	0	0	0	0	0	0	0	0
Franklin *	61	0	7	1	7	18	4	10	1	2
Fulton	6	1	0	0	0	3	0	1	1	0
Greene	31	2	3	0	4	11	4	2	1	0
Huntingdon	32	2	3	0	5	13	7	0	1	0
Indiana	55	3	5	0	8	18	6	2	0	2
Jefferson	27	3	2	0	6	6	1	3	1	0
Juniata	8	0	0	0	4	3	0	0	0	0
Lackawanna	251	7	12	0	47	82	16	18	4	8
Lancaster	174	9	11	0	25	62	20	11	0	5
Lawrence	77	6	2	0	6	29	5	8	0	2
Lebanon *	48	3	5	0	7	17	3	5	0	0
Lehigh *	148	10	7	1	22	45	14	6	3	4
Luzerne	289	14	16	0	35	93	21	24	7	9
Lycoming	79	4	7	0	11	33	9	4	1	0
McKean	46	4	3	0	7	19	4	4	0	0
Mercer	92	6	13	0	12	30	7	7	0	0
Mifflin	28	4	2	0	4	6	3	0	1	0
Monroe	31	2	1	0	3	14	2	1	0	0
Montgomery *	271	7	11	0	50	92	16	19	5	7
Montour *	27	0	6	0	4	9	1	0	2	0
Northampton	105	2	1	1	14	45	6	1	1	3
Northumberland	85	4	6	0	10	33	7	4	3	4
Perry	11	1	2	0	1	4	1	0	0	0
Philadelphia *	1776	54	86	3	263	639	144	112	39	83
Pike	2	0	0	0	0	2	0	0	0	0
Potter	15	1	1	0	3	5	3	2	0	0
Schuylkill	161	10	8	1	26	49	14	9	4	2
Snyder *	19	0	0	0	4	9	1	1	0	0
Somerset *	61	2	5	0	7	25	6	2	3	0
Sullivan	4	0	0	0	2	1	0	0	0	0
Susquehanna	23	1	2	0	2	11	1	1	0	0
Tioga	32	2	1	0	5	14	1	2	0	1
Union	14	0	1	0	1	3	1	0	0	1
Venango *	62	1	4	0	9	14	13	4	1	1
Warren *	33	2	4	0	2	13	2	2	0	2
Washington	129	6	7	0	20	37	13	7	5	5
Wayne *	29	1	0	1	4	8	4	2	1	0
Westmoreland *	189	8	13	2	21	65	21	11	5	4
Wyoming	14	2	0	0	5	6	0	1	0	0
York	149	4	14	0	21	46	15	13	2	3
State and Federal institutions	250	0	1	0	20	64	14	11	9	53
State totals	8291	359	478	19	1218	2815	731	535	179	264

* Exclusive of deaths in State and Federal institutions except general hospitals.

1949 HEALTH POSTER CONTEST

THE 1949 Health Poster Contest of The Medical Society of the State of Pennsylvania is under way—with the cooperation of county medical societies and their woman's auxiliaries.

The contest, as planned, provides for each county medical society to hold elimination contests before the close of the spring school semester.

The winning posters in these contests will be entered in the state contest to be held at the annual meeting of The Medical Society of the State of Pennsylvania in Pittsburgh, September, 1949.

The contest will be open to all school children in public, parochial, and vocational training schools in Pennsylvania.

There will be four classes of contestants: grades 1 to 6, grades 7 to 9, grades 10 to 12 in both public and parochial schools, and all pupils in vocational training schools.

Awards will be first, second, and third prizes in each of the four classes of contestants.

EXERCISE



FIRST PRIZE—Grades 1 to 6—1948
Clarence Toth, Johnstown



FIRST PRIZE—Grades 7 to 9—1948
Elaine Koncsol, North Braddock

Winners in the individual county contests will be awarded such prizes as the contest committee in each county medical society deems suitable, and will become the property of the society.

Awards in the state contest will be: \$25 first prize, \$15 second prize, \$10 third prize in each of the four classes of contestants.

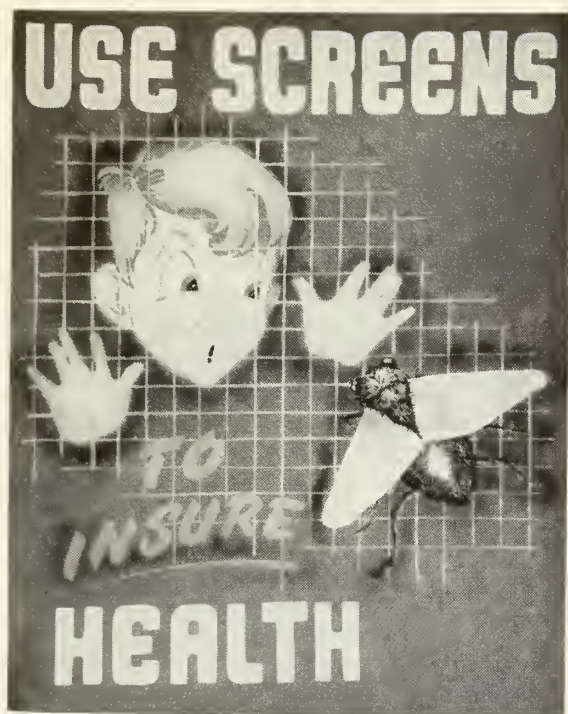
The posters are to illustrate some phase of general health or preventive medicine such as vaccination, periodical physical examination, accident prevention, nutrition, mental health, eye-sight protection, and common cold control.

Suggestions may be obtained from the family doctor, from the school doctor, from life insurance companies, and from the health magazine, *Hygeia*.

Posters may be either 20 x 30 inches or 12 x 18 inches in size; the larger poster is preferable as it is more suitable for display.

Posters may be designed in any one of the following mediums: oils, water colors, crayons, ink or cut-outs.

The posters may contain a health slogan, but



FIRST PRIZE—Grades 10 to 12—1948
Sally Motter, Allentown

no advertising matter or name of a physician are to be included.

Each contestant is to print clearly on the back of the poster his or her name, address, school, grade, date, name of county and city.

County medical societies will judge posters submitted in their contests not later than May 15, 1949.

Posters will be judged on health message, originality of design, and neatness.

Further information may be obtained from your county medical society or its woman's auxiliary.

Approximately one thousand school children submitted posters in the 1948 Health Poster Contest, which was conducted in fifteen counties.

The judging for the state-wide contest was held in Philadelphia on September 26 with the following persons selecting the prize-winning posters: Mr. Earl B. Milliette, director of art, Philadelphia Board of Education; Mr. Frederick W. Weber, past president of the Philadelphia Sketch Club and a member of the Board of Directors of the School of Industrial Art, Philadelphia; George D. Gammon, M.D., a painter who has exhibited with the AMA art group; and Gilson Colby Engel, M.D., president of The Medical Society of the State of Pennsylvania.

Clarence Toth of the Chestnut Street School, Johnstown, won first prize in the first to sixth grade group; Elaine Koncsol, of the Brinton Avenue School, North Braddock, won first prize in the seventh to ninth grade group; Sally Motter, of the Allentown High School, won first prize in the tenth to twelfth grade group.

Other prize-winners were from Wilkes-Barre, Harrisburg, Souderton, Greensburg, and Pittsburgh.

The prize-winning posters were displayed at Gimbel's Store during Pennsylvania Week and for the week of the Centennial Celebration session of the State Society.

CARELESS READER, RETRACE YOUR STEPS

To the more or less casual JOURNAL reader who passes by a paper because it appears to be "too long," the Editor advises such persons to look again at the first paper in this issue.

It deals with proven methods of therapy—pharmaceutical, surgical, and physical—that have mightily reduced the disabilities and deaths that until recently marked the frequently tragic results of thrombosis and embolism. Dr. Allen speaks from experience with 3073 patients under observation for treatment or prevention of the thrombo-embolic syndrome, in which success often begins with the doctor who first sees the patient.

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*

8104 Jenkins Arcade

Pittsburgh 22, Pa.

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State From What It Is to What It Ought to Be.

MR. EWING'S REPORT ON THE NATION'S HEALTH

In a speech delivered October 29, 1948, at the Silver Jubilee Dinner of the St. Louis University School of Medicine, Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*, charged President Truman and Federal Security Administrator Oscar R. Ewing with attempting to use medical care as a political weapon. Dr. Fishbein said that the Report on the Nation's Health, which Mr. Ewing made to the President, is a "shrewdly contrived document designed to break down the confidence of the American people in their medical care."

Mr. Ewing "called a National Health Assembly, stacked his executive committee, and then sent a report which recommended compulsory sickness insurance because President Truman recommended it to him," Dr. Fishbein charged.

"While Mr. Ewing and his fellow bureaucrats have been trying to create a political machine based on a nationwide health service, the medical profession and most of the medical personnel of our nation have been moving steadily forward and have reached a peak in medical care that towers above what is available anywhere else in the world.

"No one doubts the ability of the national government to aid medical progress. The costs of medical education have increased so greatly that additional funds are necessary to maintain the high standard that has been reached. If such funds are forthcoming from the federal government, they must be granted without the control that government usually demands when it supplies financial aid. The hospital too must have the freedom that is asked for the medical schools.

"Mr. Ewing's report to the President contains misrepresentations and follies so numerous that it would be impossible to correct all of them.

"One searches in vain for any suggestion as to how medical facilities and the medical person-

nel of the United States could be made more effective. Mr. Ewing's statement on the nation's health suggests that every state should have a medical school and a medical center around the school.

"This is a broad generalization that could be made only by someone without knowledge of medical education or its problems. A medical school is not just four walls and a lot of equipment. The fundamental factor in a medical school, as in a hospital or any other medical institution, is its medical personnel.

"Mr. Ewing's report says that a scant 20 per cent of our people are able to afford all the medical care they need. This, mind you, in a nation with the highest standard of living of any nation in the world. How pitiful then must be the situation elsewhere! The report urges that 30 per cent of American families, with incomes between \$3,000 and \$5,000, would have to make great sacrifices or go into debt to meet the costs of a severe or chronic illness. How many of these families make great sacrifices or go into debt to purchase a motor car or to find a place in which to live or to get something resembling an adequate diet or to purchase mink made out of dyed rabbit? Many an American family spends over \$180 a year on tobacco.

"Is the answer the depreciation of medical care to a ridiculous price or education of the public to a recognition of the value of high quality medical care for human happiness?"

PENNSYLVANIA PSYCHIATRIC SOCIETY

The tenth annual dinner meeting of the Pennsylvania Psychiatric Society was held at the Barclay Hotel, in Philadelphia, October 7.

William C. Menninger, M.D., president of the American Psychiatric Association, spoke on "Psychiatry Today and Tomorrow."

The following officers were elected to serve for the year 1948-1949: President, Thomas A. Rutherford, M.D., Waymart; president-elect, Harold L. Mitchell,

M.D., Pittsburgh; secretary-treasurer, Philip Q. Roche, M.D., Philadelphia; editor of transactions, Theodore L. Dehne, M.D., Philadelphia.

The Pennsylvania Psychiatric Society voted unanimously (1) to adopt the resolutions committing the society to approve in principle the proposed new constitution and by-laws of the American Psychiatric Association as published in the *American Journal of Psychiatry*, pages 135-145, Vol. 105, No. 2, August, 1948; (2) to make formal application to the Council of the American Psychiatric Association for recognition of the Pennsylvania Psychiatric Society as the district branch society of the American Psychiatric Association for Delaware and Pennsylvania as provided in Article V of the current by-laws of the American Psychiatric Association and in anticipation of the Pennsylvania Psychiatric Society later becoming the district constituent society of the American Psychiatric Association for Delaware and Pennsylvania under Article 3 of the proposed new constitution of the American Psychiatric Association, if, as and when the latter constitution and by-laws are formally approved and adopted; and (3) to conduct a mail ballot of all members and Fellows of the American Psychiatric Association residing in Delaware and Pennsylvania and eligible to vote on the above matters.

EDITORIALLY SPEAKING

In recent weeks we have been impressed with the numerous editorials on medicine which have appeared in Pennsylvania newspapers. In the majority of cases these editorial comments were commendatory to the medical profession in general. Even so, we have no great cause for rejoicing or rushing off to the hatter's to purchase a new fedora one size larger than usual. Some editorial writers are not yet convinced that the medical profession is striving diligently to render competent medical service. Their impression of the doctor is that of a money-grabbing individual who thinks first of his fee and then of his patient.

The *Philadelphia Evening Bulletin* of October 5, in saluting a century of medicine, states that "the medical profession has taken the public into its confidence." That is definitely what we want to do as a profession, but as individual physicians we often err.

The *Philadelphia Inquirer* of October 6 saw fit to re-emphasize Dr. Hutchison's Monday evening address at the State Dinner wherein he warned that "the medical profession must soon take constructive steps to relieve the formidable shortage in public medical services or 'some demagogic politician' will do it first. There aren't enough doctors, surgeons, nurses or hospitals to handle the work that ought to be done, and the whole matter is complicated in some medical quarters to choke off needed expansion for selfish reasons.

"This situation is made to order for the demagogue who would ride to power on the strength of such promises as free health care for everybody. The doctors themselves and their representative bodies are in the best position to see that nothing of this sort happens. They should make the most of it."

This is good sound advice and merits the attention of every physician—not by merely saying "that's right" or "I agree" but by pledging his active support to the county and state medical societies in their fight against such demagogic action.

From the northeastern corner of our state, in Bradford County, the *Canton Independent-Sentinel* requests

that "the American people keep an eye on England's 'free' health service which staggered into operation last July. It is the kind of thing that proposals such as the long-pending Wagner-Murray-Dingell Bill would fasten on this country.

"Instead of being 'free,' the plan will cost English taxpayers some \$600,000,000 a year in the beginning—a very large sum for a country of her population and economic position—and the cost will increase heavily in the future. Workers and employers will also 'kick in' for a period of time. The benefits paid are determined by a mass of confusing regulations, and will run to about \$5.20 a week for the sick worker.

"So it goes in the Socialist Utopia, where everybody is supposed to be protected against everything and everybody certainly has less and less freedom of choice. Compulsory medical insurance is just the step which precedes socialized medicine—which, in turn, is one more of the steps leading to the all-powerful state. We can profit by Britain's sorry experiments."

Jumping diagonally down to the other corner of the State, we find the *Pittsburgh Press* condemning the recent quack cancer cure racket uncovered in the Steel City.

"Through the centuries, the medical profession has accumulated a vast amount of knowledge on human ailments and their treatments. In medical schools, and in hospitals, this knowledge is passed on to young physicians.

"Until he has acquired a satisfactory amount of this knowledge, and has thoroughly learned how to use it, no person is permitted to practice medicine. Standards are set, and set high.

"This is not done for the protection of the medical profession, but for the public. A patient who engages a doctor must be assured of having the benefit of the best that medical science has to offer. That's why it has been made an offense to practice medicine without a license.

"Mostly, quackery is a racket. That has not been charged in the most recent case, the so-called 'cancer clinic.'

"But that is not the point. The point is that a tire dealer and former hospital cafeteria superintendent were stepping into a field for which they had no training, and into the lives of human beings.

"It is possible, of course, that an untrained person might discover a cancer treatment. But it is very unlikely, considering the fact that the best medical minds, with the best of equipment, have been working on the problem for years."

The "pen" is a mighty influence in molding public opinion and we should ever keep in mind that it can be just as scathing as it can be laudatory; therefore, may we govern our actions accordingly.

COMMITTEE ON PUBLIC RELATIONS.

Dr. Adolphus Koenig, of Pittsburgh, who is quoted on page 146 of this issue, is the oldest son of the late Dr. Adolph Koenig, also of Pittsburgh, who was the first publisher and editor of THE PENNSYLVANIA MEDICAL JOURNAL from 1897 to 1904. In the latter year Editor Koenig became president of The Medical Society of the State of Pennsylvania.

Two other sons of Adolph Koenig are doctors of medicine—Theodore R. Koenig, practicing in Knox, Clarion County, Pa., and Arthur R. Koenig, practicing in Pittsburgh.

PHYSICIANS IN 1949 AMA DIRECTORY

<i>Total Number of Physicians in 1942 Directory</i>	
(United States, its possessions, and Canada)	201,272
New names added	45,218
Deaths deleted	23,065
Cut from Directory for various reasons	357
Cut from Directory, Philippine Islands	4,209
Total deletions	27,631
New gain Sept. 15, 1948	17,587
<i>Total Number of Physicians in 1949 Directory as of Sept. 15, 1948</i>	
Retired or not in practice	8,300
Not in private practice (employed by insurance companies, industrial firms, etc.)	4,400
<i>Full-Time Hospital Service:</i>	
Interns	7,000
Residents and Fellows	15,000
Superintendents of hospitals (M.S.s), full-time M.D.s in tuberculosis, nervous and mental hospitals)	2,688
<i>Full-Time Hospital Service—Total</i>	
24,688	
<i>Government Service:</i>	
Regular Army	1,205
ASTP, serving with Army	2,550
ORC, and AUS, serving with Army	598
Total Army Service	4,353
Regular Navy	1,540
U.S.N.R.	1,154
Total Navy Service	2,694
United States Public Health Service	639
United States Public Health Service Reserve on active duty ..	408
Total Public Health Service	1,047
Indian Service	245
Veterans Administration (full time)	3,484
<i>Government Service—Total</i>	
11,823	
<i>Total number of physicians not in private practice</i>	49,211
<i>Net estimated number of physicians in private practice in 1949</i>	169,273
<i>Estimated number of physicians limiting practice to a specialty</i>	45,000
<i>Estimated number of physicians in general practice</i>	124,273
From DIRECTORY DEPARTMENT OF AMA, F. V. CARGILL, Director.	

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since August 31. Figures in first column indicate county society numbers; second column, State Society numbers.

Sept. 1 Crawford	52-57	10361-10366	\$90.00
4 Philadelphia	3128-3135	10367-10374	120.00
8 Clearfield	50-53	10375-10378	60.00
10 Schuylkill	157-158	10379-10380	30.00
Schuylkill	160 (1947)	9382	15.00
13 Delaware	280-282	10381-10383	22.50
Montgomery	324-328	10384-10388	67.50
Columbia	46	10389	7.50
15 Bucks	93-95	10390-10392	22.50
16 Bedford	11	10393	15.00
Lancaster	234-235	10394-10395	15.00
24 Jefferson	62-64	10396-10398	22.50
Montgomery	329	10399	7.50
Berks	253-257	10400-10404	30.00
27 Centre	35-36	10405-10406	15.00
McKean	50-51	10407-10408	15.00
28 Mercer	87-88	10409-10410	15.00

CHANGES IN MEMBERSHIP OF COUNTY SOCIETIES

New (35) and Reinstated (12) Members

BERKS COUNTY: Nicholas J. Christ, Birdsboro; Richard C. Reinsel, Shillington; John B. Wagner, Reading. (Reinstated) Theodore W. Gliem, Hamburg; Irvin G. Shaffer, Reading.

BUCKS COUNTY: William A. Phillips, Quakertown; Francis J. Preis, Croydon; Pasquale M. Vassalluzzo, Bristol.

CAMBRIA COUNTY: John B. Lovette, Johnstown.

CENTRE COUNTY: Paul L. Carney, William McFarland, and Lytle R. Parks, Jr., State College.

CLEARFIELD COUNTY: Russell A. Boykiw, Clearfield.

COLUMBIA COUNTY: Joseph Delozier, Millville.

CRAWFORD COUNTY: J. N. Martin, Conneaut Lake; W. J. Beckfield, Springboro.

DELAWARE COUNTY: Harry J. Fryer, Jr., Yeadon; Willard Edw. Knowles, Upper Darby; Alvin Siegel, Collingdale.

JEFFERSON COUNTY: Bryce C. Cochran, Dubois; Harry R. Cramer, Reynoldsville; Arthur R. McKinley, Brookville.

LANCASTER COUNTY: Hiram L. Wiest, East Petersburg.

McKEAN COUNTY: Samuel J. Hagen and Leslie B. Silverstine, Bradford.

MERCER COUNTY: Henry C. Carlson, Jr., Grove City. (R) Wayne D. Daugherty, Grove City.

MONTGOMERY COUNTY: Miles D. Garber, Jr., Norristown; Eugene M. Lawbowski, Conshohocken; Daniel Lee, Pottstown; Richard V. Lynch, Souderton; Edwin K. Owenby, Boyertown; Peter Vick, Huntingdon Valley.

PHILADELPHIA COUNTY: Philip L. DeLong, Haver-town; Robert W. Kiley, Leo Madow, Luther L. McCallion, and George W. Russell, Philadelphia. (R) Samuel I. Adelman, Richard W. Blizard, Leon S. Caplan, Stanley W. Conrad, and Benson Krieger, Philadelphia; Robert P. Gouldin, Cynwyd; Franklin C. Massey, Seattle, Wash.

SCHUYLKILL COUNTY: (R) Egbert L. Klock, Orwigsburg; Asa D. Young, Baltimore, Md.

Resignations (3), Transfers (6), Deaths (10)

ALLEGHENY: *Death*—Charles H. Carroll, Pittsburgh (Univ. Pgh. '06), September 5, aged 71.

BUCKS: *Resignation*—Thomas M. Thompson, New Brunswick, N. J. *Death*—William C. LeCompte, Bristol (Med.-Chi. Coll. '97), September 16, aged 73.

GREENE: *Resignation*—Matthew B. Moore, Tulsa, Okla.

LANCASTER: *Transfer*—David B. Coursin, Lancaster, from Philadelphia County Society.

LEHIGH: *Death*—Willard D. Kline, Allentown (Jeff. Med. Coll. '01), August 9, aged 71.

LUZERNE: *Transfers*—Vincent W. Banick, Wilkes-Barre, and William Rosenzweig, Kingston, from Lackawanna County Society. *Deaths*—Robert A. Gaughan, Hazleton (Univ. Pa. '13), September 16, aged 58; August Trapold, Wilkes-Barre (Med.-Chi. Coll. '91), September 16, aged 81.

NORTHAMPTON: *Resignation*—Claude C. McCormick, Ventnor, N. J.

PHILADELPHIA: *Death*—H. Maxwell Langdon, Philadelphia (Univ. Pa. '01), August 28, aged 72.

SCHUYLKILL: *Death*—Edgar E. Shifferstine, Tamaqua (Univ. Pa. '99), August 22, aged 73.

WASHINGTON: *Death*—Marshall A. Leach, Canonsburg (Northwestern Univ. '40), August 26, aged 36.

WESTMORELAND: *Transfers*—Theodore Wollak, Scottdale, from Cambria County Society; William S. Kech, Greensburg, from Allegheny County Society.

YORK: *Transfer*—Theophilus H. Boysen, York, from Philadelphia County Society. *Deaths*—Jeremiah F. Lutz, York (Coll. Phys. & Surg., Balt. '94), September 11, aged 76; Lewis H. Sterner, Hanover (Hahn. Med. Coll. '89), August 27, aged 84.

requests over the total for 1946. During the first nine months of this year there have been 899 requests.

A package of reprints will be sent immediately for a loan period of two weeks to any member of the State Society. There is a charge of 25 cents for each subject requested to cover postage and part of the expense of collecting the material. Send requests to the Librarian, 230 State St., Harrisburg, Pa.

Subjects requested between September 1 and September 30 were:

Snoring	Rectal prolapse
History of arthritis	Benjamin Rush
Nerve block	Koch treatment
Myasthenia gravis	Teropterin
Pentothal anesthesia	Diathermy
Geriatrics	Dermographism
Asthma therapy	Histoplasmosis
Pneumonia	Dissecting aneurysm
Condyloma	Amputation
Infectious hepatitis	Irradiation sickness
Gallbladder diseases	Ulcerative colitis
Myanesin (3)	Venous thrombosis
Action of diodrast	Animal experimentation
Hyperemesis gravidarum	Compulsory insurance
Miscarriage	Poliomyelitis
Toxemia of pregnancy	Infant mortality
Diabetes in pregnancy	Tumor clinics
Premature labor	Treatment of apoplexy
Sodium fluoride	Use of vitamin B
Rheumatic fever	Use of ascorbic acid
Psoriasis	Cervical arthritis
Beryllium poisoning	Glaucoma
Arthritis	Cataract extraction
Manipulative treatment	Carcinoma of prostate
Diagnosis of pregnancy	Hearing aids
Hamsters	Total gastrectomy
Sarcoidosis	Diabetes
Blood fat	Rh factor
Pancreatic function	Pheochromocytoma
Penicillin	Use of stilbestrol
Streptomycin	Multiple myeloma
Amebiasis	Adrenal glands
Nutrition	
Etiology and treatment of thyroid	
Erythroblastosis fetalis	
Intravenous procaine in accident therapy	
Adenocarcinoma of the gallbladder	
Plasma specific gravity determination	
Blood volume determinations	
American Academy of General Practice	
Treatment of Addison's disease	
Treatment of chronic vaginitis	
Homologous serum jaundice	
Toxicity of carbon tetrachloride	
Use of thephorin in allergy	
Coronary occlusion and anesthesia	
Treatment of pancreatitis	
Treatment of common cold	
Tuberculous spondylitis	
Diagnosis of tuberculous arthritis	
Serologic tests for syphilis	
Treatment of dermatoses (2)	
Registered physicians in Pennsylvania	
Carcinoma of the cervical stump	
Cardiovascular diseases	

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TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the co-operation of the Pennsylvania Tuberculosis Society
and The Medical Society of the State of Pennsylvania

THE LAG between knowledge and practice is nowhere better illustrated than in the slowness with which general hospitals have instituted the routine chest x-ray examination of all patients at the time of admission. Yet everyone benefits when this is done—the patient, the professional staff, the hospital employees, and the community.

X-RAY PROGRAMS IN GENERAL HOSPITALS

Hospitals should institute x-ray examinations of all admissions. The hospital can render this health service, which is essential for the protection of the public health, better than any other agency.

Chest x-ray surveys can be conducted in hospitals much more easily, economically, and quickly than in other groups. Hospitals also offer ideal opportunities for intensive case-finding. Most of the entering patients are free from tuberculosis, but some will have tuberculosis in its earliest stages and a few previously underdiagnosed advanced cases will be found.

In 1946 more than fifteen million people—more than 10 per cent of the total population—spent some time as patients in hospitals. This means that a new hospital patient was admitted every two seconds. In the same year nearly two million new citizens were born in the 7000 hospitals of this country. Millions more are treated as outpatients in the clinics. Each patient admitted should have the benefit of a chest x-ray.

Tuberculosis is often considered a disease of youth. Contrary to this opinion, however, mortality figures in the United States show the highest death rate from tuberculosis occurring in the 70-year age group. Too few persons—even among those engaged in tuberculosis control—recognize the fact that the phenomenal decrease in the death rate among younger persons has not been accompanied by a similar decline among the aged. Yet the trend in the death rate from tuberculosis increases with each five-year age group from 15 to 75. Tuberculosis among the elderly is frequently masked by the infirmities of age. It is often difficult to interest elderly people

in a physical examination. These same elderly people, however, make up a large proportion of admissions to general hospitals. Here is the opportunity to begin work on the difficult and enormous problem of finding tuberculosis among the elderly.

A general hospital has three compelling reasons for taking x-rays of all patients and personnel: first, to serve its community as a case-finding center; second, to protect its employees from the spread of tuberculosis infection by patients; third, to protect the patients from contracting tuberculosis infection from other patients or from the personnel.

Whenever a patient with unrecognized open tuberculosis is admitted to a hospital, he becomes a menace to some of the personnel in the institution. This hazard can be avoided only by routine chest x-ray examinations made on admission. Otherwise, proper precautions against contagion cannot be taken.

Nurses entering training should and do have careful physical examinations and chest x-rays to assure that they are free of tuberculosis. During training, however, many contract infection from hospital patients. The only preventive for this tragic accident is admission x-raying of every patient.

With a thorough case-finding procedure among personnel and routine x-raying of all admissions there is less danger of tuberculosis infection being spread in the hospital. The danger arises within the hospital, not from accepting tuberculous patients but from hospitalizing them with their tuberculosis unrecognized. This has been, and still is, the practice in many hospitals.

When patients are known to be tuberculous, most of the acute danger of contagion can be avoided. Admission x-rays usually tell us who these patients are so that adequate isolation can be provided.

Hospital admission x-rays are a public benefit. By this means, the disease can be discovered in a population group which cannot otherwise be screened by general or industrial x-ray surveys—the mother, the housewife, the maid, the self-employed and, as pointed out before, the aged. Of the fifteen million persons entering general hospitals in 1946, two million were obstetrical patients. Women of child-bearing age have a high tuberculosis mortality and often are not included in mass x-ray examinations.

Early and accurate diagnosis of chest conditions is always an aid to the physician. Even if

disease is not discovered, it guards against the dangers of incomplete diagnosis.

The program of hospital admission x-rays is approved by the American College of Radiology as a screening device; in no way does it supplant regular x-ray examinations. Chest x-rays give impetus to accurate diagnosis by the staff, interns, and house staffs and complete the hospital records of the patients admitted. The x-ray makes a graphic addition to the record; in a subsequent illness it may be consulted by the family physician if he suspects aggravation of a previously existing lesion.

What We Expect from X-ray Programs in General Hospitals, F. M. Meixner, M.D., National Tuberculosis Association Transactions, 1947.

NEWSPAPER PUBLICITY ON CENTENNIAL CELEBRATION

A total of 231 separate articles whose combined length measured 2046 inches told the story of the Centennial Celebration session of The Medical Society of the State of Pennsylvania in 84 daily newspapers throughout the State between October 1 and 7. The *Philadelphia Evening Bulletin* printed 24 stories running into 388 inches (18 columns), while the *Philadelphia Inquirer* covered the annual meeting in 22 articles totaling 240 inches (11 columns). Harrisburg's two newspapers gave the session 140 inches in 13 stories, the Pittsburgh papers had 14 stories totaling 113 inches, and newspapers in Williamsport, Johnstown, Clearfield, Easton, and Wilkes-Barre were also generous with space. The total newspaper publicity for the Centennial Celebration would fill 93 full columns or 12 complete newspaper pages.

MISCONCEPTION ABOUT MEDICAL SCHOOL ADMISSIONS

There seems to be a widespread misconception of the power of the medical profession or certain official organizations within the profession in limiting the number of students in medical schools. Judging from their comments, a few educators, who should know better, have a misconception of the real situation.

Actually, there is no such thing as a direct quota system imposed on any medical school by any accrediting agency. The only influence is indirect through setting of standards. Certainly no thinking person would want standards lowered to a point where medical schools could deliver quantity but not quality. In fact, a medical school retains full power to train as many phy-

sicians as it pleases. Nevertheless, it should be certain that it has the resources and facilities to deliver both quantity and quality.

In the final analysis, the solution to the problem of supplying a greater number of physicians—admittedly a problem—rests with the taxpayers and philanthropic organizations. If they are willing to furnish the money for sound expansion of medical schools or the organization of new ones, the problem can be solved. This is the most practical way for people who want more doctors to get them; also the safest way.—*The Ohio State Medical Journal*, October, 1948.

HOME LIFE BUILDS CHARACTER

The British press quotes the Anglican Bishop of Salisbury, Dr. Lunt, in the charge that the new National Health Service, completing the cradle-to-the-grave social security system, "has lessened the individual sense of responsibility and is causing the disappearance of much that is best in English home life." To illustrate his point, the Bishop composed a parody on the old song "Mother Machree":

"I love the clean clinic which washed me with care, and the nursery school lady who toothcombed my hair, and all the youth movements so toil-worn for me, but Mother, God bless her, she never sees me."

The British government, the Bishop declares, has become a sort of "foster mother" to the whole British population. The security of the home is being traded for the security of an all-powerful state.

That is unfortunate. For, as any social worker knows, only the home can build the strength of character that in the final analysis is the individual's only lasting security.—*California Feature Service*, Sept. 6, 1948.

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THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

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A MESSAGE FROM PRESIDENT ENGEL



The social life and teas of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania are rapidly being replaced by serious discussions at meetings and definite constructive, progressive plans to effectively educate the public. The effectiveness of their work is increasing constantly and is receiving more recognition.

The Auxiliary has become one of the most important assets of The Medical Society of the State of Pennsylvania.

A great task lies ahead and I believe that unity in organization is imperative to unity of purpose. We plan to have a more active liaison between the two groups, and I would like to see a Woman's Auxiliary member appointed as ex-officio member to the committees in charge of the medical benevolence and education funds. I believe this is essential to better correlation of the two groups.

Unity of purpose must be the keynote of these organizations. We hear a plea today for unity of our citizens. That is a "must" if America is to survive. For some years now our national administration has been setting labor against capital, class against class, and it has seemed to be the old doctrine of divide and conquer. America or any organization in America cannot long survive under this doctrine.

America had its birth in Pennsylvania at Valley Forge when suffering men did not ask how many hours, how much pay, but gave of time, energy, and their lives so that a free America might live.

The rebirth of a unified America again took place in Pennsylvania at Gettysburg, but since that time we have drifted into a phase where again our nation needs to be reborn on the theme of unity.

The Woman's Auxiliary and The Medical Society of the State of Pennsylvania, with unity of thought and action, are in a position to lead the way in the United States in helping to solve the

so-called medical economic problems for the advancement of medical science.

With the Advisory Committee to the Woman's Auxiliary being headed by the chairman of the Public Relations Committee of the Medical Society, a closer coordination of objectives with means of carrying them out should be accomplished.

Many problems will arise during the coming years. Health education of the public and the doctrine of preventive medicine are two. Blue Shield and Blue Cross plan expansion, which is the logical approach to the medical economic problem, must not only be thoroughly understood by the members but active measures must be used to explain these plans to the public.

The science of medicine cannot progress without animal experimentation. This requires a strong educational program. The antivivisectionists are constantly introducing legislation to curb animal experiments. The public and the members of the antivivisection society have been grossly misinformed by their paid leaders. First, animal experimentation is done under humane conditions. Animals have made numerous contributions to mankind; the discovery of insulin has prolonged the lives of millions of diabetics, the preparation of vaccines has protected people from smallpox, and there are many others. At every session of the Legislature we are fighting new bills introduced by this group. Only through education of the public as to the facts will this misguided group be quieted.

Each county will have problems of its own and these must be managed at the county level after consultation with the state officers. Other problems will be on a definite state level. The work and cooperation of every member are required for a successful year.

You must familiarize yourselves with pending legislation, and speakers from your group must be prepared to carry on an educational campaign.

Your membership could well be increased; and I believe, if non-members were told of your responsibilities and your plans, that interest would increase your membership in no time. Women's groups today are not the social groups

of yesteryear. They are thinkers and doers. This has been evidenced by the increase in women executives in professional, educational, business, and national affairs. If, therefore, there is something to be done, the women of America today are interested in doing it and not just sipping a cup of tea and wasting time with idle gossip.

Your president, Mrs. Paul C. Craig, is a leader, a progressive thinker, and a charming person. I would ask your full support of her program, which is excellent. I can assure you that you and your president will have not only my full support but the encouragement and support of The Medical Society of the State of Pennsylvania.

I wish to assure you that our society fully recognizes the work you are doing and the great potential possibilities of the future. We need your support to help protect the public and their health from ambitious political leaders, charlatans, and quacks.

GILSON COLBY ENGEL, *President*,
The Medical Society of the State
of Pennsylvania.

PRESIDENT'S MESSAGE



Seldom does a month pass but one finds, in current magazines and in newspapers, articles on some phase of medical care. Constant news releases from government agencies and from private organizations are being used. With the wide distribution of city dailies, Sunday supplements, and magazines whose total circulations run into the millions, it is no wonder that the public knows that socialized medicine is an important issue.

Perhaps Auxiliary members are not reading these articles, but the public is. Perhaps we are accustomed to talking with our friends whose viewpoint agrees with ours, and the over-simplification of the opposing side seems ridiculous to us—but not to the public.

The National Health Assembly last May and Oscar Ewing's Report to the President have pointed up the issues and intensified interest. We doctors' wives no longer dare to be disinterested and aloof. The way is clear; we need to talk. But we must be prepared. We must gather background information first so that we are informed.

To whom shall we talk, and what shall we say? We can talk informally where our friends

gather with us at clubs, social groups, and PTA meetings, across the bridge table, or when preparing a church supper. The articles from the magazines furnish an excellent entering wedge for bringing the subject into the conversation. Try it and see.

I have never broached the subject to anyone, from my hairdresser to the milkman, and the president of the League of Women Voters, who has not shown interest in the topic. People want to know what we are thinking and why. They are a bit confused, not quite willing to swallow the whole story of compulsory political medicine, but deeply and personally concerned about rising medical costs as they are affected as individuals.

Did you ever realize that you can talk trends in medical legislation and medical care without ever mentioning a bill by number? We must admit, to begin with, that we do not see the complete solution clearly, anymore than we see the complete solution to any other broad problem; it is too involved. But, by the same token, we know that America is too large, too diversified, to be served efficiently by compulsion on a national scale.

So we mention these points, which are almost self-evident, to our friends; yet they seem to be overlooked by those peering through rosy glasses to see a nation legislated into health.

1. Health is influenced by many things besides doctors and drugs; for instance, by how we live, what we eat, how much we worry, and who our grandparents were.

2. Medical care can be generally successful only if people are educated and informed in how to keep well. Distributing doctors by government regulation cannot do this. Education through home, school, radio, and other ways can. Dr. Edward L. Bortz has said that we do not need more doctors, but less patients.

3. Does the public realize how epidemics have been controlled, how new drugs and operative techniques have lengthened our chances for a longer and fuller life, and what sanitation has done to improve living conditions? We may have to read up on this angle a bit, but it will be worth while.

4. One can explain the changes in medical care in the last fifty years. The faithful practitioner sat up with the patient in those days while he died of "inflammation of the bowel," as my grandfather did. The modern physician uses laboratory facilities, takes a blood count, and sends his patient to the hospital; and following an appendectomy, the patient goes home within a few days, with years of life before him.



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5. Do your friends realize how medical school and hospital standards have been changed, how the medical profession constantly checks on quacks and watches laws to protect us from charlatans?

We are aware that the distribution of health facilities is not even throughout the country. But we also know that many preventive measures are in process of being developed, and that at the same time people have to be educated to make use of the services that are in a community.

In my own town a woman allowed a quack to do a cancer operation in her own home. He got her money. Then the local surgeon and hospital gave her care for a year to restore her to health. Those medical and hospital services were there for her use all the time, had she had the interest, good sense, and education to make use of them.

Health, like democracy, cannot be legislated into being. It is better to invest tax money to prevent disease than to pour it in a poor kind of medical care to cure it.

6. Do your friends know how doctors are working through voluntary plans to help people meet medical emergencies and the larger surgical expenses? A clever advertising man, well versed in his field, this last summer thought Blue Shield was in competition with Blue Cross. A bit of insight into the opportunities in Blue Shield led him to enlist the members of his firm in coverage and the satisfaction and peace of mind that go with it.

We should know enough about Blue Shield and Blue Cross to give basic points, and to describe the growth of the services when the topic comes into conversation with one's dinner partner, who may be a manufacturer or personnel head interested in his employees' welfare.

As Dr. Howard K. Petry says, "The telephone and good roads no longer make it essential for doctors and hospitals to be at close range, but modern science does make it essential that the doctor have hospital and laboratory facilities to work with." Modern physicians need extensive diagnostic aids to practice scientific medicine. They can then realize that with a medical center nearby a doctor will be willing to settle in an otherwise unattractive location. A few words about the Hill-Burton Hospital Act, to supply hospitals in rural and neglected areas as states recognize their needs, is often an eye-opener.

There are many more points. Only continuous awareness of the situation as it changes, constant reading and appraisal of what you read, and discussion with your doctor husband or in study groups can lead to clarification of the picture so that you can tell the story of what the medical

profession is doing. National health is still a debated problem, and good for an evening's conversation. There is still the fundamental issue of whether the people want the Federal Government to expand in the field of health. Are we going toward improved democratic capitalism, or is the health issue to take us a further step toward socialization of America? Are doctors used because they are a vulnerable and inadequately organized group?

Ask your friends to read both sides of the question, and then know what materials to offer them, including opinions that oppose ours.

Watch our Auxiliary news letters for suggested articles and pertinent points. A study group or a medical current events committee reporting at meetings can be very stimulating and thought-provoking.

We can have fun together, but let us realize that there are great opportunities for presenting a viewpoint too little expressed, and not nearly so glowing as those by the group that would place a bureaucracy over us. Soon it would be more than the medical profession that would be involved. Socialization grows, never lessens, once it gains a foothold.

I hope more of our members will be challenged by the potentialities of our group. We are not a civic club, duplicating a community program in an already crowded local schedule. We have as yet but fragmentary understanding of the service we can render in helping to clarify public opinion as we mingle with our friends and acquaintances. But we must know whereof we speak, and that is a continuous process. Let us copy the Boy Scout motto, "Be Prepared."

(Mrs. PAUL C.) CATHARINE PALMER CRAIG,
President.

PHILADELPHIA CONVENTION SURPRISES

No one attending the Centennial Celebration will ever forget:

Our lovely and beautiful Clara Bierly's dramatic presentation, on behalf of the Auxiliary, of one hundred red roses, a rose for each of its hundred years, to The Medical Society of the State of Pennsylvania, at the Installation Meeting held in the Academy of Music on Tuesday night, October 6, 1948.

The look in Mary Buyers' face as she realized that she had been chosen to be our first honorary

member, because of her love, loyalty, and devotion to the Auxiliary since its inception.

The fashion show at the Tea in Mrs. Buyers' honor, on Wednesday afternoon, where Old Style—New Look fashions were modeled by Auxiliary members for the enjoyment of everyone.

Our thanks and gratitude go to Mrs. Charles J. Swalm and Mrs. M. Fraser Percival, co-chairmen, and to the members of the Philadelphia County Auxiliary whose ceaseless efforts made possible an eminently successful convention.



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MEDICAL NEWS

Future Meeting Calendar

AMERICAN ACADEMY OF DERMATOLOGY AND SYPHILOLOGY—Chicago, December 4 to 9, 1948.

AMERICAN ACADEMY OF GENERAL PRACTICE—Cincinnati, March 7 to 9, 1949.

AMERICAN COLLEGE OF PHYSICIANS—New York, March 28 to April 1, 1949.

Birth

To DR. AND MRS. EDWARD B. MARENUS, of Philadelphia, a son, October 22.

Marriage

MISS SALLIE HARWOOD, of East Greenwich, R. I., to Charles M. Norris, M.D., of New Milford, November 6. Dr. Norris is on the staff of Temple University Hospital, Philadelphia.

Deaths

○ *Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.*

○ **Edward A. Weissner**, Pittsburgh; University of Pennsylvania School of Medicine, 1898; aged 72; died Oct. 18, 1948, after an illness of six months. Dr. Weissner had recently been awarded a certificate by the State Medical Society for having practiced fifty years. He was a member of the American Academy of Ophthalmology and Otolaryngology and a Fellow of the American College of Surgeons. He is survived by his widow and three sons, one of whom, Charles William, is also an ophthalmologist in Pittsburgh.

○ **Hewitt C. Myers**, Steelton; University of Pennsylvania School of Medicine, 1900; aged 73; died Oct. 24, 1948, of a heart ailment. Dr. Myers was a Pennsylvania Railroad Company surgeon for more than thirty-five years. He was a past president of the Harrisburg Academy of Medicine and of the Dauphin County Medical Society, and since 1940 served in the House of Delegates of The Medical Society of the State of Pennsylvania. Surviving are his widow, a son, and a daughter.

○ **Rossiter J. Lloyd**, Blakely; Baltimore Medical College, 1897; aged 70; died unexpectedly at his home Oct. 28, 1948. Dr. Lloyd, who was born in Lansford, Pa., was associated in the practice of medicine with his brother in Middletown Springs, Vermont, for several years. He began his practice in Blakely in 1910 and later served as roentgenologist at the Mid-Valley Hospital, Blakely. He was honored in 1947 at a testimonial dinner by the physicians of Olyphant, upon completion of fifty years of practice. He was a member of the Radiological Societies of Pennsylvania and of North America, and was a director of the Scranton Private Hospital for a number of years. In addition to his wife, Dr. Lloyd is survived by a son and four daughters.

○ **John T. Burnite**, Harrisburg; Hahnemann Medical College and Hospital of Philadelphia, 1904; aged 69; died Oct. 20, 1948, after a lingering illness. Dr. Burnite was chief of obstetrics at the Polyclinic Hospital. He is survived by his widow, a son, and two grandchildren.

○ **Clarence W. Schwalm**, Shoemakersville; Temple University School of Medicine, 1923; aged 64; died Nov. 2, 1948. He is survived by his widow, two brothers, and two sisters.

○ **Ella N. Ritter**, Williamsport; Woman's Medical College of Pennsylvania, 1893; aged 82; died Sept. 30, 1948. Dr. Ritter specialized in surgery.

○ **John P. Hall**, Pittsburgh; College of Physicians and Surgeons, Baltimore, Md., 1892; aged 81; died Oct. 21, 1948. Dr. Hall died literally with his medical kit in his hand. Only the night before he had treated his last patient. During World War I, he served with the Army medical staff at Dartmouth College. He is survived by a son and two daughters.

○ **Harry H. Rittenhouse**, Bridgeville; University of Pittsburgh School of Medicine, 1911; aged 63; died Oct. 19, 1948.

○ **Sterling C. King**, Watsonstown; Temple University School of Medicine, 1922; aged 53; died Sept. 16, 1948.

Miscellaneous

THE EASTERN SECTION OF THE AMERICAN FEDERATION FOR CLINICAL RESEARCH will hold its annual meeting in Philadelphia on Saturday, December 4, at the Temple University School of Medicine.

DURING THE SUMMER, LEONARD D. FRESCOLN, M.D., of the Philadelphia Hospital for Contagious Diseases, spent some time in the U. S. Leprosarium at Carville, La., observing treatment of 400 lepers, noting the beneficial effects of promin, and studying bone involvement.

AT THE ANNUAL MEETING OF THE ST. VINCENT'S HOSPITAL SURGICAL ASSOCIATION, Erie, held recently, Thomas E. Jones, M.D., of Cleveland, Ohio, conducted a seminar on peptic ulcer. A bronze plaque was presented to Frank P. McCarthy, M.D., retiring president of the organization.

LESTER R. DRAGSTEDT, M.D., chairman of the Department of Surgery of the Medical School of the University of Chicago, addressed the members of the Erie County Medical Society at the October 6 meeting. Dr. Dragstedt discussed "Vagotomy." He also conducted a dry clinic at St. Vincent's Hospital previous to the meeting.

AT A MEETING OF THE PENNSYLVANIA ACADEMY OF PHYSICAL MEDICINE, October 21, at the University of Pennsylvania Hospital, Philadelphia, Robert Hodes, M.D., presented a paper on "Electromyographic Patterns Following the Billig Procedure (Neurotripsy) in Chronic Poliomyelitis." The paper was discussed by Drs. Donald T. Jones and Burton Chance, Jr.

THE SIXTY-SECOND ANNUAL BANQUET OF THE ASSOCIATION OF EX-RESIDENT AND RESIDENT PHYSICIANS of the Philadelphia General Hospital will be held on Tuesday, December 7, at 7:30 p.m., at the Penn-Sheraton Hotel, 39th and Chestnut Streets, Philadelphia. The guest of honor will be Edward J. G. Beardsley, M.D. Reservations may be had by writing to the secretary-treasurer, Robert C. McElroy, M.D., 133 South 36th St., Philadelphia 4, Pa.

THE ANNUAL SCIENTIFIC MEETING OF THE PHILADELPHIA ALLERGY SOCIETY was held at the Philadelphia College of Physicians on October 27. Jean Crump, M.D., discussed "The Use of Amino Acids in Eczema in Children"; Howard Leopold, M.D., read a paper on "The Effect of Benadryl on the Hematopoietic System," and George Blumstein, M.D., and Jay Spiegelman, M.D., presented "The Philadelphia Program for Ragweed Extermination."



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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.



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THE SOUTH ATLANTIC ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS announces the establishment of "The Foundation Prize." Authors of papers on obstetric or gynecologic subjects desiring to compete for the prize may obtain information from Dr. E. D. Colvin, Secretary-Treasurer, 1259 Clifton Road, N.E., Atlanta, Ga.

THE NORTHEASTERN SECTION OF THE AMERICAN UROLOGICAL ASSOCIATION will conduct an intensive post-graduate course in urology from January 3 through January 8, 1949, under the auspices of the School of Medicine, University of Buffalo. The whole subject of urology, including the basic sciences, anatomy, physiology, bacteriology, biochemistry, and pathology of the urinary tract, will be covered by well-known teachers and clinicians from various clinics throughout the country. For further information and application, write George E. Slotkin, M.D., Chairman, Medical Center Building, 333 Linwood Ave., Buffalo 9, N. Y.

THE UNIVERSITY OF PENNSYLVANIA AND THE EPISCOPAL HOSPITAL, Philadelphia, are entering into an agreement whereby the University will operate the Episcopal Hospital at its present location. Under the agreement the hospital, which was founded in 1851, and is located at Front and Lehigh Avenue, will be operated as one of the University hospitals. In addition to continuing the hospital's activities, the University will augment the medical staff. Present members of the Episcopal Hospital staff will retain staff privileges at the hospital.

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Surgical Anatomy and Clinical Surgery, two weeks, starting November 22, February 21, March 21.

Surgery of Colon and Rectum, one week, starting March 7, April 18.

Surgical Pathology every two weeks.

GYNECOLOGY—Intensive Course, two weeks, starting February 21, March 21.

Vaginal Approach to Pelvic Surgery, one week, starting February 14.

OBSTETRICS—Intensive Course, two weeks, starting March 7.

MEDICINE—Intensive Course, two weeks, starting April 4.

Personal Course in Gastroscopy, two weeks, starting April 18.

DERMATOLOGY—Formal Course, two weeks, starting April 18.

Clinical Course every two weeks.

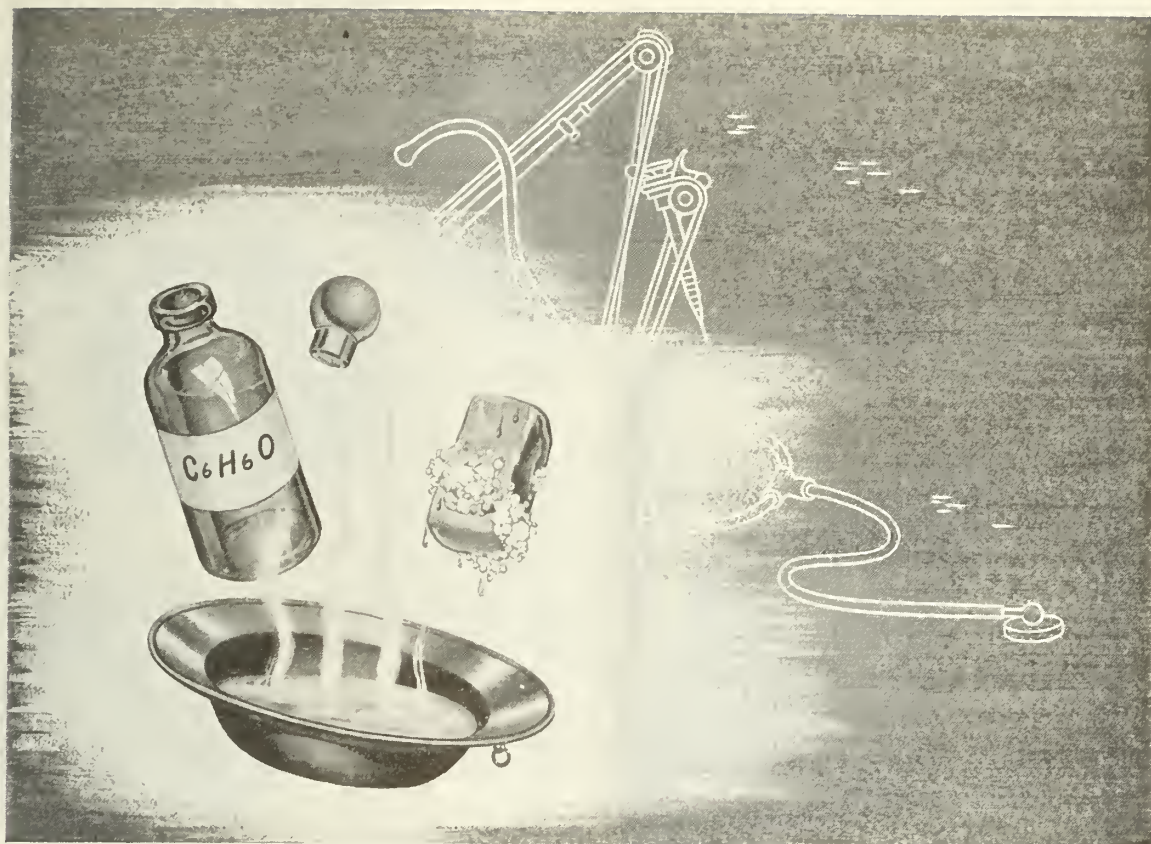
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THE AUTUMN MEETING OF THE PENNSYLVANIA ASSOCIATION OF CLINICAL PATHOLOGISTS was held in Philadelphia, October 1-3. The guest speaker was Leandro M. Tocantins, M.D., Philadelphia, associate professor of medicine at Jefferson Medical College, who discussed "Diagnostic Limitations of Cytologic Studies of the Bone Marrow."

There was a round table discussion on "The Training of Residents" with Samuel R. Haythorn, M.D., Pittsburgh, director of the Wm. H. Singer Memorial Research Laboratory of Allegheny General Hospital, as moderator.

Officers elected for 1949 were: Drs. Theodore R. Helmbold, Pittsburgh, president; Frank B. Lynch, Philadelphia, vice-president; and Henry F. Hunt, Danville, secretary and treasurer.

THE CHILDREN'S HOSPITAL OF PHILADELPHIA opened its pediatric diagnostic clinic on November 1. The clinic, the first of its kind in this part of the country, is designed to aid physicians in reaching a diagnosis of obscure or difficult medical and surgical problems of infancy and childhood. Patients will be accepted by a referring physician and by appointment only.

The staff of the clinic is composed of the visiting staff of the Children's Hospital, including consultants in medicine, surgery, and all specialties necessary for a complete pediatric diagnostic service. The laboratories of the Research Department are also incorporated in this service.

The clinic is under the direction of Andrew D. Hunt, Jr., M.D., who may be reached for additional information and appointments at the Children's Hospital of Philadelphia, 1740 Bainbridge Street, Kinsley 5-2051.

MEDICAL SCHOOLS IN THE UNITED STATES AND CANADA are invited by the John and Mary R. Markle Foundation to make nominations for the second group of Scholars in Medical Science on or before December 1, 1948. Each school, through the dean, may nominate one

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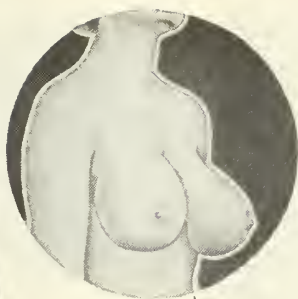
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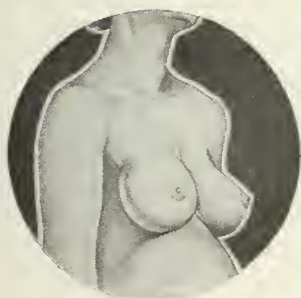
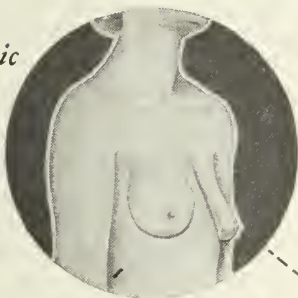
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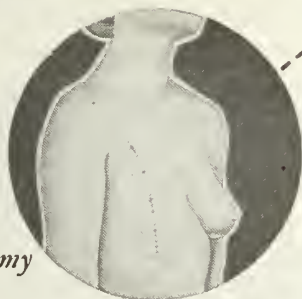
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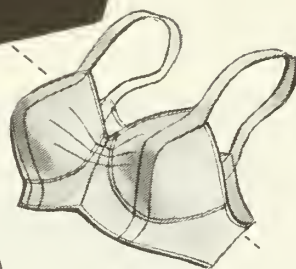


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candidate. No nominations from individuals will be considered.

The program is designed to aid promising young men and women planning careers in academic medicine, who have not yet made their reputations. They should have completed the usual fellowship training in some area of science related to medicine and should hold, or expect to hold, in the academic year 1949-50 a full-time faculty appointment on the staff of a medical school.

Grants of \$25,000, payable at the rate of \$5,000 annually, will be made to the schools over a five-year period for the support of each scholar finally selected, his research, or both.

The number of scholars to be appointed in 1949 has not yet been determined. Sixteen were chosen in 1948. A new booklet describing the plan is available on request from the Foundation, 14 Wall St., New York 5, N. Y.

EXERCISES DEDICATING THE LABORATORIES OF THE SAMUEL S. FELS RESEARCH INSTITUTE, Temple University School of Medicine, were conducted Friday, October 22, and Saturday, October 23.

On Friday morning there was an inspection of the laboratories. Friday afternoon was devoted to a symposium on "Recent Advances in Gastric Physiology" by Boris P. Babkin, M.D., research professor of physiology, McGill University, Montreal, Canada; "Regulation of Pancreatic Secretion" by J. Earl Thomas, M.D., professor of physiology, Jefferson Medical College, Philadelphia; "Problems in Hepatic Physiology" by Frank Charles Mann, M.D., director of Division of Experimental Medicine, Mayo Foundation, Rochester, Minn., and "Experimental Gastro-intestinal Carcinoma" by Harold L. Stewart, M.D., Chief of Pathology Section, National Institute of Health, United States Public Health Service, Bethesda, Md.

The dedicatory exercises were held Saturday morning at 10:30 with addresses given by the following: Dr. Robert L. Johnson, president of Temple University; Mr. Louis Magaziner, architect of the new laboratory; and Harry Shay, M.D., clinical professor of medicine, Temple University School of Medicine, who spoke on "Mr. Fels and the Scientific Attitude."

The principal address was delivered by Dr. Edwin G. Conklin, after which Mr. Samuel S. Fels, president of the Samuel S. Fels Fund and founder of the Fels Research Institute, delivered an address.

THE EFFICIENCY OF MEDICAL SERVICE

Family doctors have ample opportunity these days to see themselves as others see them. From such an emotional outlook as that of Ian Maelaren it was a heart-warming view, and many a patient continues to share it with those who knew the horse-and-buggy doctors at their best. In many of the mirrors held up to the physician of today, however, there is an emotional screen that removes all trace of sentiment and feeling.

The industrial or business point of view is one where efficiency sits enthroned, and where lack of efficiency is viewed with impatience. Doctors, in their daily lives, are inclined to place a higher value on the end result than they do upon the efficiency with which it is achieved. In matters seriously involving life and limb this attitude is understood and is even encouraged by thoughtless people when they tell the doctor that he is to "spare no expense" in this and that, believing that the more the service costs the better it must be. People

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believe this because they may have no better method of appraisal. Modern industry wants the best results too; it not only is beginning to demand them but also is aware of the fact that the efficiency with which they are achieved is a measure of their value, and to some extent of their quality as well. Although industry still employs largely the private doctor, and upon his own terms too, his methods as well as his results are being scrutinized by businessmen, by labor leaders, by engineers, and by other physicians, all of whom are geared to modern industry's heartless demand for efficiency as well as for good results.

How may the quality of medical service be appraised? The answer depends upon the critical capacity of the appraiser. There are probably more ways of judging medical service than there are of judging horseflesh; some are good and some are not. What is a good method for one situation may not be for another. When much is known and appreciated about the self-limitation of disease, there may be created an entirely different

standard of judgment. On the whole, medical service may be said to be judged by informed public opinion, and public opinion is becoming more informed every year.

Doctors practicing in a certain locality may see themselves as the industrial physician sees them by reading Shipman's article in this issue of the *Journal*. They should remember that the author is naturally trying to emphasize the points at which friction occurs. These points are not peculiar to that industry or that region; in fact, it is pointed out that similar occurrences have been noted in California. These little conflicts of opinion, of judgment, and of action are rooted deep in human nature, in the competitive spirit of man, and in the circumstances of the environment in which we all must live and strive to live together.

Not only industrialists but also welfare boards, insurance carriers, and compensation authorities are vividly aware of medical efficiency, or its lack, in the care of the patients in whom they are interested. When a



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The above studies should be supplemented when possible with courses in mathematics, qualitative analysis, quantitative analysis, physical chemistry, foreign languages (Spanish, French, or German), sociology.

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GENERAL—Sixty-fourth annual session began September 13, 1948. Catalog and information regarding courses on request. Address all communications to

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welfare official finds that 90 per cent of the money paid in a small community goes to a single doctor (on a fee-for-service basis) and that his patients do not seem to have more serious ailments or different end results than those of the other doctors, that official is rightly suspicious of that doctor. Such doctors are scattered here and there, generally believing themselves smart in their padding activities. They are notoriously well known among people whose business it is to handle financial adjustments that involve medical services. Inefficient is a very polite adjective to describe this type of medical practice.—*The New England Journal of Medicine*, Oct. 21, 1948.

MATURITY

The nation needs children who have the ability to withstand the pressures of life. An intelligent understanding of the influence of environmental factors and of emotional adjustment is a necessary reinforcement to the best programs of nutritional care and physical hygiene. Pediatricians can make practical application of this fact in contacts with the youngster, as well as by

constructive advice to parents. Interpretation and counsel to provide guidance in home training require the application of tact, intelligence, and good judgment. Parents must work out many of these problems for themselves. But the ultimate development of emotional stability and good adjustment to the demands of later life requires proper environment and the formation of correct habits during early life.—W. W. QUILLIAN, M.D., *Journal of South Carolina Medical Association*, August, 1948.

MATERNAL DEATHS BY COUNTIES

On page 150, this issue, will be found a listing of "Deaths from Selected Causes in Pennsylvania, June, 1948." The column "Maternal Deaths" totals 19, divided by counties as follows: Philadelphia, 3; Allegheny, Bucks, and Westmoreland, 2 each; Berks, Blair, Cambria, Centre, Dauphin, Franklin, Lehigh, Northampton, Schuylkill, and Wayne, 1 each. It is important that the causes for these deaths were determined and discussed by members of the medical societies in the counties where such deaths occurred.



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Wanted.—General practitioner for Protestant community of McClure, Snyder County. Population of 1,000 in town and 3,000 in surrounding area. Living quarters and office available. For further information, contact MR. PAUL MARSHALL, Chamber of Commerce, McClure, Pa. Telephone—Beaver Springs, 19R4.

Wanted.—Assistant to certified EENT man in private practice. Must be under thirty-five years of age. Protestant, licensed in Pennsylvania, certified or qualified to certify either in Otolaryngology or Ophthalmology, with working knowledge of the other. Salary for first year. Thereafter, percentage basis with eventual partnership. Write giving qualifications and references to Dept. 142, PENNSYLVANIA MEDICAL JOURNAL.

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Wanted.—Laboratory technician for Masonic Homes Hospital, Elizabethtown, Pa. Preference given to middle-aged person not interested in matrimony who wants to make her home in small community. Must be able to do usual routine hospital laboratory tests and be experienced or willing to be trained in giving physical therapy treatments with heat lamps, massage, etc., to aged guests numbering 165. Fixed salary plus full maintenance. Communicate with MR. SCOTT C. REA, 5th and Orange Sts., Northumberland, Pa.

Wanted.—Resident physician for Masonic Homes and Hospital, Elizabethtown, Pa. Qualifications: Must be kind and appreciative to our aged guests who number 165 in hospital and 450 in homes. Prefer man between 40 and 55 years and member of the Masonic Fraternity. Hospital of 165 bed capacity. Fixed salary, plus full maintenance (includes desirable apartment of four bedrooms, baths, living and dining rooms, kitchen, etc.; and meals for physician and family). For particulars, write MR. SCOTT C. REA, 5th and Orange Sts., Northumberland, Pa., giving age, medical experience and other details.



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*Downing, J. G., Hanson, M. C. and Lamb, M.: Use of 5-Nitro-2-Furaldehyde Semicarbazone in Dermatology, J. A. M. A. 133:299, 1947. • Shipley, E. R. and Dodd, M. C.: Clinical Observations on Furacin Soluble Dressing in the Treatment of Surface Infections, Surg. Gynec. & Obst. 84:366, 1947. • Miller, J., Rodriguez, J. and Domonkos, A.: Evaluation of Penicillin in Topical Therapy, New York State J. Med. 47:2316, 1947.

BOOK REVIEWS

PRACTICE OF ALLERGY. By WARREN T. VAUGHAN, M.D., Richmond, Va. Revised by J. Harvey Black, M.D., Dallas, Tex. Second edition. 1132 pages and extensive bibliography. St. Louis: The C. V. Mosby Company, 1948. Price, \$15.00.

Dr. Black has ably revised Dr. Vaughan's text. Included in the book are the history of allergy, the general characteristics of clinical allergy, and diagnosis. Food allergies are discussed at length. Pollens occupy the space with the detailed descriptions that they merit. Fungi and bacterial allergies are described. There are adequate chapters on contact allergies and the dermatologic features. Anaphylaxis, allergic diseases, and pharmacology, including the antihistaminics, are fully discussed. This is an encyclopedic, up-to-date volume about most aspects of allergy and is of definite value to practitioners and specialists alike.

OCCUPATIONAL MARKS AND OTHER PHYSICAL SIGNS. A Guide to Personal Identification. By FRANCESCO RONCHESI, M.D., Instructor in Dermatology, Boston University School of Medicine; Dermatologist-in-Chief, Rhode Island Hospital, Providence, R. I. Foreword by John G. Downing, M.D., Professor of Dermatology, Boston University School of Medicine and Tufts College Medical School, Boston, Mass. New York: Grune & Stratton, 1948. Price, \$5.50.

Better than a detective story, especially interesting to the dermatologist, and useful to the medicolegal examiner, is Dr. Ronchese's book. Apparently every occupation has its telltale stigma and the author has assembled hundreds of these distinctive marks plus not only excellent photographs but clear pen and ink diagrams. If you would like to know what granite cutter rings, landscape gardener knuckles, surgeon calluses, reel fisherman moles, saxophone player bumps, welder burns, and scars of the cocaine addict are and look like, by all means obtain a copy.

PUBLIC HEALTH ADMINISTRATION IN THE UNITED STATES. By WILSON G. SMILLIE, A.B., M.D., Dr. P.H., Sc.D. (Hon.), Professor of Public Health and Preventive Medicine, Cornell University Medical College, New York City. Third edition. New York: The Macmillan Company, 1947. Price, \$6.50.

This is a comprehensive text on public health administration written to correlate the various public health organizations' activities, and fit each into its proportionate place. Present practices and probable future developments are analyzed. The basic, essential public health functions are discussed first irrespective of their relation to any special division or unit of government, then various divisions of government that are common to our political life in the United States—the federal, state and local units—are considered. The relation of the various voluntary agencies to the official program is discussed, as well as the functions of various professional groups, particularly the relation of the

practicing physician to the general public health program.

This current edition has been completely revised and brought up to date. It is virtually a new book as compared with the previous editions.

HUMAN NEURO-ANATOMY. By OLIVER S. STRONG, formerly Professor of Neurology and Neurohistology, College of Physicians and Surgeons, Columbia University, and ADOLPH ELWYN, Associate Professor of Neuro-anatomy, College of Physicians and Surgeons, Columbia University. Second edition. Baltimore: The Williams & Wilkins Company, 1948. Price, \$6.00.

In this first edition the authors did a commendable piece of work. They reviewed the fundamental embryology and histology, correlating the resulting information in such a fashion as to render the complex subject of neuro-anatomy a logical study.

The interrelationship existing between the clinical and didactic concepts was made most practical and served to make the reader's approach to neurologic cases more sound.

The illustrations merit mention inasmuch as they enable the reader to develop a functional "three dimensional" concept of the intricacies of human neuro-anatomy.

In this second edition the authors have developed a chapter on the peripheral distribution of nerves with respect to its importance in neurologic innervation. Also, they have included a more detailed study of cerebral circulation, a subject whose clinical importance is increasing rapidly.

This text is an excellent source for fundamental information concerning the subject and is heartily recommended for the undergraduate and the graduate groups of students.

OPHTHALMOLOGY IN THE WAR YEARS. Edited by MEYER WIENER, M.D., Professor of Clinical Ophthalmology, Washington University School of Medicine; Honorary Consultant in Ophthalmology, Bureau of Medicine and Surgery, United States Navy. Volume II (1944-June, 1946). 977 pages. Chicago: The Year Book Publishers, Inc., 1948. Price, \$16.00.

This new edition of *Ophthalmology in the War Years* is a compilation of articles which were published during the period from June, 1944, to June, 1946, and also a few important reports published before 1944 but which were not available at the time the first volume came from the press. The purpose of the editorial staff has been to present a book not only for those who did not find the time to read or were unable to obtain the literature contained therein during the war years but also for those who might wish to have a résumé of advances in all branches of ophthalmology during the period covered by this book. That purpose has been accomplished.

The book is well documented and each contributor, each of whom is an editor of his particular department,

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has handled his subject matter well. The printing is easily read and the paper is good. This volume is complete and up-to-date; it has upheld the high standards of the first volume and is recommended.

PRACTICAL BACTERIOLOGY, HEMATOLOGY, AND PARASITOLOGY. By E. R. STITT, M.D., Ph.M., Sc.D., LL.D., Rear Admiral, Medical Corps, and Surgeon General, U. S. Navy, Retired; PAUL W. CLOUGH, M.D., Physician-in-Charge of Diagnostic Clinic, Johns Hopkins Hospital; SARA E. BRANHAM, M.D., Ph.D., Sc.D., Senior Bacteriologist, National Institute of Health; and contributors. Tenth edition. 991 pages with 765 illustrations including numerous colored plates. Philadelphia: The Blakiston Company, 1948. Price, \$10.00.

This book is divided into four parts, namely, bacteriology, hematology, parasitology, and clinical and pathologic examinations of the various body fluids and

organs. It is written in textbook style by authorities in each field. It is easy to read and at the same time is very instructive.

In the section on bacteriology, the various organisms are considered not only from the standpoint of morphology, cultural characteristics, viability, variation, types and other pertinent information, but also in relation to disease situations with all the clinical pictures and treatment. The technique of blood examinations, description of cells, and diseases of the blood with the clinical picture are discussed under hematology. The parasites are presented in a readable form with a discussion of morphology, life history, transmission, method of diagnosis, and the clinical illness with other pertinent information. The section on examination of body fluids and organs is written in a practical fashion with an interpretation of the significance of the tests. There is an appendix containing tables and additional laboratory and clinical information.

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This is a very good book for reference by students and laboratory personnel and contains a great deal of information valuable to the clinician.

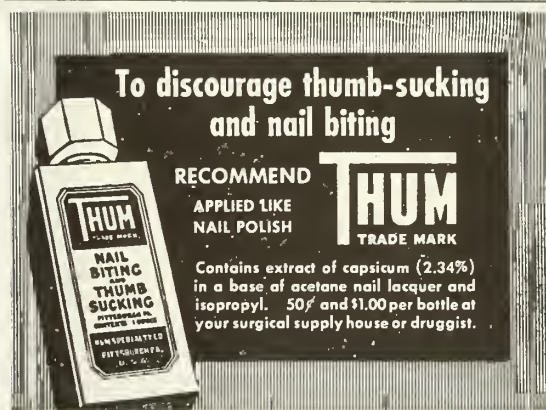
DISEASES OF THE EAR, NOSE, AND THROAT. By WILLIAM WALLACE MORRISON, M.D., Professor of Otolaryngology and Attending Otolaryngologist, New York Polyclinic Postgraduate Medical School and Hospital; Senior Assistant Surgeon in Otolaryngology, New York Eye and Ear Infirmary; Associate Clinical Professor of Otolaryngology, New York University College of Medicine; Captain, Medical Corps (U. S. N. R.). 722 pages with 359 illustrations. New York: Appleton-Century-Crofts, Inc., 1948. Price, \$8.50.

The author and his new publishers have taken the opportunity presented by the new appearance of this text to amplify somewhat and to bring the contents up to date. The book remains a fine text, especially for the undergraduate medical student and the general practitioner, because it is simple, complete, and scholarly.

The contents are systematically arranged in eight main parts as follows: (1) general considerations, (2) diseases of the ear, (3) diseases of the external nose and the nasal cavities, (4) allergic diseases of the respiratory tract, (5) diseases of the paranasal sinuses, (6) diseases of the throat, (7) diseases of the larynx, (8) diseases of the trachea, bronchi, esophagus, and

mediastinum. In addition to a subject index, there are included separate sections consisting of a symptom index and a formulary of prescriptions which are invaluable.

The concise and orderly coverage of the subject with many practical suggestions makes this book of interest to the general practitioner, pediatrician, student, and specialist alike, for every phase of examination and treatment is fully covered.



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BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

STERILITY AND IMPAIRED FERTILITY. Pathogenesis, Investigation, and Treatment. By CEDRIC LANE-ROBERTS, C.V.O., M.S., F.R.C.S., F.R.C.O.G., Gynecologic Surgeon, Royal Northern Hospital, Consulting Obstetric Surgeon, Queen Charlotte's Hospital, London; ALBERT SHARMAN, M.D., Ph.D., M.R.C.O.G., Senior Assistant Surgeon, Royal Samaritan Hospital for Women, Glasgow; Assistant Lecturer in Clinical Gynecology, University of Glasgow; KENNETH WALKER, M.A., M.B., B.C. (Cantab.), F.R.C.S., F.I.C.S., Jacksonian Prizeman and Hunterian Professor, Royal College of Surgeons; Emeritus Surgeon, Royal Northern Hospital; Andrologist, Philip Hill Parenthood Clinic; B. P. WIESNER, D.Sc., Ph.D., F.R.S.E., Consulting Biologist, Royal Northern Hospital; and MARY BARTON, M.B., B.S., First Assistant to the Fertility Clinic, Royal Free Hospital, London. New York: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1948. Price, \$6.50.

PLASTER OF PARIS TECHNIQUE. By EDWIN O. GECKELER, M.D., Professor of Orthopedic Surgery, and Chief of the Fracture Service, Hahnemann Medical College and Hospital, Philadelphia; Fellow of the American College of Surgeons, the American Academy of Orthopedic Surgeons, and the American Association for the Surgery of Trauma, and Diplomate of the American Board of Orthopedic Surgery. Second edition. Baltimore: The Williams & Wilkins Company, 1948. Price, \$3.00.

FRACTURES AND DISLOCATIONS FOR PRACTITIONERS. By EDWIN O. GECKELER, M.D., Fellow of the American College of Surgeons, the American Academy of Orthopedic Surgeons, and the American Association for the Surgery of Trauma, and Diplomate of the American Board of Orthopedic Surgery. Fourth edition. Baltimore: The Williams & Wilkins Company, 1948. Price, \$5.00.

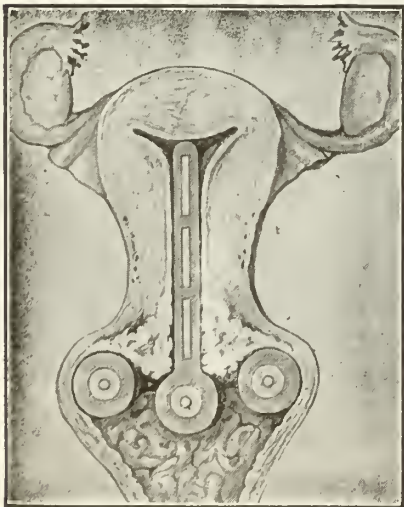
THE ALCOHOLIC WOMAN. Case Studies in the Psychodynamics of Alcoholism. By BENJAMIN KARPMAN, M.D., Chief Psychotherapist, St. Elizabeth's Hospital, Washington, D. C. Sponsored by Washington Institute of Medicine Research Foundation. Washington, D. C.: The Linacre Press, 1948. Price, \$3.75.

DETAILED ATLAS OF THE HEAD AND NECK. By RAYMOND C. TRUEN, M.S., Ph.D., Associate Professor of Anatomy, College of Physicians and Surgeons, Columbia University; and CARL E. KELLNER, Artist, Department of Anatomy, College of Physicians and Surgeons, Columbia University. New York: Oxford University Press, 1948. Price, \$15.00.

YOUR BABY. The Complete Baby Book for Mothers and Fathers. By GLADYS DENNY SHULTZ, contributing editor of *Ladies' Home Journal*, and LEE FORREST HILL, M.D., former president of American Academy of Pediatrics. Photography by Joseph Di Pietro. Line drawings by Reisle Lonette. Garden City, N. Y.: Doubleday & Company, Inc., 1948. Price, \$3.50.

A TEXTBOOK OF GENERAL PHYSIOLOGY. By PHILIP H. MITCHELL, M.D., Robert P. Brown Professor of Biology, Brown University. Fourth edition. New York: McGraw-Hill Book Company, Inc., 1948. Price, \$7.50.

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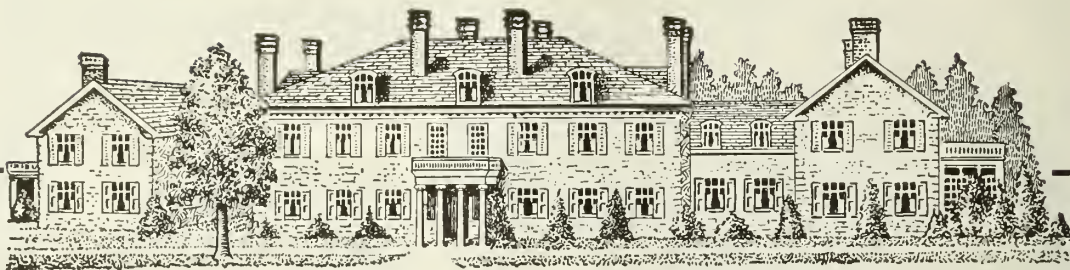
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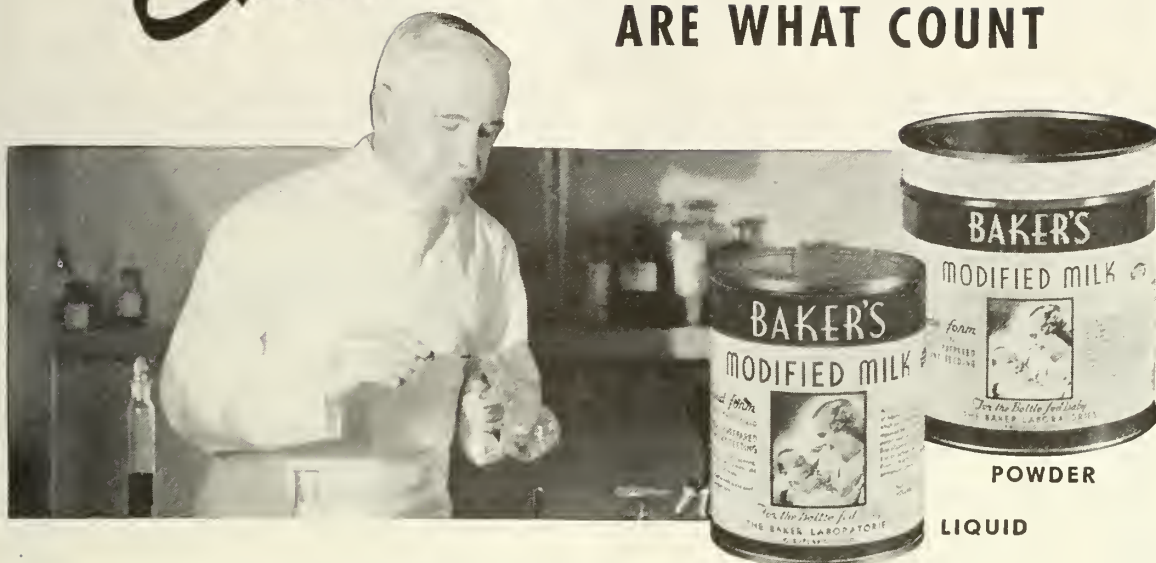
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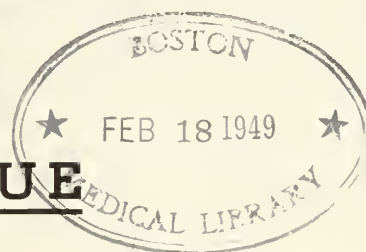
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VOLUME 52



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Recent Advances in Pre- and Postoperative Care

Jonathan E. Rhoads



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An Editorial



Minutes of the Ninety-eighth Annual Session

Pages 222 to 305



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1. Lennox, W. C. (1947), Tridione in the Treatment of Epilepsy, *J. Amer. Med. Assn.*, 134:138, May 10. 2. Merritt, H. H. (1947), Recent Advances in the Treatment of Epilepsy, with Particular Emphasis on the Use of Tridione, *Arch. Neurol. & Psychiat.*, 57:130, Jan. 3. Gibbs, F. A. (1947), New Drugs of Value in the Treatment of Epilepsy, *Annals Int. Med.*, 27:548, Oct. 4. Fetterman, J. L., and Weil, A. A. (1947), Practical Aspects of Epilepsy (with special consideration of epilepsy in children), *Med. Clin. N. America*, 31:1273, Sept. 5. Liebert, E. (1947), Treatment of Neurological Disorders with Tridione, *Ill. Med. J.*, 91:311, June.

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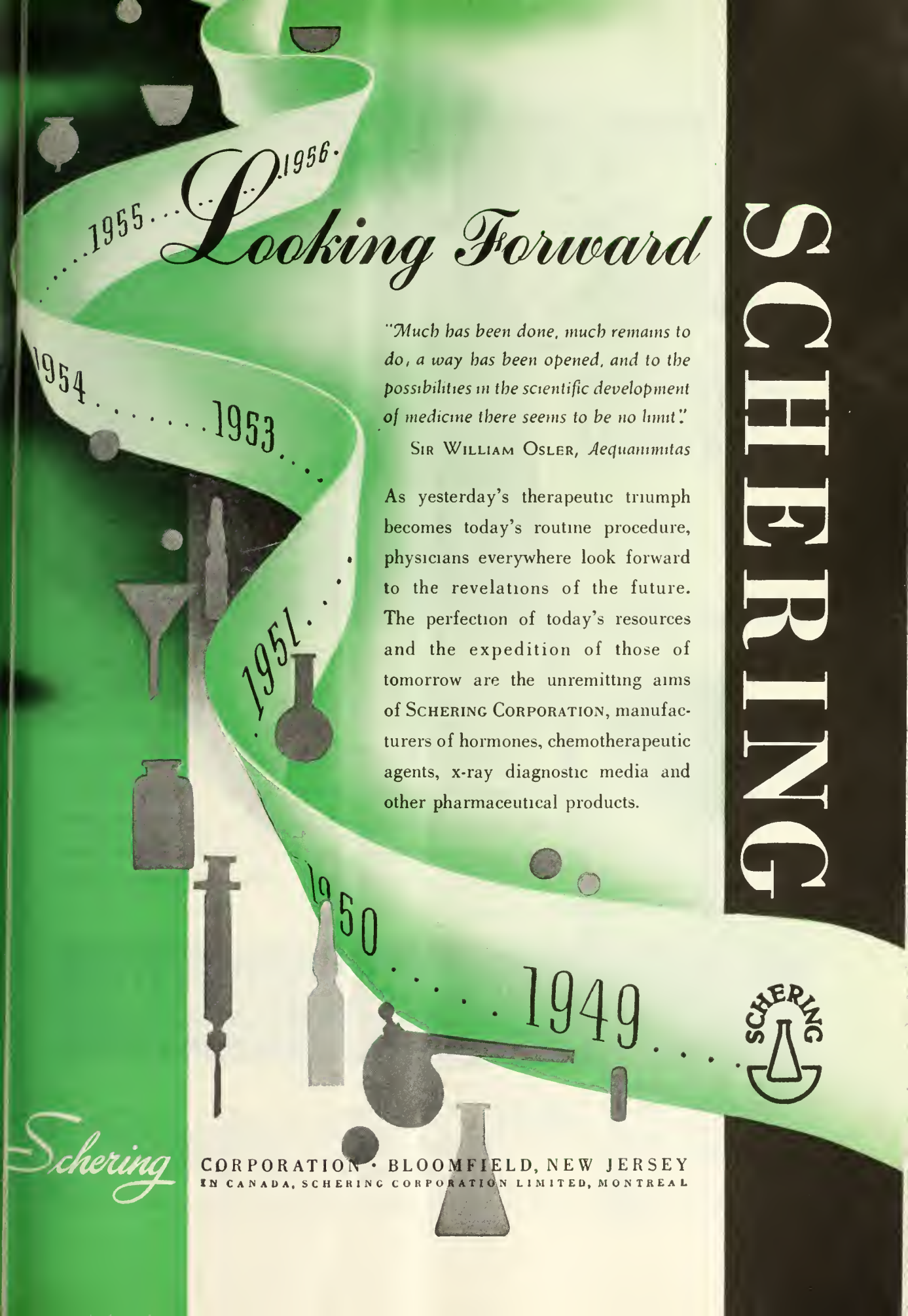
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Berks	Leon C. Darrah, Reading	Clair G. Spangler, Reading	Monthly
Blair	John O. Prosser, Hollidaysburg	George R. Good, Altoona	Monthly*
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Cambria	C. Reginald Davis, Johnstown	Warren F. White, Johnstown	Monthly
Carbon	Dennis Bonner, Summit Hill	John L. Bond, Lehigh	Bimonthly
Centre	John G. Weixel, Bellefonte	Hiram T. Dale, State College	Monthly
Chester	William A. Limberger, West Chester	Francis Jacobs, West Chester	Monthly
Clarion	Charles C. Huston, Knox	James M. Hess, Fryburg	Quarterly
Clearfield	Roy F. Tompkins, Philipsburg	Lorenzo G. Runk, Philipsburg	Monthly
Clinton	John L. Brown, Lock Haven	David W. Thomas, Lock Haven	Monthly
Columbia	G. Paul Moser, Bloomsburg	Jesse G. Fear, Berwick	Monthly
Crawford	James N. Strausbaugh, Meadville	Samuel E. Hoke, Meadville	Monthly
Cumberland	Selden S. Cowell, Carlisle	Richard R. Spahr, Mechanicsburg	Bimonthly
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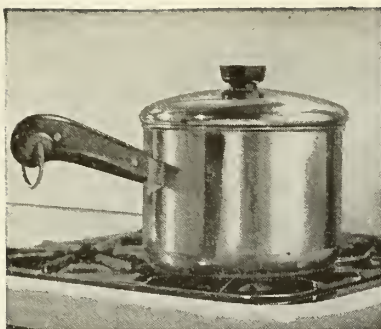
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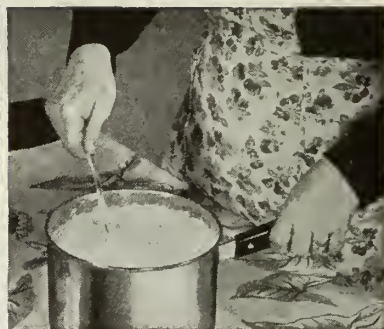
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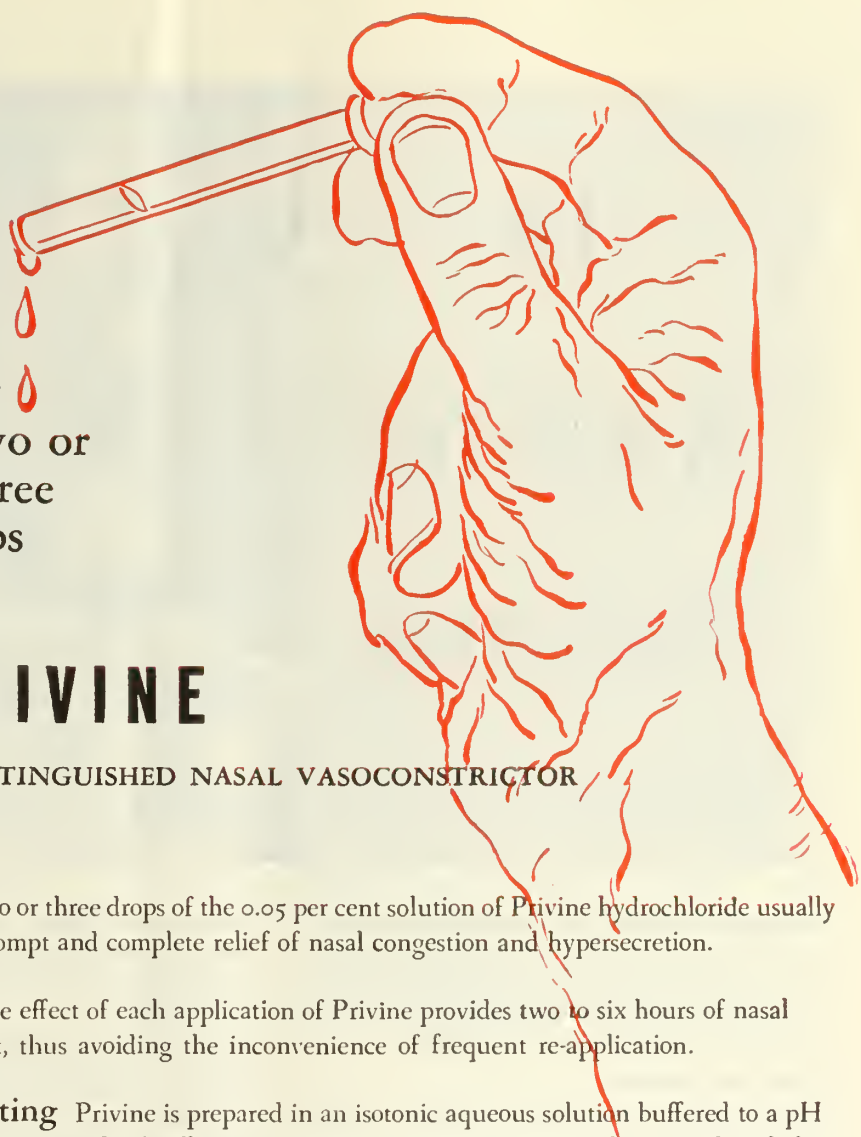
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OPEN PAGES IN NEUROLOGY

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Madison, Wis.



THE following three topics are presented since they are frequent office cases, since we are familiar with the diagnoses, and since we are often unable to treat them effectively. All three have in common (1) unexplainable exciting etiologic factors, (2) well-defined clinical subdivisions with sometimes strongly positive symptomatology and signs, (3) very inadequate information of the pathologic factors leading to neurogenic dysfunction or somatic disintegration, and (4) palliative but non-curative therapeutic procedures.

It is true that composite laboratory investigations including x-rays, pneumo- and electroencephalography have enriched our diagnostic armamentarium and that sometimes effective drugs, physical medicine, and neurosurgery are very beneficial, without, however, leading to a cure for either of the three disorders. Epilepsies, multiple sclerosis, and congenital neurocutaneous dysplasias are obstacles on which the neurologist stubs his toes and bumps his head.

Epilepsy

Epilepsy is not a disease entity; it is a clinical paroxysmal neurophysiologic symptom of very many neurologic disorders. It manifests itself often in an aura, in a partial or complete lapse of consciousness, in somatic-sensory convulsions with post-ictal confusion or amnesia, and often

with involuntary behavior; it is documented by an abnormal electrical potential record which is a dysrhythmic brain wave pattern (electroencephalogram). What causes this periodically altered conduction of nerve impulses or produces explosive-like irritability of nerve cells in an apparently healthy person? Lack of oxygen, endogenous excitation or arrest of cellular metabolism, changes in the acid-base equilibrium, meteorologically induced cerebral vasospasm, or a genetically inherited cerebral dysrhythmia are possible causative postulates for the genetic epilepsies.

Let us omit the acquired "symptomatic" epilepsies, in which a variable motor or sensory spreading fit (symptomatic of jacksonian types, with focally induced dysrhythmias) is produced by traumatic pia-arachnoid scars, infection, degeneration, or neoplasm. For this group of epilepsies many palliative and curative surgical interventions supported by phenobarbital have been recommended. This leaves us with the large group of genetic epilepsies, which by designating or by prefixing them as essential, idiopathic, genuine, cryptogenic, or true epilepsy indicates only our ignorance of etiologic noxae. The clinical symptoms range from giddiness, dreamy states, clonic muscle jerks (myoclonus epilepsy), short lapses or absences without (petit mal) and with tonic or atonic muscles (tonic-atonic epilepsy) to the major tonic-clonic convulsion (grand mal).

Lennox (Bostonian group), whose contributions to the problems of epilepsy and whose clin-

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From Wisconsin Psychiatric Institute.

ical and diagnostic investigations are outstanding in the field of genetic epilepsy, divides the periodic, involuntary neuronal explosions into three types: grand mal, petit mal, and psychomotor. The former is the overt expression of a diffuse physiologic spreading disturbance at the cortical level, so that its normally integrated coordination, with deliberate inhibition of somatic activity as well as its conscious selective liberty of intelligence with reality expression in thoughts or feelings, is blocked or uncontrollably excited during a seizure. The petit mal group with its typical three per second wave and spike electroencephalogram suggests automatic dysfunction at a subcortical motility level in which probably the subcortical ganglia induce a peculiarly vague subconscious automatization with neither fully conscious nor completely unconscious compulsive reactions, lacking, however, ideation and volition. The psychomotor classification incorporates a variety of confusional behavior states associated with coordinated repetitious somatic phenomena. These fit-patterns, being a mixture of psychic, sometimes mainly motor interrelationship disturbances, may be called complex psychosomatic epilepsy.

For the diagnosis of epilepsy without clinical and laboratory confirmations a most accurate descriptive history of symptoms, signs, behavior, and seizure pattern is essential, which then is corroborated by electro-encephalogram before a judiciously adjusted drug schedule of frequency and quantity is given. The latter should never be fixed; it must be altered individually and systematically until a program—"the drug or combination of drugs," the physical and professional activity, dietary and hygienic measures—summarizes a total approach to the individual's fit problems. Various therapeutic statistics give 29 per cent amelioration from grand mal seizures, 28 per cent markedly improved in severity and frequency of attacks after such individualized medication has been effected for five years. The potent anticonvulsant drugs (phenobarbital, dilantin, mesantoin, tridione, alone or in combinations) may have toxic side effects—dermatitis, leukopenia, gingival hyperplasia, glare vision like snow blindness, irritability, drowsiness, apathy, and ataxia. Such undesirable reactions militate naturally against clinical improvement.

An abnormal inherent electro-encephalographic record with overt seizures is rarely eradicated even with the most successful clinical results. The changes in the electro-encephalogram and in the seizure pattern are not concomitant. A partially satisfactory drug schedule must be altered by slowly substituting drugs or by combining

drugs and, if successful, must be adhered to for many years even after cessation of overt seizures.

Clinical experiences with drugs against grand mal and psychomotor attacks confirm that dilantin alone or combined with phenobarbital is a potent anticonvulsant closely equaled by mesantoin, whereas tridione potency is highest in the petit mal group. Continuous convulsions—status epilepticus—cannot be relieved by oral medications. Here sodium luminal, sodium amytal, and tridione intravenously must be used, of which drugs tridione has the highest margin of safety (1.0 Gm. intravenously every fifteen to thirty minutes up to 7.0 Gm. until convulsions cease).

The relationship between epilepsy and pregnancy is of interest with three questions before us: (1) Do convulsive disorders influence the course of gestation? (2) What are the probabilities of transmitting the convulsive disposition to the offspring? (3) How can we differentiate genetic from eclamptic convulsions, especially if the initial fit occurs during pregnancy? A summary statement suffices: Pregnancy has, as a rule, no appreciable influence or effect upon the course or frequency of epilepsy and vice versa; there is no indication for therapeutic abortion since a very generous figure of about 10 per cent suggests only convulsive tendency transmission; eclampsia is differentiated from epilepsy by the history, by a persistent hypertension, by albuminuria, and by edema.

Is there a direct inheritance of genetic epilepsy? Lennox and Gibbs have stated that 60 per cent of the parents, siblings and children of epileptic patients have abnormal brain wave patterns, but not clinical seizures. It seems that cerebral dysrhythmias are inheritable as dominant characters. Cobb's statement in reference to the eugenic problem of epilepsy, "there are probably 25 persons with abnormal brain waves and an inherited predisposition who never show clinical fits to one person who is clinically epileptic," demonstrates the difficulties in the inheritance question. The chance of propagating epileptic children is greater if both parents have pathologic brain wave patterns. In families with genetic epilepsy, marriage and offspring questions are answered by examining and testing carefully the chosen spouse (including electroencephalogram). In my opinion persons with abnormal brain wave patterns alone but without clinical manifestation of epilepsy should never be treated prophylactically with anticonvulsants.

Provocative measures to produce seizures, i.e., freezing of peripheral arteries (reflex epilepsy), hyperventilation (low CO₂ concentration in the

blood), antidiuretic hormonal drugs (hydration—tissue edema), are not dependable. Since the introduction of convulsive electroshock therapy, a small number of very cooperative genetic epileptics with a monthly fixed seizure pattern were submitted to artificially induced convulsions in the hope of dispelling the building up of electrical potentials to an "explosion peak," but the results were discouraging. The trials only aggravated the frequency and changed the periodicity of the seizures.

Much has been written about the personality of the epileptic which textbooks describe as ego-centric, selfish, fanatical, pedantic, seclusive, suspicious, moody, malicious with a tendency to alcoholism or to violent and cruel behavior. The cerebral disorder of epilepsy is too often accompanied by a lowering of the sensory motor affective threshold, which in itself augments tendencies to psychoneurotic behavior, to maladjustment, and to precipitation of seizures by offensive stimuli—noise, light, full bladder, constipation, social rejection, professional limitation, and argumentations. The knowledge of unpredictable fits and the public's attitude create a continuous anxiety, and the fear of social stigmatization in the young epileptic produces constant frustration. Present-day authors regard the so-called "epileptic personality" a misnomer, a myth; furthermore, they reject the pessimistic view of considering all epileptics as being faced with subnormal intelligence or progressing into deterioration. The majority of genetic epileptics present no characteristic personality traits; their psychologic reaction spread parallels the general run of humanity. The young epileptic with frequent attacks and with early obvious deterioration, who is resistant to any drug schedule including glutamic acid, harbors both "gene characteristics" of epilepsy and feeble-mindedness which result in a complete psychosomatic deterioration, and is found finally in the epileptic hospitals.

Epilepsy is largely a social problem which the National Association to Control Epilepsy (N.A.C.E., 22 East 67th St., New York 21, N. Y.) has brought effectively before families, schools, employers, and society in its educational program as well as helping one out of every 200 in our population afflicted with seizures.

Multiple Sclerosis

Among the maladies of the central nervous system, which bring to us a humiliating sense of helplessness, is multiple sclerosis. It is today one of the commonest chronic neurologic disorders of acute, intermittent, and chronic nature,

though an estimate of its prevalence and geographic incidence remains difficult. Why the disorder—alike in rural and urban regions as well as in the sexes—is common in the Baltic states, at our Atlantic seaboard, around the Great Lakes, rare in the Mediterranean countries and in our own South, but almost unknown in the Asiatic races, has not been answered by ingenious discussions of racial constitutional factors, of nutritional habits or dietary indiscretions (canned food, synthetic fats), of national vaccination programs, or of occupational machine age influences.

What is multiple sclerosis? The name signifies an irregular scattering of firm pinpoint, ellipsoid to wedge-shaped plaques throughout the nervous system with greater predilection and regional preference for the white substance and optic nerves and having less effect upon the gray substance and peripheral nerves. These insular foci do not start simultaneously; they develop slowly—depending naturally on the intensity of some obscure noxious agent—over the years, which explains such frequent transient findings as blindness, paresthesias, palsies, and dyscoordination as a dynamic clinical symptomatology. New and severe exacerbations lead progressively to severe debilitating psychosomatic deterioration with its serious social implications.

Search for an etiologic agent or combination of factors has confused even neuropathologists without furnishing the answers to certain fundamental questions: Is the process infectious or a toxic degeneration, and what is the relationship of plaques to pathologic blood vessels occluded by thrombi? It is agreed that myelin changes, first showing swelling and fragmentation, later diffuse demyelination without destruction of many axis cylinders sparing nerve cells, are the primary histologic changes, and that gliosis is secondary to damaged axis cylinders. Acute lesions are exudative-inflammatory reactions marked by edema, variably intensive glial proliferation and perivascular infiltrations. Acute and mild initial lesions can be repaired functionally though imperfectly anatomically, leaving a fibrous glial demarcation which in older plaques becomes diffusely "sclerotic." Depending partly upon the constitutional and restitutional faculty, but mainly upon the intensity of the primary excitation and the age of the patient, we differentiate acute remittent from chronic progressive cases of multiple sclerosis, the ratio being 6:1.

Unfortunately the outcome cannot be forecast. Therefore, in the absence of confirmatory laboratory criteria, acute stormy cases often are diagnosed as demyelinating encephalomyelitis of

"post-infectious etiology." The serious prognostic implications attached to the diagnosis multiple sclerosis suggest that we differentiate a "neurosclerosis syndrome" from multiple sclerosis the disease, since the former with a more favorable outcome may be the temporary response to infectious disorders, to nutritional or metabolic disturbances, or to cumulative tissue fatigue.

In their etiologic search clinicians look for possible exogenous and endogenous agents. Foremost among exogenous factors are virus infections (Guillain, Krabbe, Schaltenbrand, Margulis), since often a banal respiratory illness may usher in a suggestive phase of the multiple sclerosis in a "predisposed member" from a family with neuropsychiatric afflictions; next one must consider nutritional deficiencies of vitamin origin and their enzymes; physical or emotional traumatic or shock reactions need only to be mentioned. The endogenous theories comprise a primary neuroglial proliferation as the neoplastic gliosis (Strümpell); a lipolytic or lecithinolytic ferment causing myelinolysis (Marburg, Crandall, Weil); the arterial spasm or vasomotor theory (Brickner, Wetherell) has shifted to the more comprehensive perivascular hypothesis of Putnam's phlebotaxis, venous thrombi, ischemia, and of faulty blood coagulation. Popular speculations today center on the allergic inflammation theory of Ferraro or the hyperergic theory of Pette, which are founded upon the long known postulate that edema, hemorrhage, and perivascular infiltration constitute an allergic reaction (Arthus phenomenon). Both Pette and Ferraro believe that all demyelinating diseases appear as an allergic response reaction of nerve tissue, that they differ only in intensity, diffusion, and age of the lesions, and that resolution as well as repair facilities are demonstrated in the residual histopathology.

The extremely important experimentations of Ferraro and of Jervis produced by antigen injections (50 mg. brain tissue and 12.5 mg. of killed tubercle bacilli per cc.) in monkeys and guinea pigs have even clinical predilections, i.e., optic system involvement with blindness, vestibulocerebellar involvement with dysmetria, ataxia, tremors and mild general symptoms with apparent recovery and without pathologic residuals.

We have not been able to demonstrate from histories or by cutaneous testing even a suggestion of an allergic diathesis in our multiple sclerosis cases. This negation, however, does not exclude a possible anaphylactic reaction in sensitized nervous tissue by an unknown x factor with detrimental hypersusceptibility to subse-

quent contact. None of these etiologic theories are generally accepted except by their proponents.

To give a definite clinical picture of multiple sclerosis is difficult because of the richness of evanescent and progressive syndromes. Charcot's triad (nystagmus, intention tremor, and scanning speech) is present in a very small percentage of early cases, less than 10 per cent, but common in the late stages. Lesions in the pons demonstrate differences in the vulnerability of nuclear to tract structures, since the frequency of ocular paresis supervenes sensory affections. Recurrent clinical symptoms such as spastic paresis, cerebellar ataxia, and retrobulbar neuritis permit the diagnosis of true multiple sclerosis. Spinal, cerebral, or cerebrospinal types are seen, but an overlapping is more common. Acute posterior funiculi involvement with sensory disturbances, astereognosis, and arm-hand ataxia points to the cervical spinal cord; motor dysfunction with regional atrophy may be present. Thoracic spinal types are more subacute with less annoying paresthesias, but with early paraplegic spasticity and absent abdominal reflexes, if the plaques are located above T6. Dissociation of sensation in truncal segments with severe girdle pain and abdominal pressure sensations in combination with pathologic reflexes suggests thoracic central cord demyelination. Lumbosacral forms may produce a pseudotabetic syndrome, a combined system disorder with bladder, rectum, and potency disturbances. Jacksonian seizures from a parietal center, stereognostic dysfunction from postcentral, or dysphasias with confusion from frontal centers are less common, but indicate cortical multiple sclerosis. Baffling are the spastic hemiplegic or diplegic types if not associated with "surety" symptoms in the history and in the clinical findings. The same difficulties are encountered in pontine and bulbar forms with their variety of symptoms and signs—palsies of one or multiple cranial nerves with vague pyramidal signs, dissociated sensation with such reference signs to pontocerebellar tracts as ataxia, intention tremor, adiadokokinesis, and equilibratory dysfunctions. The similarity of these complex forms to intrapontine but less to cerebellopontine tumors leads to diagnostic errors.

Visual disturbances (scotomata, transient blindness, optic neuritis), cranial nerve palsies (VI, III, IV, VIII, VII, V, X), spasticity with paresis and reflex alterations, subjective and objective sensory disturbances, when associated with euphoria or emotional lability, point to multiple sclerosis.

The cerebrospinal fluid of multiple sclerosis

may be normal or shows only moderate lymphocytosis, increase in protein, and a slightly or decidedly abnormal colloidal gold curve without offering support to the diagnosis except for differentiation. Lumbar puncture even with forty-eight hours' bed rest produces commonly a lasting post-punctural headache. Gastric anacidity even after histamine stimulation favors more progressive chronicity. Blood findings are normal including clotting and coagulation mechanisms.

Upon arriving at the diagnosis of multiple sclerosis or the neurosclerotic syndrome, the much asked question concerning effective therapy is before us. The spontaneous remissions are accredited to one or another form of empiric treatment—fibrolysin, arsenicals, mercuries, iodides, sulfur oil, radiation, pyramidon, quinine, sympathectomies, vitamins, histamine, vasodilators and anticoagulants, Laignel's rabbit serum (sensitized by spinal fluid and red blood corpuscles from multiple sclerosis patients), and Margulis' specific vaccine, and the antihistamines. The rationale of the antihistamines would be to suppress capillary fragility and permeability, assuming that multiple sclerosis is of allergic etiology. Therapeutic supplements are: (1) regular physiotherapeutic rehabilitation measures, and (2) dietary factors, raw vegetables, dairy products, and poly-vitamins. These procedures do not cure multiple sclerosis. A palliative selection and a safe therapy is histamine (Horton), anticoagulants (Putnam), or only general and symptomatic support measures with antihistamine trials.

Congenital Neurocutaneous Dysplasias

The time-old adage—observe, examine, and study your patient and then deduce carefully—which we inherited from our medical ancestors finds a beautiful confirmation in the understanding of congenital anomalies occurring synchronously in the skin, retina, and the nervous system. These structures arise from the ectoderm, and they must be "nourished" by the mesoderm; therefore, primary malformations, delayed or arrested development by disease or hereditary factors, give rise to cerebro-cutaneous or neurodermal dysplasias. The degree of aberration, from the norm, of overtness, and of clinical symptomatology depends on many factors and not alone upon faulty embryologic differentiation and organization, especially since they harbor within the defect a pronounced tendency to blastomatous growth. The resulting congenital neurocutaneous syndromes incorporate skin lesions in the form of pigmentary, vascular, fibrous, lipomatous,

sebaceous, or xanthomatous nevi, nodules or tumors of various size in single, multiple, or generalized form over the whole body. These moles or blemishes are frequently arranged in symmetrical segments, often corresponding to the cutaneous distribution of trigeminal, truncal, or of peripheral nerves; they may be found also in the retina, mucosa, and intestinal tract. Unfortunately they are significant not only because of cosmetic flaws and embarrassment. Their real practical importance lies in their possible reference to disorders in the physical and mental sphere of the nervous system, since externally they mirror the blastomatous cause of a variety of neurologic and psychiatric disturbances. Four main groups shall be mentioned briefly for orientation:

1. Neurofibromatosis of von Recklinghausen.
2. Angiomatosis—hemangioblastoma of von Hippel, Lindau, and Sturge-Weber.
3. Tuberous sclerosis of Bourneville.
4. Melanosis of Virchow.

The best known of the malformations arising from the ectodermal and mesodermal anlage is *von Recklinghausen's disease*, in which occur numerous pendulous, doughy or firm skin lesions (*molluscum fibrosum*) with café au lait spots or with hard pea-sized subdermal tumors about the trunk and scalp, and in which solitary or plexiform neoplasms may arise in the terminal filaments of peripheral and with very serious import along the intracranial or intraspinal meningeal sheaths of nerves. These neurofibromas, neurinomas, or perineurial fibroblastomas may be isolated and multiple. They find a classic representation in the acoustic or cerebellopontine angle tumor with early unilateral cochlear-vestibular symptoms, followed by incoordination, ataxia, headaches, vomiting, choked disks, impairment of facial, trigeminal, or adjacent nerves, medullary compression signs, and cerebellar seizures. Ten per cent of optic nerve tumors are associated with various skin lesions and with neurofibromatosis of peripheral nerves, but they are, however, glioma though closely related to von Recklinghausen's disease. Optic glioma, neurosarcomas, and meningo-encephalic gliomas are like neurofibromas, angiomas, and ectomesodermal dysplasias, differing only in the evolution or differentiation of their primitive glia and in their particular localization.

The complex pathology of von Recklinghausen's disease suggests that it originates in the embryonal rests of epithelial cells lining the neural tube and from cells of the neural crests. It is a

primary ectodermal neoplasm with secondary mesodermal hyperplasia.

Angiomas are commonly located at the nape of the neck, the face, and less commonly in the extremities and the trunk. The port wine stained nevi occur commonly in the face, but may be diffusely scattered over the body. Angiomas are present at birth, having developed at the third embryonic month, and grow during the first and second year of infancy, but never in adults.

Extensive port wine facial nevi with a trigeminal distribution are associated with intra-ocular and intracranial hyperplastic vascular abnormalities, either retinal or venous engorgement in the meninges; in the brain, often with gyriform calcifying of convoluted vessels. The variety of the rare encephalo-trigeminal angiomatosis (Sturge-Weber type) manifests itself in young people with visual and contralateral motor disturbances, with migraine, symptomatic epilepsy, and mental deficiency. X-rays of the skull may reveal ipsilateral to the nevus characteristic calcium deposition, either focally in the occipitoparietal region, diffusely in the cortex, or symmetrically in the basal ganglia at or after puberty.

From these angiomas we must differentiate the *neoplastic, often cystic hemangioblastomas*, which have a common predilection for the posterior lateral cerebellum and which have a familial tendency. The easily detected retinal hemangiomas (von Hippel's disease) is in 20 to 25 per cent of cases complicated by cerebellar cysts with a primary mural hemangioblastic tumor, occasionally by medullary or brain-stem hemangiomas, and by cystic vascular tumors of the central spinal cord. The cutaneous and retinal nevi, café au lait spots, progressive visual failure, mild exophthalmos, hemiatrophy, and dyscoordination are some of the alarming symptoms of hemangioblastomatosis. The possibility of gliomatous alterations of an angioblastic "tumor" must be kept in mind. Cerebellar cysts with a vascular nodule are *Lindau's disease*. Its clinical syndrome depends upon the location, size, and extension in the cerebellar hemispheres, vermis, medulla oblongata, or in the roof of the fourth ventricle. Surgery with extirpation of cyst and tumor preceded or followed by radiation offers excellent results.

These disturbances in the mesodermal anlage may be quite diffuse, since Lindau's disease is associated with additional cyst and hemangioma

formations in pancreas, kidneys, liver, and lungs. Lindau has stressed the analogies with von Recklinghausen's disease.

Skin lesions of sebaceous adenoma, butterfly-shaped facial acne rosacea, occasional retinal phacoma, and less prominent nevi and vitiligo shagreen patches over the body when associated with epilepsy and mental deficiency support the diagnosis of *tuberous sclerosis*. "Potato-like" blastomatous firm tubera in the brain convolutions and in the white matter often can be demonstrated by x-rays; they can be localized and their protuberances into the ventricular system can be visualized by pneumo-encephalography. The epileptic seizures usually respond satisfactorily to anticonvulsants. In a series of cases, we treated the "cerebral tuberousities" with radiation and believe from our results that the therapeutic effort warrants confirmation by others.

The clinical discussion of skin lesions with tumorous complications in the nervous system would be incomplete without a brief reference to the term *cerebrocutaneous melanosis* which Virchow described in 1895.

Pigment-containing cells of the pia-arachnoid, the melanophores, may produce melanoblastic tumors; these are associated with melanotic skin nevi. These tumors are more common in adults. The nevi are of variable size, often larger than the nevi in the three mentioned disorders, but are blackish, irregular, granular, and hairy.

Primary melanoblastosis of the meninges produces a meningitis-like syndrome with obstructive hydrocephalus. However, the cortical involvement and the progressive invasion along the perivascular spaces with tumor formation contributes to a variety of intracranial syndromes. The "benign" melanotic nevi may grow to annoying and embarrassing size and are treated by radiation, radium, or CO₂ snow. Why not excise? Because a benign melanin-containing tumor may be activated into a malignant growth usually two years after the excision and produces a fulminating, metastasizing fatal melanosis with the clinical similarities of a meningeal melanosarcomatosis.

In concluding, I confess that the three obstacles have not been displaced, nay even moved, but by discussing their rough surfaces and by engraving facts of today into smooth places, others may learn, improve our knowledge, and tomorrow cure.

Recent Advances in Pre- and Postoperative Care

JONATHAN E. RHOADS, M.D.

Philadelphia, Pa.

PRE- and postoperative care are aimed mainly at the prevention or treatment of infection, shock, nutritional deficits, distention, water and electrolyte imbalance, hemorrhage, and thrombosis. These fields are often interlocking. If I touch rather lightly on some of the important advances, it may be either because they will be covered more fully by one of the other speakers this afternoon or because the subject is already too well known to be considered in "What's New in Surgery."

In the field of antibacterial chemotherapy, we have three new agents—chloromycetin, polymyxin, and aureomycin. The first of these agents has proved to be of great potency against bush typhus and has not been available for extensive trial in surgical patients as yet. Polymyxin is derived from the *Bacillus polymyxa*. At present it is available for investigative use in ampules of 40 mg. It is suitable for local and systemic application and is potent against a wide variety of gram-negative organisms and some Rickettsia. The other agent, aureomycin, is obtained from the growth of *Actinomyces aureofaciens* in sunlight. It, too, is available only for investigative use as yet and in very limited quantities. It is taken by mouth in doses of one-half to four grams per day and apparently exerts its effects systemically, though its pharmacology has not been completely worked out. The response of a patient with pylephlebitis due to a *Corynebacterium* is shown in Fig. 1. The organism which was recovered from a liver abscess and at one time from the blood stream was sensitive to aureomycin but not to penicillin, streptomycin, or sulfadiazine. The range of usefulness of this drug is not fully known, but it has been effective against many strains of both gram-negative and gram-positive bacteria.

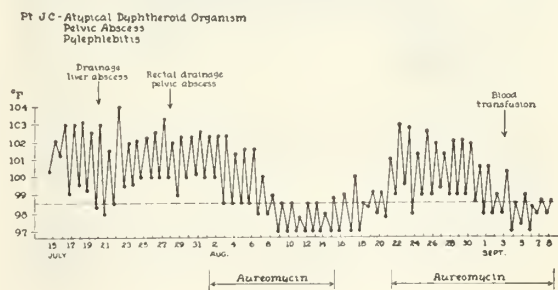
An earlier antibiotic, bacitracin, has been found to be of value against certain organisms that are resistant to penicillin and streptomycin, but Dr. Alexander Michie has shown that this agent in its present form is seriously nephrotoxic

in man and we have abandoned its use except for topical application to small lesions.

Shock therapy has been aided not only by the introduction of new agents but also by better methods of gauging dosage. The occurrence of homologous serum jaundice in patients receiving pooled plasma has resulted in several deaths and there has been a pronounced trend away from the use of plasma. Where it is available, human serum albumin is very effective in the treatment of shock and so far no cases of homologous serum jaundice have been traced to its use. It is believed that the processing used in its production inactivates the virus. Safer also than pooled plasma and very effective in hemorrhagic shock is ossein gelatin, which is prepared in 6 per cent solution and dispensed in 500 cc. bottles. A typical response to this agent is shown in Fig. 2, which indicates the blood pressure changes in a patient (treated by Dr. Koop and Dr. Fletcher) who sustained a sudden severe hemorrhage.

Whole blood remains the best agent for treatment of most types of shock. Some advantages are claimed for giving it into the artery rather than into the vein. A simple apparatus for doing this has been devised by Porter, Sanders, and Lockwood. This route is believed to lead to quicker elevation of arterial blood pressure and probably to somewhat prompter restoration of coronary and cerebral blood flow.

Many times the proper amount of blood for treatment of shock may be available and yet one may fail to give enough for fear of overloading the circulation. Estimations of the blood volume by the older methods were unreliable or unsafe in the very ill patient. However, the dye method,



A presentation of "What's New in Surgery" at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 6, 1948.

TABLE I

PREOPERATIVE PLASMA VOLUME DETERMINATIONS IN A GROUP OF PATIENTS WITH GASTRIC LESIONS

General Surgical Service

Hospital of the University of Pennsylvania

Name	Predicted Plasma Volume ml.	Measured Plasma Volume ml.	Plasma Deficit ml.	Whole Blood Deficit ml.
J. J.	3000	2145	855	2300
F. McB.	2850	2470	380	690
M. L.	2800	2260	540	980
M. R.	4000	3520	480	875
R. Z.	2700	2175	525	955
J. O. L.	3100	2560	540	1020

using Evans blue or the tagged red cell method using radioactive sodium, can be used with minimal disturbance to the patient. The former method is the easier for most laboratories and we now determine the plasma volume and hematocrit on most gastric cases and most other patients with weight loss who are likely to undergo extensive operations (Table I).

In patients with cardiac handicaps, it is an additional safeguard to follow the venous pressure. Several methods are now available for following the circulatory status of patients on the operating table. They are the oximeter, the ballistocardiograph for cardiac output, and the direct arterial pressure device developed by Peterson and introduced by Peterson, Risman, and Dripps, which will be described in another presentation.

In the field of fluid administration, attention has been focused on serum potassium by the work of Darrow and others. The flame photometer permits accurate measurement of sodium and potassium with small samples and in a relatively short time. In patients who have a large fluid exchange and who are getting no potassium in their intake, a potassium deficiency may devel-

op with a decline in the serum potassium from a low normal of 3.5 mEq./L. to 2.0 mEq./L. or less. This represents a loss of about 2 grams of potassium chloride from the extracellular space in the average adult. The work of Tarail and Elkinton has shown that such a deficiency is attended by a much larger intracellular loss, often four to seven times as great. The precise relationship between the intracellular loss and the extracellular loss is not as yet predictable.

The symptoms of hypopotassemia are lassitude, torpor, electrocardiographic changes, and unexplained high serum CO_2 . In the cases that we have had the lassitude which may verge upon stupor has been very striking.

TABLE II

DEMONSTRATED DANGERS OF HYPOPROTEINEMIA

1. Wound rupture due to poor fibroplasia.
2. Vomiting after gastro-enterostomy.
3. Delayed gastro-intestinal motility.
4. Delayed callus formation as shown by x-ray in experimental fracture.
5. Increased predisposition to hemorrhagic shock.
6. Decreased resistance to infection.

In restoring such a deficiency, care must be taken to avoid hyperpotassemia, as this may precipitate cardiac arrest. The safest route is the oral one and isotonic potassium chloride may be used (12 Gm./L.). If this route is not available, the same solution may be mixed with equal parts of physiologic saline and given slowly by vein in patients with a good urinary output. In patients with a poor urine output, however, sudden death has been observed in at least one series (by Elkinton and his associates), so that for the present we regard good renal function as a *sine qua non* for the parenteral administration of potassium. The high serum CO_2 which was very striking in one of our cases was observed previously by Darrow. The mechanism of its production is not fully understood, but it seems to be a retention of CO_2 with an elevation of the pH and not a change in the CO_2 combining power of the blood.

The use of sodium chloride in intravenous therapy has been further reduced and few surgical patients today receive more than 500 to 1000 cc. of physiologic saline solution per day, unless there is an abnormal loss.

In patients with renal shutdown, the use of dialyzing membranes as an artificial kidney has made some headway. The first successful artificial kidney was that of Kolff of Holland, which was exhibited at the A.M.A. convention in 1947. Drs. Schwegman and Fletcher have recently built a machine working on the same principles

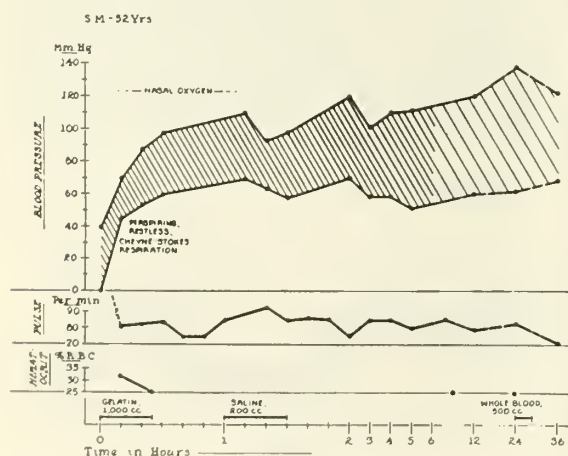


Fig. 2

TABLE III

WHAT'S NEW IN NON-OPERATIVE SURGICAL CARE

- The introduction of chloromycetin, polymyxin, aureomycin.
- The abandonment of bacitracin (systemically) because of nephrotoxicity.
- The substitution of whole blood, serum albumin, or ossein gelatin for pooled plasma.
- The use of intra-arterial transfusion in occasional cases of shock.
- The prevention of operative shock by measurement of blood volume and correction of preoperative deficits.
- The recognition of the occurrence and clinical significance of potassium deficiency.
- The successful use of an artificial kidney in temporary renal shutdown.
- Demonstration of the beneficial role of a moderate fat intake during the phase of repair of liver injury.
- Demonstration of a liver fraction having a vitamin-like influence in the regeneration of liver protein.

at the Hospital of the University of Pennsylvania.

In renal failure, we believe that it is often wisest to avoid the administration of intravenous fluids. Thirst may be used as a criterion for giving water by mouth. Seven hundred to one thousand cc. per day usually satisfies the patient with anuria. A high carbohydrate-high fat intake is used to reduce the catabolism of body protein.

If anuria passes and a diuresis develops, Collier and his associates have found that there may be a large and rapid loss of sodium chloride. Under these circumstances, the kidneys may for a time lose their ability to retain salt and large amounts of saline solution may be required to prevent hypochloremia.

In the field of nutrition, emphasis is still on protein in most surgical patients. The dangers of hypoproteinemia are summarized in Table II. The use of amigen and other hydrolysates has increased, but it is difficult to maintain nitrogen balance unless the requisite number of calories can be given. This is very difficult in patients who must be fed parenterally and, while it has been accomplished in many individual patients, I do not feel that we have a method of complete parenteral nutrition which may be universally applied.

Jejunostomy for nutritional purposes has largely fallen into disuse. A frequent experience is that diarrhea develops when the caloric intake in the jejunostomy feeding is brought up to the desired levels. The method should not be lost sight of however, as it has at times been useful.

Therapy in the field of coagulants and anticoagulants has not advanced rapidly. No methods are in general use for increasing coagulabil-

ity of normal blood. To decrease coagulability of blood in the postoperative period, heparin and dicumarol remain the standard agents. In a recent study, Kirby and his associates have shown that arterial clotting in the experimental animal is not delayed materially by dicumarol unless the prothrombin is decreased to 40 per cent or less of normal. Vein ligation is practiced in patients who develop signs of thrombosis of the deep veins, but prophylactic vein ligation is not done frequently by us. Two cases of fatal embolism after such prophylactic ligation in patients with femoral neck fractures occurred in our hospital.

Time does not permit consideration of many of the special problems in pre- and postoperative care. The 20 per cent protein-75 per cent carbohydrate diet is used routinely in preparing patients with hepatic injury for operation. Postoperatively, however, recent experiments of Vars and his associates indicate that 15 to 20 per cent of fat is advantageous during the period of liver regeneration. Certain liver fractions seem to have a specific effect in aiding repair of liver tissue in animals. This fraction is present in ledinac, and this preparation may be given to patients with severe liver damage in doses of 1 Gm. per kilogram per day.

In thyroid surgery, propyl thiouracil has replaced thiouracil and thiobarbital in the preparation of the severely toxic patient, but iodine still suffices for preoperative preparation of mild to moderately toxic patients and is also given during the last ten to fourteen days before operation in those patients who are prepared with propyl thiouracil to make the gland firmer. It is important to remember that, in diabetic patients, thiouracil and its derivatives may increase the severity of the diabetes.

To summarize progress in pre- and postoperative care during the past three years, I believe that one must stress the development of three new antibiotics, chloromycetin, polymyxin, and aureomycin, which seem to have promising possibilities; the abandonment of one antibiotic (bacitracin) in its present form as too toxic for systemic use; the partial abandonment of pooled plasma in favor of whole blood, serum albumin, and ossein gelatin in the treatment of shock; the improvement in estimation of the needs of the patient for blood and other intravenous fluids; recognition of potassium as an ion that must be kept in balance; increased recognition of the danger of excessive saline (Table III).

There has been a continuation of emphasis on the maintenance of protein nutrition, also continued emphasis on the value of suction drainage in the immediate postoperative period.

THE HEALING MISSION

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IT IS not enough to be interested and pursue one's own specialized function in life. That makes for a kind of spiritual isolationism which destroys the individual just as political and economic isolationism destroys society. Man is whole and indivisible, and society or the human race must be conceived as whole and indivisible. I understand that the exigencies of a complex social structure compel to specialization. We must have experts in the innumerable subdivisions of life, and expertness demands concentration on a limited number of objectives. We can't create unlimited numbers of Admirable Crichtons, skilled and talented in scores of pursuits. I know that your honored profession has long struggled against the dangers of increasing specialization, aware of the possible injury to the patient and to the specialist himself. The solution is not an easy one and demands rigorous and conscientious planning, and I feel confident that in this generation methods will be devised to achieve this great dream of the "Healing Mission"—the dream of treating the whole man, of preventing the ills that cripple and kill. Much has already been done in this direction. Psychosomatic medicine has emphasized and developed what skilled physicians have known for centuries, long before Freud initiated his well-known therapy. Our Bible and other ancient literatures have taught that mind and body are interdependent. When the Bible says (and I allow myself just one illustration out of many) "Hope deferred maketh the heart sick," it intended no mere figure of speech; it was a statement of hard, physical fact, observed by our ancestors thousands of years ago. People do sicken and die of hearts broken by frustration, and minds do weaken and dissolve because of viruses and bacteria and malformations.

But all of this is common knowledge and I repeat it here merely as introductory to an application of this principle to a matter of the gravest importance. We are in the center of a world-shaking hurricane. As in the center of all great

winds, all seems relatively calm here. But at the periphery there is catastrophe. In distant China and India, in Palestine and the Near East, in Greece and the Balkans, there is frustration and destruction. Even here, in the relatively calm center, there is evidence of unrest. Strikes, political corruption, struggles for mastery by competing economic theories, increasing intolerances between racial and religious groups, all these and many more evils are indices of a profound constitutional disease in the body politic and social. Many of us have a sense of impending doom for the whole human race, a sense which antedated the discovery and application of the atomic bomb. It is vitally important to find the causative factors of this world-wide pandemic disease. There are those who trace it to economic hunger, contending that the world is no longer able to feed adequately its growing population. And when one considers the recurrent famines in China and India, with their teeming millions, when one notes the devastating annual floods in all our continents, the millions upon millions of eroded and useless acres, the preventable forest fires, one sees the validity of this diagnosis.

But there is still another series of causes which are perhaps just as fundamental. The world has experienced two great psychic traumas in one generation. The two world wars, of which the second was the more destructive, have deranged the normal functioning of the world mind. The first was sufficiently severe to create a whole lost generation of young men and women who lost all hope of world betterment and individual salvation. We had not recovered from the first great shock when we were catapulted into this last great struggle. The destruction of lives and property, the burden of debts and reconstruction, the dislocation of millions of human beings seeking refuge, the hunger and poverty—this is enough to disturb the world mind. But, worst of all is the feeling of hopelessness and helplessness that is widespread. Even we, in our American security belt, are growing cynical and are no longer shocked when we see nations still fighting each other for supremacy in what we call

Delivered at the "Religious Hour" of the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Sunday afternoon, Oct. 3, 1948.

the "cold war" fashion. Spiritual leadership is in the doldrums; the practical men are in the saddle. Gandhi is dead and the atheist cynic Stalin rules over hundreds of millions in Europe and Asia. The world's vital capacity is, at the moment, very low.

But, you will ask, with justice, what has this to do with us as physicians? And my answer is that it has much to do with you. You are first of all citizens of the leading free country of the world, and as citizens you have a great and inspiring responsibility. No citizen is exempt. The weaknesses in our democracy are due precisely to our failure to assume this responsibility. If we have inept and weak leadership, the fault is ours. If this dream of "One World" is not realized, it is because the citizens of free lands have not asserted their rights and have defaulted in their duties.

You are also members of a distinguished profession which from the earliest times has dedicated itself to the cause of humanity in the largest possible sense of the term. The average layman may not feel the impulse to serve in so unselfish a fashion. But a member of a learned profession, whether or not he takes the oath of service, is impelled to devote himself to the highest possible causes. The Oath of Hippocrates, when seriously taken, implies a very definite responsibility with all these high issues. If the learned professions fail to do their duty, then, indeed, the world is in a woeful state. But your profession—and this is the burden of my preachment—has a special duty, far above the ordinary duties that are assumed by thinking men and women. It is obvious that mankind is suffering from disease, as I have indicated, partly physical and partly psychic, and no one is better fitted to assume the cure of it than your profession and mine. Hitherto another learned profession, namely, that of law, had interested itself particularly in the attempted solution. Many of our political leaders derive from the legal profession. And it is quite true that if the principle of law were to be applied to many of the outstanding complexities of our civilization, we would probably be tremendously benefited. The law is also not a static thing. It grows, develops, and adjusts itself to changing circumstances. But it lacks some qualities which the medical and clerical professions possess in larger measure. These latter apply themselves to the problem of the individual man and realize the whole man must be considered in any possible solution of the human problem. I have called the work of the physician a "healing mission," and I feel it is high time that members of your profession dedicate some small fraction

of their busy time to developing a diagnosis and a therapy for the diseases of society. Who else is better fitted to undertake this great task? And while it would seem that this is an added burden placed upon the shoulders of a profession already too much burdened, I can see no hope unless the intelligent and cultivated members of the learned professions combine to put an end to the present chaos and suffering. This is not a matter to be postponed or dealt with in idle moments. It is a matter requiring immediate and prayerful and earnest study and action.

Fortunately, it is not too late. Adversity and suffering are good teachers, and while many of the weaker vessels have been shattered, the strong men and women will rally if a genuine, intelligent leadership is created. There is a constant cry for peace in the world, and all the contending factions are agreed that we must have peace, but they fail to see that unless men are ready to sacrifice some of their time, energy, and wealth to achieve this peace, it cannot be achieved. You cannot purchase peace with appeasement or with war. It cannot be gotten by imposing phrases. It must be done by the cultivation of a humble and contrite heart. It may be that our scientific and material achievements have intoxicated us. We have become arrogant and proud of what little progress we have made in solving some fundamental problems. It is true that we have cured certain diseases, but other diseases have grown apace. It is true that we have annihilated distance and that the world has grown comparably smaller. It is true that we can be hurtled through space at incredible velocities. But the spirit of man has not grown sufficiently to be able to rise above these petty achievements. For what boots it to gain the world and lose one's soul? Of what avail is it to devise new ingenuities, and have no serenity of mind or peace of soul? Wars are moral symptoms of an underlying dissatisfaction, with the world as it is presently constituted.

Then one of the first things all of us have to learn is to develop the technique of walking humbly with the Lord our God. You physicians have frequently told the world that religion has now been given a place of honor in the cure of sick souls. The next step will be to give that place of honor in the cure of a sick world.

This, then, is the task that I should like to see assumed by your profession—to conceive of your "healing mission" not simply as a way of curing sick bodies and sick minds but also as a way of healing the hurt of mankind in its largest sense. Your organization has had one hundred years of really worth-while achievements. I have been

interested to read the striking record of what you have done during this past century. After all, in your accomplishments there has been the implication that you feel the impelling desire to serve

mankind. I pray, therefore, that the next hundred years will witness greater achievement for your organization and for the individuals that compose it.

NINE-MONTH COMPARISON SHOWS SUBSTANTIAL GROWTH OF MSAP

Continued, accelerated growth of the Medical Service Association of Pennsylvania is shown in comparisons of the first nine months of this year with the corresponding period in 1947.

Subscribers enrolled on September 30 were pushing the 300,000 mark, with 294,430 having Blue Shield protection in this State on that date as compared to 120,620 a year ago. The enrollment gain was 144.1 per cent, or 173,810 subscribers.

The number of physicians' services paid increased 138.7 per cent during the first nine months of this year, with the total being 15,254 on September 30 as compared to 6390 a year ago.

The cost of physicians' services incurred from January 1 to September 30, this year, amounted to \$990,791—an increase of 135.6 per cent over the same nine months of 1947. This item totaled \$420,565.50 for the same period last year.

Annual subscription fees in force jumped 171.8 per cent for the first nine months of the current year, with the gain amounting to \$1,704,464.40. As of September 30 this year, annual subscription fees in force totaled \$2,696,810.40 as compared to \$992,346.00 on the corresponding date in 1947.

THE INTERNSHIP

The transition to the residency system by the majority of our hospitals has placed greater emphasis on the resident staff of each individual hospital and to some extent a lesser emphasis on the intern. It goes without saying that the internship is—or should be—the time when the groundwork is laid for future success in a physician's chosen field. This is ideally accomplished by the usual manifold duties of the intern, plus daily contact with the attending staff and a certain amount of systematic teaching by the latter group.

It is imperative that in the care and teaching of the resident staff, all of whom are receiving specialized training, the intern is not slighted or overlooked. There is a tendency for the attending staffs to concentrate on the resident staff, which policy in some instances leaves the intern to fend for himself, and pick up the crumbs, so to speak. It is the duty of every hospital to see to it that the intern receives adequate instruction in each and every service to which he is assigned. While it is true that the internship would not aim to produce a specialist in any given field, for this is the domain of the residency system, it should aim at the development of character, at teaching the intern to put into practice what he has

learned of the uses as well as the limitations of instruments, of precision, learning to care sincerely and honestly for the sick, and at implanting and developing responsibility. This can be accomplished only by the attending staff of each hospital taking a decided personal interest in the intern and his future career.

It is well to remember that all interns do not automatically go on to residency training, and not every intern wishes to be a specialist—at least not at first—although after his period of training is up he may have a decided change of mind and for good reason.

Many of the internships today are of one year's duration. At the end of that time many interns manage to obtain a residency. Some do not. These men are in a precarious plight. Obtaining additional training is extremely difficult, competition being what it is today. In many instances an individual is forced to repeat the one-year internship at another institution. If, in this repetition, they do not receive adequate teaching and instruction, of what value is the training?

A one-year rotating internship, which is in vogue at many institutions, may be a good stepping stone for a residency, but it is not for general practice. Perhaps the shortage of general practitioners may be in part attributed to the fact that in meeting the various board requirements in the training of specialists, our hospitals have neglected the training of well-rounded general men.

In any event, this is a good time to closely scrutinize the problems of the intern, and make careful evaluation of just what constitutes a good internship.—*New York Medicine*, Nov. 5, 1948.

DEFINING

Compulsory Sickness Insurance.—Compulsory sickness insurance is a system of sickness insurance in which all members of a given group of persons in a given governmental area are compelled by law to contribute to and be enrolled in the scheme. Any compulsory sickness insurance program under direct control of the state is socialized medicine; *insurance principles no longer prevail and the compulsory contributions become a special tax.*

Voluntary Sickness Insurance.—Voluntary sickness insurance is that system whereby individual costs are spread over a period of time by a group of people who voluntarily band together to protect themselves against the economic burden of sickness. It involves the insurance principle and an organized system of payment. It is popularly known as voluntary prepayment medical care insurance.

The Roentgen Diagnosis of Otitis Media and Mastoiditis in Infancy and Early Childhood

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ROENTGEN examination of the mastoids is an essential part of a diagnostic survey when there is clinical evidence of otitis media and mastoiditis. The procedure is utilized frequently in infancy and early childhood and in these periods disease changes are usually difficult to demonstrate due, in part, to exacting technical requirements but largely to immature mastoid development.

Mastoid cells are rarely demonstrable before the sixth month of life and at this age they are small, few in number, and closely related to the periphery of the tympanic cavity. The cells are formed by the evagination of the mucous membrane which lines the middle ear cavities, the tympanic cavity, and mastoid antrum. They remain closely related to the periphery of the tympanic cavity until the period between the tenth and twelfth months when cellular expansion progresses laterally toward the portion of the petrosa that ultimately becomes the mastoid process.

In the second six months of life the cells are few, thin-walled, and incompletely pneumatized. As a result, mucous membrane and cell wall changes are difficult to detect. It is therefore evident that before ten months of age there is seldom sufficient mastoid development to allow detection of disease and thus a diagnosis of mastoiditis is rarely possible before this age and cannot be made in the first six months of life.

In contrast, a diagnosis of otitis media can be substantiated by roentgen examination in the early months of life because the tympanic cavity is relatively large and the petrous bone is not sufficiently ossified to obscure changes due to disease. The relative transparency of the petrosa and the relatively large size of the tympanic cavity in the first year of life make it possible to appreciate abnormal opacity due to otitis, espe-

cially when films of the opposite normal side are available for comparison.

In the second year progressive extension of the mucous membrane into previously unexpanded bone results in further development of the mastoid. At the end of eighteen months the mastoid process is still immature, but profile and other views reveal a semblance of adult configuration including mastoid tip formation.

Continued evagination of the lining membrane causes increased pneumatization and development of the mastoid process, so by the end of the second year the process is adult in configuration.

This statement is true provided the middle ear and mastoid remain healthy. Suppurative disease retards or stops normal development. Comparative studies of patients with unilateral chronic suppurative otitis media and mastoiditis made in early life, soon after the onset of ear infection, and a number of years later, reveal a complete arrest of cellular development on the side of disease.

Previously the limitations of the roentgen method in the diagnosis of mastoiditis in early life, especially in the first year, have been stressed. After the first year it is often possible to make a diagnosis of mastoid disease and toward the end of the second year the mastoid is sufficiently developed to allow a clear-cut demonstration of abnormality.

A diagnosis of mastoiditis is not indicated from the roentgen evidence alone because abnormal opacity in the mastoid is produced by conditions other than inflammatory changes in the cells. Proper interpretation of disease is based on a correlation of the roentgen and clinical findings. Accurate information about the onset and duration of the disease and the clinical findings, including those of the otologist, is necessary before attempting to evaluate the roentgen appearance of the mastoid.

It is usually not difficult to demonstrate clouding of the well-developed so-called pneumatic type of mastoid and thus establish a diagnosis of

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mastoiditis when the disease is unilateral and roentgenograms of the normal opposite mastoid are available for comparison.

Bilateral involvement is more difficult to evaluate, especially when the opacification of the mastoids is approximately the same on the two sides. The lack of difference in the degree of opacity on the two sides may lead to an erroneous conclusion that increased density in the mastoids is on the basis of a variation in technique and therefore is only apparent. Such a mistake is possible when an attempt at evaluation of the roentgenograms is made without a knowledge of the clinical findings and the bilateral disease has produced neither bone destruction nor sclerosis.

The detection of early bone absorption is usually very difficult because the contrast is lessened by thickening of the membrane lining the cells and at times by an exudate in the cells. The diagnosis of beginning bone breakdown is based on a lack of sharpness of the bony septa and a break in the continuity of the cell walls. More advanced manifestations of bone breakdown are not difficult to demonstrate, especially when a large area in the mastoid process is destroyed. A careful comparison of suspected involved areas with corresponding zones in the healthy opposite mastoid facilitates proper evaluation of the diseased mastoid.

Evaluation of the chronically diseased mastoid is difficult, particularly if the mastoid is underdeveloped and not pneumatic. In this type the cells are small and are usually limited to the petrosa around the tympanic cavity and mastoid antrum. Chronic infection usually produces bone sclerosis which interferes with visualization of the small cells. Since the cells are small and few

in number and are apt to be obscured by bone sclerosis, a convincing demonstration of bone breakdown is difficult to obtain.

In an occasional case, the chronic infection starts after the mastoid has become pneumatic and then bone breakdown is not difficult to detect; in fact, the entire pneumatic area may show extensive bone destruction.

Roentgen examination of the mastoid is indicated when complications such as petrositis, cholesteatoma, otogenic meningitis, and brain abscess are suspected. Opacification and destruction of the petrous pyramid and mastoid occurring in these conditions are frequently demonstrable and therefore valuable information is obtained by roentgen studies.

Summary and Conclusions

A roentgen diagnosis of mastoiditis is impossible in the first six months because cellular development is meager. In the occasional case, there is enough pneumatization in the seventh to the tenth months to detect disease.

A diagnosis of otitis media is feasible in the first year because the tympanic cavity is relatively large and the petrous bone is not yet sufficiently opaque to obscure changes due to disease.

After the first year it is less difficult to reveal disease in the mastoid, and by the end of the second year the diagnosis is not more difficult than in older children and adults.

The roentgen findings in acute and chronic mastoiditis and their complications are considered and the effect of chronic disease on mastoid development is discussed. Illustrations pertaining to the textual matter are found elsewhere.¹

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EDITORIALS

WINDOW TRIMMING

The retail trade places high value on its show windows. Here potential customers pause briefly to view the merchants' ware. Thousands of dollars are spent daily in window trimming to increase customer satisfaction and to whet customer desire.

Medicine in Pennsylvania has ten thousand or more show windows before which a hundred thousand customers, at least, pause daily. Sometimes they are required to wait for long periods before this show window; what a wonderful medium for customer education! We refer, of course, to the doctor's waiting room table.

In what percentage of cases is this fine opportunity for customer stimulation wasted? The waiting patient is conditioned to fix his attention on things medical and what does he find—dog-eared copies of several-months-old magazines, and a few trade journals intermingled with a scattering group of technical journals.

Here exists an approach for popular education. Where could better be displayed for interested perusal a few recent copies of *Hygeia*, a Brook-

ings report, and for the reader with heavier interests, a few pamphlets on preventive inoculation procedures, possibly several volumes presenting medicine's problems briefly and popularly, e.g., *Magic in a Bottle**—it will help to blast the anti-vivisectionist's arguments; *Doctors of the Mind*—telling the story of psychiatric developments in simple readable language; *Devils, Drugs and Doctors*, portraying the doctor in his historic roles; a few pamphlets describing the Blue Shield program. These are but brief suggestions. *Hygeia* especially has definite educational value; its pictorial setup will rival *Life* in its popular appeal. Your subscription will help your woman's auxiliary, and displaying your copies prominently in your waiting room show window may encourage other subscribers.

Have we overlooked the educational and, if you want to so characterize it, the propaganda value of our best display case? Think it over, doctor, and do a little constructive window trimming. You can thus make a real personal contribution to medical public relations. Ask your Auxiliary member wife to help you. Your public relations committee will try to suggest new trimmings frequently and occasionally furnish some. Russell Conwell talked about "Acres of Diamonds"—I wonder if your waiting room table is not one of medicine's undeveloped "acres."

H. K. P.

* *Hygeia*—monthly publication of A.M.A. Subscribe through your woman's auxiliary.

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OUR PROBLEM FOR CONCENTRATION

Progress in American medicine is an achievement which we, as doctors, are proud to relate to the general public.

Yet, for some time now, many stories reaching lay readers have dealt with isolated cases of distress, indicting the medical profession, along with articles based on glib promises of social planners.

During the ensuing year the medical profession must concentrate its efforts on one program: tell the American people about the many contributions which the medical profession has made to alleviate disease, preserve life, and postpone death. Our story must stress the importance of our present system of voluntary care and present the true facts about medical care and health protection.

The House of Delegates of the American Medical Association, at the Interim Session in St. Louis, fully recognized these problems by creating a means for carrying on a nation-wide health education program. To finance this program an assessment of \$25 was made on each member of the American Medical Association. Members of the American Medical Association do not pay dues. If they desire to become Fellows of the Scientific Assembly, they make application and pay \$12 a year dues, which includes a subscription to *The Journal*. This hardly pays for the paper and printing, notwithstanding the fact that the doctor receives the best medical periodical published anywhere in the world.

In 1947 the expenses of the Association exceeded its income. For that reason dues of Fellows were raised from \$8 to \$12. However, even higher costs have kept pace with this raise and the Association may show a net loss for 1948.

The medical profession as a whole is of the firm opinion that governmental control of medicine would lower the standards of medical care in the United States, and is so sincere in this belief that it feels everything possible should be done to prevent such control from being thrust upon us.

A coordinating committee has been formed to help solve many of the problems which we face, and it is enlisting the support of every physician. This committee is composed of Drs. E. L. Henderson, chairman, Edward S. Hamilton, Gunnar Gundersen, Walter B. Martin, Louis H. Bauer, John W. Cline, William Bates, R. B. Robbins, R. L. Sensenich, and George F. Lull, secretary and general manager of the A.M.A.

GEORGE F. LULL, M.D.

EARLY DIAGNOSIS FIRST LINE OF ATTACK

A Review of the Ten Leading Causes of Death

Medical progress, as it affects us individually and collectively, has been tremendous during the past ten years, and has been influenced chiefly by the untiring efforts of the family physician, by the ingenuity of physicians in clinical and laboratory research, and by the general advances in preventive medicine and public health. In fact, there are few among us who have not benefited in some measure from the recent advances in medical research!

Without any thought of its morbid aspects, a review of the ten leading causes of death has an educational value to all of us. Regardless of our age group, we are all interested in the possibilities of our eventual fate, but we are chiefly interested in how best to prolong our useful life.

First, it is important for us to consider briefly several items of general information. The population of this country has recently increased by leaps and bounds, as evidenced especially by the housing shortage. In 1847, one hundred years ago, the population of the United States was eighteen million, and today this figure has increased eightfold to 144,000,000 persons.

In the past several years the number of births has reached a new high record, with 3,800,000 in 1947. And since there were only 1,400,000 deaths in the same year, there was an excess of 2,400,000 births over deaths. Thus, our population was increased considerably (2,400,000), even in the year 1947.

With the benefits of modern medical treatment, and the advances in preventive medicine, we are all getting "added years" of life. In 1900 life expectancy was 42 years, and in 1947 it was 67 years—a gain in life expectancy of 25 years in the past forty-seven years. This gain was the greatest in any period of the last 2000 years.

With modern methods of contagious disease control we no longer have the fear of typhoid fever, diphtheria, scarlet fever, etc. However, with the increase in population and longevity, we are now entered upon a *new era—the era of degenerative diseases*. The term degenerative disease applies particularly to the slowly progressive disorders of the blood circulation and metabolism which are associated with the process of getting older. Among these diseases we include arteriosclerosis, heart disease, hypertension, diabetes mellitus, kidney disease, cancer, and certain types of arthritis. Thus, in the coming years, our attention will be drawn more to these degenerative

erative diseases than to the infectious diseases—and medical research will proceed along the same direction.

One glance at the recent statistics of the U. S. Death Rates (1946) focuses our mind on the progressive increase in deaths due to these degenerative diseases.

In the year 1946 there were 1,400,000 deaths in this country, or one to every one hundred persons.

Heart disease (including coronary artery disease) was the *number one cause of death*, and was increased for the third consecutive year; 430,000 persons died of heart disease in 1946, or 31 per cent of the total deaths. In the past ten years the toll from heart disease has practically doubled. It kills twice as many persons annually as does cancer, nine times as many as tuberculosis, and nearly four hundred times as many as infantile paralysis.

Through the efforts of the American Heart Association, a broad program of research in heart disease has recently been planned.

Cancer (and other malignant tumors) was responsible for 182,000 deaths in 1946, and is the *second leading cause of death*. Comparatively, there were 72,000 deaths from cancer in 1920, 114,000 in 1930, and 158,000 in 1940. These figures demonstrate a progressive increase in the number of deaths from cancer in the past three decades, but we must remember that our population has increased, and that increased longevity will naturally permit an increase in the number of potential cancer cases.

Apoplexy (cerebral hemorrhage) was the *third cause of death*, and 125,000 deaths were reported in 1946. Arteriosclerosis, high blood pressure, overweight, and overexertion are contributory causes to this condition.

Kidney disease (nephritis) is the *fourth leading cause of death*, and has held this rating for some forty years without any ballyhoo, without any public notice, and without any campaigns for research on kidney disease. In 1946 there were 82,000 persons who died of kidney ailments.

Accidents (excluding auto accidents) caused 64,500 deaths in 1946. Included were accidents in the home, such as falling down the cellar steps, and many industrial fatalities.

Pneumonia (including influenza) is now the *sixth cause of death*, but it held first place between 1900 and 1920. Since the discovery of the sulfonamide drugs, and the antibiotics (penicillin and streptomycin), the death rate from pneumonia has diminished remarkably in a mere

ten years; 62,000 deaths occurred in 1946 from pneumonia.

Tuberculosis (90 per cent tuberculosis of the lungs) was the *seventh leading cause of death* in 1946 and 52,000 deaths were reported. With isolation technique, pneumothorax therapy, modern nutrition, and now the advantage of streptomycin, we are well able to continue reducing the number of deaths from tuberculosis of the lungs.

Premature births were the *eighth cause of death* and accounted for 40,000 deaths in 1946. Included were birth injuries, deformities, etc.

Diabetes mellitus was the *ninth leading cause of death* in 1946, and in 1900 was the twenty-fifth leading cause of death. In 1946 there were 35,000 deaths from diabetes. Recent surveys have shown a progressive increase in the number of diabetics. The National Health Survey in 1935-36 gave an estimate of approximately 700,000. A very recent survey by Wilkerson in the town of Oxford, Mass., has revealed an even higher general incidence, based on blood sugar and urine studies. Joslin now believes that the estimate should be revised upward to almost *two million diabetics*—one million "known diabetics" and one million "unknown diabetics." It has also been estimated by Marks that there are *55,000 new cases of diabetes annually*. Deaths from diabetes should never be due to diabetic coma, but may be the result of blood vessel complications in the heart, kidneys, and extremities, or to acute infections. Diabetes is a typical example of an increasingly prevalent, degenerative disease. The early discovery of diabetes may be considered a form of preventive medicine, because it is generally agreed that the case detected early does the best.

Motor vehicle accidents constitute the *tenth leading cause of death* in the United States. In 1946 there were 33,500 deaths from auto accidents. The automobile age, with its "loose nuts behind the steering wheel," has taken a terrible toll in lives when it is considered that approximately a half million persons have been killed by autos or trucks in the past twenty years!

In the preceding discussion an attempt has been made to outline an inventory of the leading causes of death in the United States. The growing importance of our increasing population and longevity on one hand, and the increasing incidence of degenerative diseases on the other, has been emphasized. Early diagnosis of heart disease, cancer, tuberculosis, diabetes mellitus, and other diseases is the first line of attack for the family physician, and will constitute another advance in preventive medicine.

In the line of thought regarding degenerative diseases, it is fitting to close with the philosophic quotation of George Bernard Shaw, who wrote, "Life is a disease; and the only difference between one man and another is the stage of the disease at which he lives."

OLIVER E. TURNER, M.D.

WHAT PRICE AUTOMOBILE TRAFFIC?

The tragic status of automobile traffic and the mounting fatalities are shocking to all, but very little that is fundamental and constructive is being done about it. Sporadic enforcement drives by the authorities have accomplished little in the control of this menace against the welfare of society. We must revise our attitude toward the whole problem, establish the cause or causes for this terrible situation, and deal with it regardless of whom it may hurt.

In the opinion of the writer the problem is bound up with human behavior under a given set of circumstances, and in this case the circumstances are such that they lead to non-observance on the part of many drivers. This is so because of (1) the difficulty of detecting traffic law violators; (2) the tremendous number of drivers; (3) the fact that they are so widespread, and try as they may, officials cannot be everywhere; (4) the tendency of people, otherwise law-abiding citizens, to take a chance, thus leading to accidents; (5) the lack of easily available records of the behavior of each individual driver, and (6) spotty and lenient enforcement by the authorities after some of the violators are apprehended. What is necessary, then, is to devise laws which correct these shortcomings and thus bring about improvement in the behavior of the large part of the public, and a weeding out of those who do not respond even under the strictest enforcement of the laws.

Before outlining this new approach it is necessary to emphasize two points to which the community as a whole has to be educated: (1) driving, because of its serious potentialities for harm against society if not performed properly, is a privilege granted by the state, and *not a right*; (2) because of the dangers involved, society has a right to use whatever drastic measures are necessary to curb these dangers.

Suggested Steps for a New Automobile Law

In order to meet the menace, the following steps are suggested:

1. For the larger part of the driving population, ease

of detection would probably be a sufficient deterrent. This could be accomplished as follows:

a. Observers recruited from among drivers with long safety records could be asked to report on all traffic violators whom they observe during their driving. This information would be only for the purpose of enabling the authorities to study the behavior of the driver. It is obvious that a driver who is being reported upon frequently is not too careful, to say the least. This information could be used at most only to caution the driver that he is a piling up a poor record.

b. The use of plain-clothes officers patrolling the roads in plain cars would help greatly in deterring many and catch the serious offenders much easier.

2. In order to detect the more hardened part of the population, it is necessary to introduce an easier means of detection by which their record can be read at a glance. The driver's license card could be used to show his driving-life record. This could be accomplished by the use of cards of different colors, depending on whether minor or major infractions have been committed and the drivers are found guilty under due process of law. The card could carry the initial date of issuance.

a. White card for the careful driver and to each new driver. This alone would act as an incentive for careful driving by a large part of the population.

b. Gray card for drivers who commit minor infractions of the law. The Highway Department authorities could determine what they consider a fair number of trials before a gray card is issued.

c. Red cards for serious violators such as those having been found guilty twice or at most three times of more serious violations, such as crashing red lights, disregarding stop signs, illegal passing of other vehicles on dangerous curves, speeding, etc.

If the holder of a red card is arrested once more on a serious offense, it should be mandatory on the authorities to deprive him of his driving privileges. Whether, revocation should be permanent or not can be left to the judgment of legislative bodies in the light of future experience. If the holder of a gray card persists in his disregard of the automobile laws, he should be given a red card, and subsequently treated as the other red card holders.

A capital letter on the red card might be used to classify the drivers further. Thus, D.D. 2 could stand for two convictions of drunken driving, or P.V. for persistent violator, etc.

The cards could then serve as the driving-life history of the driver which any enforcement officer could easily decipher. This system would also help to put a stop to leniency on the part of judges and grand juries, a complaint frequently aired in the daily press. It would also produce a body of statistics which would enable us to study the behavior of the driving population. And above all, in a few years it would weed out the hardened violators who show a lack of responsibility and are unworthy of being entrusted to run loose on streets and highways in a death-dealing instrument, which the automobile is in their hands.

A great deal remains to be said about the use that could be made of psychiatric and psychological examinations in order to classify various types of individuals who constitute poor driving risks, but this phase is not as urgent as is the introduction of the measures advocated above.

The cry might be raised against the increased cost of such a program, but in view of the tragic state of affairs at present, it is a very reasonable cost. Besides, serious students of the problem are advancing more costly measures, such even as building special separate one-way highways for trucks and for pleasure cars. This is a staggering program, and yet some people consider it worth the price. One thing is certain. Something more must be done for the protection of human life and limb and the sooner the better. The writer is convinced that the measures advocated above would greatly decrease traffic accidents, and would bring about more careful driving. Obviously, the effect of this simple and comparatively inexpensive program may really be definitely evaluated after two or three years. Pennsylvania should take the lead in its 1949 legislative session and incorporate these suggestions in its highway control laws.

MAX. H. WEINBERG, M.D.

FROM BISMARCK TO HITLER TO EWING

Socialized medicine in Germany had its beginning under Bismarck (1815-1898), founder of the German Empire. From the beginning that type of medical practice has been criticized because it leads to the physician's gradually looking on the governmental beneficiary as a number rather than as his private patient. Dr. Andrew C. Ivy, of Chicago, who acted as medical counsel in the recent German medical crimes trials, was brought into intimate contact with the incredible crimes and their perpetrators.

Recently, in addressing a fraternity group of medical undergraduates, Dr. Ivy chose some very cogent thoughts on the future of the medical profession in America. From Volume XXXVII, 1947-48, of the Nu Sigma Nu Bulletin we quote the following anent Dr. Ivy's remarks:

"He pointed out that many of the men on trial were considered prominent doctors in Europe. Their ability as medical men did not prevent their performance of some of civilization's most heinous crimes. Since the time of Bismarck, who instituted a system of medical insurance, German medicine has been characterized by increasing disregard of the patient as a person. According to Dr. Ivy, this callous attitude toward the patient was an important factor in the transformation of medical science into a corrupt, inhumane, political minion of the Nazis. He emphasized that the medical profession in America must

vigorously oppose all measures which tend to destroy the intimate doctor-patient relationship so basic to our system. His thought for the evening was 'The Hippocratic Oath Is Merely the Medical Golden Rule, Which Must Be Sacred to Every Physician.'"

In order to give a more pointed slant to the reader's thinking we at this writing like and add the appended comments from the pen of the editor of the *Jackson County (Mo.) Medical Society Bulletin* of Nov. 20, 1948. We quote Dr. Vincent F. Williams because he most interestingly expresses our own basic concept that "every physician in discussing sickness insurance during the next few months must support such arguments for voluntary forms of sickness insurance as have meaning only in relation to the good of the public." With that basic truth well imbedded in our minds we may with confidence discuss our profession's own plans for more and better medical service with any one from our next-door neighbor to our own representative in the 81st Congress.

Thanksgiving—1948

"... But, to keep the record straight, let us recall a bit of history. Soon after Harry Truman was made President (early in the "honeymoon" period), the writer was designated by a committee of Missouri physicians to visit our fellow-Missourian. We were appointed to offer him our sincere congratulations; and moreover, we were to advise him that all Missouri physicians would be proud to help in any possible way with his unprecedented burdens. That offer still stands.

"Here in Missouri, inscribed on our Great Seal, is the motto: *Salus populi suprema lex esto*. Mythology reveals that the word *salus* refers to the goddess of health and welfare. We physicians of Missouri remain ready and willing to back the President, as best we know how, if our joint battle is actually for the principle and philosophy expressed on the seal of our great state.

"The people have declared (November 2) their confidence in the President's integrity and sincerity; they believe in the program he has outlined, including his interest in health measures. He has stated that he does not favor 'socialized medicine.' We of the medical profession in Missouri will support any health legislation our President recommends which embodies the true concept that the 'health and welfare of the people is the supreme law.'

"Perhaps too much heat and too little light has been exchanged over the contentious phrase 'socialized medicine.' Being from Missouri, there is naturally some of the 'show-me' attitude, but that is justifiable and understandable in all physicians. Our professional heritage is precious and deserves our most zealous care.

"We must rededicate ourselves to the proposition that this is the greatest nation on earth with an urgent need for us to serve our fellow-Americans to the utmost of our ability. Therefore, it is not opportunism, it is not apostasy, to renew this pledge: that whatsoever is good for all the people will receive our unstinted effort, our unqualified support.

"We can be very thankful this Thanksgiving Day, thankful to Him who permitted a spirited—even bitter—public hearing on issues, and subsequently, a free ballot on these same issues. Most of all, we can be thankful to Him that when the heat of battle has receded we Americans join, in one common front, striving to solve those problems which confront us. Thus, we shall continue trying to do what is in the best interests of the entire Nation!"

THE BROOKINGS INSTITUTION

When addressing lay audiences on the issues of compulsory health insurance, no doubt many of us will be referring to the Brookings Institution report* recently prepared on this subject.

In order to present a convincing argument regarding the issues discussed in the report, it is of vital importance that our audience be acquainted with the fact that The Brookings Institution is an impartial, unbiased, non-political research business enterprise.

An article published in the October 31 issue of the *New York Times* entitled "Object: Objectivity," written by Gershon Fishbein (no relation to Morris), reviews the activities and accomplishments of the institution since its inception in 1916.

Controversial issues having a wide divergency of opinions, such as the European Recovery Program and the Taft-Hartley Act, were objectively studied by The Brookings Institution.

The *Times* article quotes Senator Vandenburg's commendation on the Institution's report on ERP to the Senate: "To fit these conflicting specifications into a common pattern was indeed a jig-saw puzzle. I express our great obligation to the Brookings Institution for the masterly job it did. The provisions of the pending bill follow its recommendations."

Mr. Fishbein's article states that "the chief factor which influenced a Senator in appraising

the Brookings recommendations on ERP was his certainty that the institution had no axe to grind, that its report represented the judgment of the best-trained minds on the subject, and was framed only after the closest scrutiny of any alternatives." Without doubt the same appraisal may be applied when judging their qualifications to report "The Issue of Compulsory Health Insurance."

"Contrary to popular belief, only a very small percentage of Brookings studies are at the request of government agencies. Nearly all of them are initiated by the institution itself. Many of them are financed, however, by private foundations whose requirements of objectivity must be scrupulously satisfied. Brookings is equipped to do this. In fact, the charter establishing Brookings states that the institution shall be administered 'without regard to the body politic, whether political, social or economic.' The institution frequently turns down requests by organizations for studies lest it be suspected of catering to group interests," so states the *New York Times* article.

Mr. Fishbein says: "Brookings reports find approval on all levels of society. In 1932, after a lengthy critique on the American Indian, a member of the Blackfoot tribe commented: 'Eight hundred pages of the saddest and truest annals of the Indian that have ever been written. But the light of a better day is about to shine upon my people.'"

"The Brookings staff roster reads like a roll call of the nation's outstanding economists. Leo Pasvolksy, Lewis Merriam, and Dr. George Bachman are only a few of the economic specialists who today are providing the country with a check on the continuous task of self-improvement."

With these facts in mind, you can rest assured that whenever you are quoting from the Brookings report on "The Issue of Compulsory Health Insurance" you are passing on the decisions and recommendations reached by one of the outstanding research organizations in America.

H. K. P.

* EDITOR'S NOTE: See pages 894-5-6, May, 1948 PENNSYLVANIA MEDICAL JOURNAL, for report of president of Brookings Institution on "Medical Care for the Individual."



A PUBLIC RELATIONS CASE HISTORY

An integral part of any public relations program is the attention and care given to *incoming mail*. Numerous requests, complaints, and suggestions are received, all of which are answered as promptly and satisfactorily as possible.

The following letters, we believe, make an excellent case history of good public relations:

GENTLEMEN:

I have been told to seek your aid in obtaining a position. I am 40 years of age. I am crippled and have not worked for over three years due to a serious operation. I have tried to obtain a part-time position, but have not been successful. I can do work such as addressing envelopes or office work of some type where I would not have to stand.

I was last employed repacking drugs and as an information clerk at the Abbott Laboratories, Philadelphia branch. However, the branch has been moved to Chicago, Ill.

Should you know of any suitable work, I would be very grateful if you would inform me. Thank you, and I shall be looking forward to hearing from you should you know of any position.

MISS SUSAN G———.

DEAR MISS G———:

Your letter addressed to the Industrial Bureau of Medicine, Harrisburg, has been referred to The Medical Society of the State of Pennsylvania, and it is hoped that we can guide you to the proper authority for the assistance you desire. It is suggested that you contact the district office of the Bureau of Rehabilitation, 261 N. Broad St., Philadelphia, and explain your circumstances to them. The purpose of this Bureau is to promote the interests of the physically handicapped.

Enclosed is a leaflet which explains this service. We are sending your letter, along with a copy of this letter, to the Philadelphia office of the Bureau of Rehabilitation. We urge you to make this contact, for we are sure that they will assist in training and placing you in a position that you will be physically able to handle.

COMMITTEE ON PUBLIC RELATIONS.

STATE BOARD OF VOCATIONAL EDUCATION,
Bureau of Rehabilitation,
Philadelphia, Pa.

GENTLEMEN:

The enclosed letter was received at our office. We have answered this letter and have referred the individual, as a copy of our letter states, to you. We are sure that you will make every effort to assist this woman in acquiring permanent employment.

COMMITTEE ON PUBLIC RELATIONS.

COMMITTEE ON PUBLIC RELATIONS:

Miss Susan G——— reported to this office August 24, 1948, where she was interviewed by the undersigned. Taking her previous experience into consideration, an appointment was arranged which resulted in her being hired at a starting salary of \$28.00 per week. She reported for work on August 26, two days after being interviewed in this office.

The personnel manager has advised us that her services are very satisfactory. The client stated her satisfaction with her type of work, her employer and fellow employees, the working conditions, and rate of pay. She is very appreciative of the service received.

R. T. HOWARD, *Rehabilitation Councilor,
State Board of Vocational Education.*

DEAR MR. HOWARD:

Certainly such fine cooperation merits a prompt reply bearing our congratulations and thanks for the splendid assistance which you have given Susan G———. It is not often that the mail passing over my desk gives me such pleasure as your letter did this morning, explaining how you had followed up our request to completion, placing Miss G——— in a position whereby she will be able to earn her own living and be a contributing member to society again. It is such fine cooperation as you have displayed that really makes our jobs worth while.

LEO E. BROWN,
*Executive Assistant to the
Committee on Public Relations.*

DEAR SIR:

Please accept my many thanks for your help in obtaining a position through your Society. I received your letter of November 23 and I want you to know that I have been working now since August 30 and have been very happy knowing that I can earn enough to feel that I do not have to depend on someone's support.

Thank you for the kind help once again.

MISS SUSAN G———.

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Minutes of the Ninety-eighth Annual Session

Philadelphia, October 4-7, 1948

MINUTES OF THE HOUSE OF DELEGATES

Monday Morning, Oct. 4, 1948

The House of Delegates of The Medical Society of the State of Pennsylvania at the Centennial Celebration Session convened in the Clover Room, Bellevue-Stratford Hotel, Philadelphia, Pa., at ten-fifteen o'clock, the Speaker of the House, Dr. Lewis T. Buckman, presiding.

SPEAKER BUCKMAN: The House will please come to order.

We are convening the ninety-eighth session of the House of Delegates of The Medical Society of the State of Pennsylvania.

The Chair recognizes Dr. Wilson, of the Credentials Committee.

DR. FRED B. WILSON (Beaver): There is a quorum present, Mr. Speaker.

SPEAKER BUCKMAN: If there be no objection from the floor, the order of business today will be that suggested on the inside cover of your copy of the Transactions. If there be no objection from the floor, we will dispense with the roll call.

The minutes of the ninety-seventh annual session (1947) were printed in the December, 1947 *PENNSYLVANIA MEDICAL JOURNAL*. Are there any corrections or additions to be made to those minutes as printed?

We will accept them as the official transcription of the 1947 session.

This brings us to remarks by our retiring president. Gentlemen of the House, your president, Dr. Elmer Hess!

President Hess' Address

Mr. Speaker and Members of the House of Delegates:

For the past two years, I have been greatly honored to serve you as president-elect and president of this medical society. This has given me an unusual opportunity to learn something about the problems and the needs of the medical profession, and particularly those of The Medical Society of the State of Pennsylvania.

A number of important objectives have been achieved that have been outstanding. I will review some of them. Other matters of great importance to medicine have been sadly neglected. I wish to call some of these to your attention.

Many of the accomplishments of our society during my two years of intimate connection with its affairs have been due largely to the ability, experience, and efficiency of your secretary-treasurer, Walter F. Donaldson. It is understandable that we have not always agreed, but I have always found his advice worth taking.

To Chauncey Palmer should go our thanks for an exacting job well done. He is the ever active chairman of several committees, and the most important part of his work, of course, has been the maintenance of an understanding liaison between our society and the

official government of the Commonwealth. To both of these fine medical statesmen, my wish is for many, many years of continued service to the medical profession.

It has gradually become necessary to have a large staff of laymen to carry on the expanding work of the Society. These, our employees at our own headquarters in both Harrisburg and Pittsburgh, have been loyal and faithful to the high principles we proclaim and have made our machinery function smoothly and efficiently. Talented Lester Perry has been the spark plug of the Harrisburg group, and his studious judgment on many occasions at the county, state, and national levels has reflected great credit to our society. Time does not permit me to mention the names of all the Society's office employees, but to each of them we owe our appreciation for many hours of effort on behalf of the physicians of this state.

Under the able chairmanship of Park Deckard, your Board of Trustees has worked long hours and has given thoughtful consideration to all the problems that have been brought before them. Their work is not easy, but I can truthfully report that their judgment, their loyalty to all of us, and their devotion to the profession remain unquestioned. Again, they do not always agree, but that is the democratic way. The interests of the individual physician and the public have always been paramount in their decisions. We owe them a deep debt of gratitude for their devotion to duty and for the able way in which they have handled our affairs during my term of office. One of the ablest and most devoted men of this group died during the year—Walter Orthner—may God rest his soul. His successor, Dr. Joseph S. Brown of Lewistown, impressed me when I attended the councilor district meeting which Dr. Orthner had planned and over which Dr. Brown was obliged to preside. It was the first time in my experience that such a meeting was opened with a prayer requesting the guidance of the Supreme Being in the deliberations and actions of that body. I am impressed with the spiritual side of our great profession, and there is increasing evidence to prove its existence. Witness the splendid attendance at our State Society's religious services on Sunday.

Time does not permit me to discuss the splendid work of the various committees and their chairmen for the year. I wish to thank all of them for their devotion to the Society. The reports of the activities of their committees have been completely printed in the September, 1948 issue of the *JOURNAL*. Too few of us realize the value scientifically, socially, and economically of this valuable adjunct to our work. Too few of us bother to read it; if we did, there would not be so many of our people who know so little about our problems and how we are attempting to solve them. It should be your "must" reading. We have opened its pages to the various sections of the Department of Health and its contents are factual. The caliber of the scientific papers has been excellent and is directed toward the education of the general practitioner. Paper shortages have prevented the enlargement of the *JOURNAL* and it has often

been impossible to print valuable scientific contributions, both to the regret of the author and also, believe it or not, of the Editor. The work of several of the committees has been unusually outstanding and beneficial and I would ask all of you to read every word of these reports.

An important event took place during the year for which our medical society was severely criticized by welfare workers, prominent laymen and women, and even by members of our profession. A Department of Mental Health, with its head a cabinet officer, was advocated by many people. The proper legislation was prepared and many of us, including myself, favored the new department until amendments to the law were included in the pending legislation. One amendment proposed that the head of the new department need not be a physician interested in neuropsychiatry nor a man with executive training. This, we felt, was wrong. The second amendment proposed that mental patients belonging to religious sects might be cared for by that religious group and beyond the supervision of the Commonwealth. That piece of legislation failed to come out of committee. In my opinion, such police power belongs to the government alone. One other thing must be mentioned. The creation of such a department would not have helped the present situation in the mental health program of the State and, as advocated last year, I still believe that mental health and its problems belong in the Department of Health. I would recommend that the House of Delegates designate approval by resolution to this effect. When we oppose certain legislation, it behooves us to take the lead in advancing other constructive legislative ideas to help those who represent us. We should never be simply an opposition body.

I want to call your attention to the coordination of the cancer program of the Department of Health, the Pennsylvania Cancer Society, the Philadelphia Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania. These groups have all been completely coordinated as a result of the efforts of Chairman Martin Kleckner. A meeting was held under Senator Chapman's (Dr. Chapman) leadership attended by the Cancer Commission, the deans and chancellors of the medical schools, the Committee on Preventive Medicine and Public Health, and the Appropriations Committee of the House and Senate. The need for proper appropriations to the medical schools and the establishment of a school of preventive medicine, either in Philadelphia or Pittsburgh, or both, was considered necessary. Pools of valuable trained technicians and public health workers could thus be established to man these institutions. Mr. Fitzgerald, Chancellor of the University of Pittsburgh, said that this was the most historic meeting he had ever attended. Resolutions covering these advances would be in order.

During the past year, our society has contributed substantially to the work of the Woman's Auxiliary. This work should be continued. These splendid women wish to make that organization an effective weapon in our public relations program and they should receive both our active and financial support. They are peculiarly fitted to sense public opinion long before we, as individuals, appreciate what is going on. They should also take an active part in the work of the Committee on Defense of Medical Research. Powerful interests under the name of the prevention of cruelty to animals are attempting to prevent proper research from which everyone has benefited. To prevent qualified research

scientists from carrying on their important work would be criminal. The cooperation of the Woman's Auxiliary can be very useful in the continuation of this research. A resolution from this House concerning the humane use of animals for medical research purposes is in order.

One hundred years of service to the citizens of this Commonwealth by The Medical Society of the State of Pennsylvania is being celebrated by us at this meeting. We are offering here a composite picture of our great accomplishments. The scientific program is an outstanding contribution to the success of this meeting, and to Dr. Bortz and his magnificent committee for their splendid year-long effort, our thanks is small reward. We can appreciate why he was given the highest honor by American medicine—President of the American Medical Association.

Many physicians criticize the action or lack of action on certain problems by both The Medical Society of the State of Pennsylvania and the American Medical Association. This must be due to a complete lack of knowledge of the constitutional make-up of both organizations. The basis of all the activity of the medical profession is the county medical society. Its meetings are a "must" for every physician. The state society is a federation of county societies and the A. M. A. is a federation of state societies. Actions depend on the support and vote of the majority of the elected delegates assembled in annual or properly called meetings. The authority for every action of federated medicine originates not from the top but from the bottom. A physician gets an idea, talks it over with his fellow practitioners, they take it up with the county society, and a resolution is passed or defeated there. If the resolution is passed by a county society, it is sent to the annual meeting of the delegates from all the other county medical societies which comprise the state society, and there it is passed or defeated. The state society can do only those things which the majority of the county society delegates authorize—no more—no less.

Our state and national organizations have been severely criticized for not taking disciplinary measures against physicians or related organizations connected with medicine. It is the function of the county society to examine the evidence, and if an individual physician has violated the Code of Ethics and refuses to mend his ways, he may be expelled. Even this action has been challenged by the courts as an act to restrain trade. Several years ago, the largest county medical society in the world so disciplined one of its members; he took the decision to the courts and the county medical society was obliged to return the erring physician to his former status as a member in good standing. This does not mean that the county society does not have the obligation to try and settle these problems, but certainly it is not the function of your state or national groups.

There is only one way to clean our own house. Each physician should be above the sordid things which can so easily creep into the practice of medicine, such as unnecessary operations, overcharging those who can least afford to pay, refusing to answer emergency calls, fec-splitting, et cetera. One weak, selfish, unethical physician can really ruin a public relations program. This problem belongs to the county society. Individuals must have the courage to sit not in judgment of their fellow members but as counselors and friends to those who they may feel have either willfully or thoughtlessly slipped.

I would like to see each county society have a committee that would take the young men and women under their wing when they join the society, and make an honest effort to have these young folks realize that there is a right and a wrong way to practice medicine. We can help many of these people over the hard rocks ahead in the establishment of a practice. We can inculcate in them the fact that we do not live alone. We can help them in their problems, but above everything else we can bring them actively into the county medical society's work, and, once they have been shown the value of organizational cooperation, they will become valuable assets to themselves and the great profession to which they owe allegiance. My plea is for a thoughtful, helpful attitude toward all of these splendid young people who tomorrow will be the leaders of our profession.

At least on one occasion this House of Delegates has advised the county societies to assume another obligation. There are certain contractual relationships to which heretofore we have paid little attention. These take on increasing significance since we have become Blue Cross and Blue Shield minded. The Code of Ethics, specifically defining these relationships, states plainly that that which is for the public good is ethical. There have arisen grave misunderstandings and differences of opinion between individual physicians, groups of physicians, industrial organizations, governmental agencies, and hospitals concerning contractual agreements. These differences have been brought to the House of Delegates of the American Medical Association and to The Medical Society of the State of Pennsylvania. The problem belongs to the county society, which should act as a neutral arbitration board to bring both parties, professional and lay, together. It is important that their differences be settled amicably and to the satisfaction of the profession and those other groups with whom, for efficient public service, a contract of one kind or another seems necessary. If the county society feels for one reason or another that the debatable problem cannot be properly adjudicated at the county level, it should then be referred to a committee or commission from the state organization. Such a committee appointed at the state level should then be brought into the picture to act as an arbitration board, hoping that the controversy might be settled amicably to the satisfaction of all parties. The provision for such a commission is a featured part of the new Constitution and By-laws. In the county society, policies are discussed and decided. Here, community leadership in all health matters should be aggressive and constructive. Many communities are led in matters pertaining to health by lay individuals and groups, and the county medical society is seldom considered. The public does not think we are interested, and local governments side-step us in health and sickness matters. The county society should always cooperate with government and civic groups interested in the health problems which belong in their province. At times we medical men fail to cooperate with each other and it must be remembered that we are just human beings. Being physicians, I find, does not completely change human nature.

I would like to pay tribute to my own county society. It is an outstanding example of what a county society and its right arm, the Woman's Auxiliary, can do if they make up their minds that there is a job to be done and if they work together. The physician as an individual is the most beloved and respected man in the

community. Prove that confidence by offering further the outstanding leadership in your community.

[If I might extemporize for a moment, something has happened in Crawford County which requires at the moment medical leadership. A judge, at the request of some farmers who have cattle infected with Bang's disease, has granted an injunction against the state authorities that prevents the slaughtering of cattle with Bang's disease in Crawford County. This is a serious situation. This state medical society should support the efforts of the Crawford County Medical Society to see that the health laws of this state are obeyed. It is something for you to think about. Right now progressive leadership is needed.]

Politics: This is a crucial political year for us, and while the State Society cannot and should not specifically support any party, it is our individual obligation to register with the party of our choice and to vote. It is also our duty to know the legislative desires of our county, state and national medical organizations, so that we may consult with the political leadership at these levels on all matters pertaining to the health and sickness needs of the public. In the past, we have been good physicians but poor citizens. Government has a distinct role to play in matters pertaining to public health, but it is our belief that government should not interfere in the personal relationships between the patient and the physician. For that reason, we have opposed compulsory sickness insurance of any type. However, the threat of compulsory sickness insurance or socialized medicine is not dead, and we must always remember that the keystone of the communist arch is complete socialization and federal control of the medical profession. The practice of medicine has not changed. Things considered unethical twenty years ago are often today accepted procedures and our Code of Ethics must change gradually to meet new challenges. We object to radical but not to evolutionary change. We must always remember that that which is best for the public is ethical and we must be careful that any position which we take is legal as defined by our courts. This all is a part of politics and it becomes necessary for us to openly support the political leaders who believe in the evolutionary theory of life—social, economic, and political.

I would like to urge all of you to cooperate fully and be participating physicians in the Blue Cross-Blue Shield program. Our cooperation with both of these organizations is essential for the best interests of the public. I would oppose a national insurance company unless so advised by the House of Delegates of the American Medical Association.

Salaries: We have a rapidly expanding society program. We have many efficient and valuable employees, both professional and lay. The entire program costs money, and the trustees should thoroughly evaluate the allocation of our finances with extreme care. Our employees do not receive incomes comparable with many other medical organizations. This should be corrected. Young medical men with a flair for executive work should be sought and trained so that there will be no break in the continuity of our thinking nor the work in the higher executive fields. The salaries here, too, must be such that they will attract the type of men whom we would welcome as medical leaders. A resolution requesting careful study and re-evaluation of these salaries by the Board of Trustees would not be out of order.

The Press: Again, I wish to emphasize our dependence upon a favorable press. Last year I stressed proper publicity and cooperation with the gentlemen of the press. During the past year I invited the officers of my county society to dine with all of the members of the fourth estate in our county. At the end of a fine dinner, I told the officers and the representatives of the press the object of the invitation. I asked that the cards be placed on the table and that we all tell each other just what we thought of each other. I then turned the meeting over to Dr. Ralph E. Schmidt, who is chairman of our county public relations committee, as chairman of the meeting. It was a hot session. No punches were pulled, but we now understand each other thoroughly in Erie County, and as a result of that meeting the county society and the press have a relationship that never existed before. We cooperate with them and they in turn have become marvelous allies. This relationship should be cultivated all over the State. We have nothing to hide. They will be our friends if we let them in on the ground floor. We have proven our point in my county society and we can have a good press only if we deserve it and are willing to modernize our thinking in our relationship to the public. Again, I say that it is ethical if it is in the public interest.

To William Bates and his committee should go our thankful appreciation for the comprehensive job they have rendered in rewriting our constitution and by-laws. I wish to recommend to this House that it give careful and sympathetic consideration to their proposals. This is a time-consuming and monumental task. My personal request would be that the changes be approved as recommended by this committee.

The difference in the fiscal year of many county societies and that of the State Society has caused delays in many important cases and decisions. Dr. Petry called this to your attention last year. A resolution from this House of Delegates requesting that the county societies, wherever possible, change their by-laws so that their fiscal year conforms to that of the State Society is in order.

In conclusion, we and all the things we stand for have been challenged. Individually and collectively, we dare not ignore it, nor can we ignore the evolutionary changes which are bound to come. We have the dual role of providing professional services and good citizenship. Because a man has been chosen to lead for a brief period, it necessarily follows that if he be a good citizen he must still work and be active in the affairs of his fellowmen, both professional and lay. Too often, men have been so chosen and, after they have served in high office, feel that their work is done. They lose interest in their organizations, their objectives, and also in their civic organizations. We have also had many examples of continued devotion to this Society of men who like myself have been honored by you. Witness the many men who have been president of this great Society who still serve us.

Medicine has been more than good to me, and I owe it and you much. I shall endeavor to repay you for your confidence in me by serving you in any capacity that will be of benefit to The Medical Society of the State of Pennsylvania and to each individual practitioner in this organization.

My final plea to you is to train, indoctrinate, encourage, and help in any way you can those fine young men and women who each year become eligible to membership in the county societies and, through them,

strengthen the State Society. To my successor, Gil Engel, good luck. To you, my friends, never forget that if your efforts are always in the public interest, you serve yourselves, the profession, and the public as well. You must never compromise your principles.

SPEAKER BUCKMAN: The address of President Hess is referred to the Reference Committee on Reports of Officers and Standing Committees.

The next order of business is In Memoriam.

The members of the House stood during the reading of the report by Secretary Donaldson, as follows:

In Memoriam

Members of the House of Delegates of The Medical Society of the State of Pennsylvania who have passed away since the 1947 session of the House (the years following each name indicate the years they served in the House):

ALLEGHENY COUNTY: Amos W. Colcord, 1914, 1916, 1917; Arthur H. Gross, 1928-1935, 1938 (9 years); John A. Hawkins, 1914, 1915, 1920, 1921; Charles H. Henninger, 1927, 1930-1938, 1940-1947 (18 years); Alexander A. MacLachlan, 1917.

BUCKS COUNTY: Anthony F. Myers, 1917, 1920, 1923, 1929, 1935.

CHESTER COUNTY: Joseph Scattergood, Jr., 1935, 1936, 1938-1941 (6 years); William T. Sharpless, 1916, 1919, 1924, 1930.

DAUPHIN COUNTY: John B. McAlister, 1907-1911, 1917, 1918, 1926-1927, 1934 (10 years).

GREENE COUNTY: W. Sturgis Frankenburger, 1933, 1934, 1935, 1941.

HUNTINGDON COUNTY: Walter Orthner, 1936-1944 (9 years).

LACKAWANNA COUNTY: John J. Brennan, 1924-1935 (12 years).

LEHIGH COUNTY: Lawrence C. Milstead, 1935, 1939; Charles H. Muschlitz, 1919, 1929.

LUZERNE COUNTY: Samuel P. Mengel, 1917, 1923-1929, 1931 (9 years).

MERCER COUNTY: Frank M. Bleakney, 1917; Jonathan B. Perrine, 1934, 1936.

MONTGOMERY COUNTY: J. Newton Hunsberger, 1918-1944 (27 years).

PHILADELPHIA COUNTY: T. Turner Thomas, 1923, 1924, 1926.

SCHUYLKILL COUNTY: Edgar E. Shifferstine, 1933.

WASHINGTON COUNTY: G. Allen Perkins, 1946.

SPEAKER BUCKMAN: The following is the roster of reference committees of the House:

COMMITTEE ON CREDENTIALS

Fred B. Wilson, Beaver, *Chairman*
Dorothy C. Blechschmidt, Philadelphia
Thomas J. Lewis, Williamsport

COMMITTEE ON PLACE OF MEETING

John F. McCullough, Pittsburgh, *Chairman*
William J. Corcoran, Scranton
Joseph A. Parrish, Bellefonte

REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND STANDING COMMITTEES

Thomas W. McCreary, Rochester, *Chairman*
Frederick O. Zillessen, Easton
Charles L. Brown, Philadelphia

REFERENCE COMMITTEE ON SCIENTIFIC BUSINESS

Augustus S. Kech, Altoona, *Chairman*
 Henry F. Hunt, Danville
 Constantine P. Faller, Harrisburg

REFERENCE COMMITTEE ON NEW BUSINESS

John W. Fredette, Pittsburgh, *Chairman*
 James A. Biggins, Sharpsville
 Elwood T. Quinn, Jenkintown

REFERENCE COMMITTEE ON REVISION OF
CONSTITUTION AND BY-LAWS

Francis F. Borzell, Philadelphia, *Chairman*
 John W. Shirer, Pittsburgh
 Daniel Ritter, Johnstown
 L. Dale Johnson, Connellsville
 Walter E. Wentz, Jr., Media

Ex officio:

Elmer Hess, Erie
 Gilson Colby Engel, Philadelphia
 Lewis T. Buckman, Wilkes-Barre
 Walter F. Donaldson, Pittsburgh

The Speaker would refer to these several reference committees the reports of officers and standing committees and special committees and commissions in the following order as they were previously mailed to each reference committee member:

To the *Reference Committee on Reports of officers and Standing Committees* the reports of: Chairman of Board of Trustees, Secretary-Treasurer, Editor, Executive Secretary, Trustees and Councilors, Advisory Committee to Woman's Auxiliary, Committee on Archives, Centennial Celebration Committee, Committee on Defense of Medical Research, Delegates to American Medical Association, Committee on Graduate Education, Committee on Medical Benevolence, Committee on Mental Hygiene, Committee on Neurology, Committee on Psychiatric Services to Criminal Courts, Committee on Public Health Legislation (paragraphs 1, 2, 3, 4, 5, 6, 8, 9, 10), Committee on Public Relations, State Healing Arts Advisory Committee (paragraphs 3, 4, 5, 6), and Committee on Telephone Directory Classification.

To the *Reference Committee on Scientific Business* the reports of: Commission on Acute Appendicitis Mortality, Commission on Cancer, Committee on Child Health, Commission on Diabetes, Committee on Laboratories, Committee on Nutrition, Committee on Physical Medicine, Commission on Public Health and Preventive Medicine, Committee to Study Control of Rheumatic Fever, Commission on the Control of Syphilis and Venereal Disease, Committee on Tuberculosis, and Commission on Maternal Welfare (except concluding paragraph).

To the *Reference Committee on New Business* the reports of: Advisory Council of Medical Service, Committee on Conservation of Vision, Committee on Deafness Prevention and Amelioration, Commission on Industrial Health and Hygiene, Commission on Maternal Welfare (concluding paragraph), Committee on Medical Economics, Conference of Professional Licensees, Committee on Public Health Legislation (paragraphs 7, 11, 12, 13, 14), Advisory Committee to the State Board of Vocational Education, Bureau of Rehabilitation, Committee on Rural Medical Service, State Healing Arts Advisory Committee (paragraphs 1 and 2), and Committee on Workmen's Compensation Laws.

This brings us in the order of business to the reports of the officers. If the officers as they are called upon have reports additional to those published, this is the time to make them.

SECRETARY-TREASURER DONALDSON: No additional report, Mr. Speaker.

Supplemental Report of Chairman of
Board of Trustees

DR. PARK A. DECKARD, chairman of the Board of Trustees: I have a supplemental report from the Board of Trustees, as follows:

The Board of Trustees respectfully submits the following items for the careful consideration of and action by the House of Delegates:

1. A request received from the combined executive committees of the Philadelphia and Pittsburgh Societies of Anesthesiologists for the creation of a scientific section on Anesthesiology was referred by the Board of Trustees for action to the 1948 Committee on Scientific Work. The personnel of the latter committee includes the chairman and the secretary of each of our eleven existing scientific sections.

The request was accompanied by the information that there were at that time 125 doctors of medicine in Pennsylvania in the specialty of anesthesiology and several such residencies filled in hospitals throughout Pennsylvania.

The vote of the Scientific Work Committee was unanimously in favor of the authorization by the 1948 House of Delegates of the creation of a scientific Section on Anesthesiology.

2. The 1948 Committee on Scientific Work also recommends that a request referred to it by our Board of Trustees from the Section on Dermatology be granted. This will add to the title of that Section the words "and Syphilology," thus changing the name of the section to read "Section on Dermatology and Syphilology."

3. All members contemplating entry into military medical service in 1949 should pay their county and state medical society dues promptly, as usual, same to be refunded on satisfactory evidence that they entered such service before June 30, 1949.

4. Resolution—Volunteer or Be Drafted

WHEREAS, The 1948 House of Delegates of the American Medical Association at its meeting in June, 1948, took action calling upon state and county medical societies to exert every effort in their communities to insure that a sufficient number of physicians be encouraged to volunteer to serve their nation during this period of emergency, at the same time approving a program of priority for the activating or calling up of civilian medical personnel or units into the armed forces (see page 1, Official Transactions, in the hands of members of the 1948 House of Delegates of the MSSP, and page 1267, August PENNSYLVANIA MEDICAL JOURNAL), and

WHEREAS, Reliable information as of September 22 indicates that the medical department of the Army in need of a total, within the next three to five months, of 6900 doctors of medicine, has at present but 3000, including interns, and

WHEREAS, Response to the urgent request for action of the House of Delegates of the AMA last June has not been feasible until the present time, and

WHEREAS, The medical profession of Pennsylvania accepts, as it always has, the responsibility for providing its quota (currently estimated as 700) of qualified physicians necessary to give the best possible medical care to the officers and enlisted personnel of the nation's armed forces, and

WHEREAS, If young medical doctors do not volunteer in sufficient numbers, the Congress of the United States, when it again convenes in mid-January, 1949, will doubtless reinstate in the Selective Service Law provisions for "drafting" large numbers of them; and

WHEREAS, There are in Pennsylvania a number of physicians of the specified aged and training who for various reasons were not called for service during World War II; and

WHEREAS, There is also in Pennsylvania a large number of young, recently graduated physicians whose medical education

was paid for by the national government under the A.S.T.P. and V-12 program, but who were not called for service; now, therefore, be it

Resolved, That the Board of Trustees of The Medical Society of the State of Pennsylvania earnestly requests all such individuals to present themselves without delay to the proper officers of Army, Navy, or Air Force as candidates for commissions as medical officers in the armed forces, thus repaying the debt they owe the nation as citizens and as beneficiaries of the program by which their medical educations were conferred on them;

Also, that the Board of Trustees of The Medical Society of the State of Pennsylvania urges all physicians who as hospital or school administrators, as directors of clinics, or of laboratories or in similar capacities, have any individuals referred to on their staffs or faculties or as assistants or residents, to promptly make them available for military medical service and to urge them to volunteer for such service.

I also have a resolution that was presented by President-elect Engel to the Board of Trustees to be presented to the House of Delegates:

Resolution

WHEREAS, In recent years the official duties and demands on the time of the president and president-elect of The Medical Society of the State of Pennsylvania have continuously and constantly increased; and,

WHEREAS, The death of the president of the Society would be followed by the elevation to that office of the first vice-president of The Medical Society of the State of Pennsylvania; therefore, be it

Resolved, That the Board of Trustees of The Medical Society of the State of Pennsylvania recommend to the House of Delegates of The Medical Society of the State of Pennsylvania that the dignity and importance of the office of vice-president of The Medical Society of the State of Pennsylvania be duly considered and properly recognized in the process of nominating and electing members of the Society to that office.

SPEAKER BUCKMAN: The Chair will refer the first two paragraphs of the supplemental report from the Board of Trustees to the Reference Committee on Scientific Business.

Paragraph 3 is a comment of the Board which does not require referral. Paragraph 4 is a series of resolutions regarding medical service and that will be referred to the Reference Committee on New Business.

The final resolution presented by Dr. Engel through the Board will be referred to the Reference Committee on Reports of Officers and Standing Committees.

This brings us to additional reports of the several trustees and councilors. Instead of going through the list, I will ask if anyone of the twelve trustees and councilors has an additional report to make. This is the opportunity for him to ask for the floor. None!

That brings us, then, to the supplemental or additional reports to be received from the several committees and commissions. The Chair will recognize Dr. Palmer, chairman of the Committee on Public Health Legislation, to present his report. Dr. Palmer is entitled to ten minutes of verbal presentation, in accordance with the by-laws adopted last year, he having previously placed in your hands the mimeographed sheets containing the entire supplemental report.

Supplemental Report of Committee on Public Health Legislation (Appendix A, Page 284)

SPEAKER BUCKMAN: Of this supplemental report, we have assigned to the Reference Committee on Reports of Officers and Standing Committees paragraphs 1, 4, 8, 19 and 20, 24 and 25; to the Reference Committee on New Business, paragraphs 7, 15, 17, and 23.

Since Dr. Palmer's committee does not ask for immediate action on paragraphs 16, 18, 21 and 22, they are not referred to any reference committee, which brings us to the supplemental report of the Committee on Public Relations. The Chair recognizes Dr. Howard K. Petry, chairman.

Supplemental Report of Committee on Public Relations (Appendix B, Page 290)

SPEAKER BUCKMAN: This supplemental report has been referred to the Reference Committee on Reports of Officers and Standing Committees.

Are there additional supplemental reports?

[The Speaker called on all officers and committees in the order named in The Order of Business, and the following supplemental reports were presented.]

SPEAKER BUCKMAN: The Chair recognizes Dr. Louis W. Jones, chairman of the Committee on Medical Economics.

Supplemental Report of Committee on Medical Economics

DR. LOUIS W. JONES: Col. J. C. Harding and Dr. W. A. Jacques of the Veterans Administration met with Dr. Gilson Colby Engel, president-elect of The Medical Society of the State of Pennsylvania, and myself in Philadelphia, Sept. 19, 1948. Each of the approximately 160 fee items in dispute was thoroughly discussed and agreement was reached on every item. A few of our proposed fees seemed excessive when compared to the fees charged in other states for similar services and these fees in our schedule were accordingly reduced. Ninety-five per cent of the fees in dispute were found by all of us to be equitable charges and were approved in full by the Medical Department heads of the Veterans Administration. This would seem like "peace in our times."

Since all fee schedules and contract agreements have been removed from the hands of the Medical Department and been assigned to the Office of Supply in Washington, it now remains for the Medical Department to see that the Office of Supply approves both the fee schedule and the modified agreement form No. 2. This will of necessity take some time, and it was agreed by all present to extend our present agreement unchanged for another period of ninety days. The committee requests approval of its labors with the Veterans Administration.

As instructed by the Board of Trustees, the committee gave careful consideration to the request of the National Foundation for Poliomyelitis for the formation of a statewide fee schedule for the treatment of indigent and semi-indigent polio victims aided by the Foundation, and concluded as follows:

Inasmuch as the National Foundation for Infantile Paralysis has already approved the policy of paying hospitals, nurses, physical therapists, and occupational therapists, at their local actual rate, we believe that physicians should be reimbursed at their local prevailing rate and, therefore, we do not recommend the formation of a statewide fee schedule for the National Foundation for Infantile Paralysis at this time.

The committee will continue to study this problem in connection with a fee schedule for all governmental agencies.

SPEAKER BUCKMAN: This supplemental report is referred to the Reference Committee on New Business.

DR. PALMER: There is a supplemental report from the State Healing Arts Advisory Committee, which Dr. Appel, of Lancaster, can give.

SPEAKER BUCKMAN: The Chair recognizes Dr. James Z. Appel.

Supplemental Report of State Healing Arts Advisory Committee (Appendix C, Page 290)

SPEAKER BUCKMAN: This supplemental report is referred to the Reference Committee on New Business.

Is there any further report from the delegates to the American Medical Association?

DR. PALMER: Mr. Speaker, there is a supplemental report from the Committee on Conservation of Vision. The chairman of that committee is not a member of the House of Delegates.

SPEAKER BUCKMAN: Is there any member of the Committee on Conservation of Vision prepared to present this supplemental report? If not, the Chair will ask Dr. Palmer to present it.

Supplemental Report of Committee on Conservation of Vision

DR. PALMER: The Committee on Conservation of Vision wishes to present to the House of Delegates as a supplemental report a resolution passed by the Blair County Medical Society at their regular meeting held Sept. 28, 1948.

Resolution

WHEREAS, The greatest asset of Pennsylvania is the school child; and

WHEREAS, The present law requires a complete examination of all school children, according to Act 174 of the Pennsylvania State Legislature, 1945; and

WHEREAS, The proper examination and correction of eye defects in children is probably the most important part of this examination and should be done only by a trained recognized ophthalmologist; therefore, be it

Resolved, That the House of Delegates make every effort to change this Act 174 to read "recognized ophthalmologists" instead of "recognized ophthalmologists or optometrists," with the approval of the school medical examiner.

SPEAKER BUCKMAN: We will refer this to the Reference Committee on New Business.

The Chair recognizes Dr. Louis W. Jones.

Supplemental Report on Proposed Fee Schedule for All Governmental Agencies

DR. JONES: This is a progress report concerning the proposed fee schedule for all governmental agencies. The matter was assigned to the Committees on Medical Economics, Public Health Legislation, and Public Relations by the 1946 House of Delegates.

The chairmen of these three committees have compiled a list of items from the fee schedules endorsed by approved connections of The Medical Society of the State of Pennsylvania with the Department of Public Assistance, Medical Service Association, Veterans Administration, and the Bureau of Vocational Rehabilitation. This compilation is the result of a request from your chairman of the Committee on Medical Economics, for the purpose of comparing the fees of these different fee schedules.

It is evident that there are many discrepancies. While the VA and the Vocational Rehabilitation fee schedules consist of similar items, the Department of Public Assistance and MSAP fee schedules do not. Therefore, it is understandable that a list endeavoring to compare the four fee schedules could not be accurate.

The Committee on Medical Economics has been informed, and its chairman, Dr. Jones, has on several occasions reported to the Board of Trustees of the State Medical Society that the VA and the Committee on Medical Economics have not as yet agreed on a new fee schedule.

After several months of study by the VA, the original approved fee schedule was not acceptable to them,

and on several occasions they have requested a reconsideration and suggested changes, which have not as yet been acceptable to the Committee on Medical Economics. (Later accepted; see page 278.)

Until an approved fee schedule is developed with the VA, it seems futile to draft a fee schedule for all governmental agencies; therefore, the members of the three committees, after careful consideration, are of the opinion that they can only report progress regarding such a fee schedule and, until final approval is obtained from the VA, recommend that the matter remain as it is.

The members of these three committees believe that consideration of the question of a fee schedule for governmental agencies should be continued.

SPEAKER BUCKMAN: This matter is referred to the Reference Committee on Reports of Officers and Standing Committees.

Gentlemen, doubtless there are several who have resolutions they would like to present. We will be very glad to receive them in due course. However, we are honored today by the presence of distinguished visitors. The Chair suggests that the order of the day be set aside at the moment and the House give the Chair permission to recognize the several guests.

DR. GEORGE L. LAVERTY: I so move.

[The motion was seconded by Dr. Frederick O. Zillesen, Easton, put to a vote, and carried.]

SPEAKER BUCKMAN: The order of the day is set aside temporarily.

From Schuylkill County we have a member of our society who is a member of Congress—the House of Representatives. The Chair will ask Dr. Charles V. Hogan, trustee and councilor of the Fourth Council District, to bring this guest before us at this time.

DR. CHARLES V. HOGAN (Pottsville): It is a distinct pleasure to me to present the gentleman who has just been escorted to the platform. He is a member of the Schuylkill County Medical Society in good standing. He represents the Twelfth Congressional District of Pennsylvania, which includes the counties of Schuylkill and Northumberland. He has had ten years of service in the House of Representatives. He is now a very important member of the House Appropriations Committee. He has been the friend of organized medicine not only in the State of Pennsylvania but in the Congress as well. Last July he attended the World Health Conference at Geneva, Switzerland. He served as the official adviser of the delegation selected by the Congress of the United States.

I am very happy to present to you now Dr. Ivor D. Fenton, member of Congress from the Twelfth Congressional District of Pennsylvania.

Address of Congressman Fenton (Appendix D, Page 292)

SPEAKER BUCKMAN: Thank you, Dr. Fenton, for a very graphic description of the World Health Organization work.

The House will stand in recess for two minutes.

[Recess]

SPEAKER BUCKMAN: The House will please come to order.

Gentlemen of the House, the Medical Service Association of Pennsylvania petitioned the Board of Trustees of The Medical Society of the State of Pennsylvania to ask the House of Delegates to receive a representative of the Associated Medical Care Plans. As a

consequence, you have this morning the opportunity to hear Dr. Paul R. Hawley, who is the executive officer of the A.M.C.P. It is my pleasure and privilege at this time to introduce to you, and to ask to make a few remarks, General Hawley.

Dr. Hawley's Address

DR. PAUL R. HAWLEY: Mr. Speaker, Members of the House: I appreciate very much receiving this morning the privilege of your floor. I want to congratulate you upon one hundred years of organized medicine in the State of Pennsylvania. In that hundred years, and for a time before that, until quite recently, the pattern of medical economics was practically unchanged. There have come changes in the last few years, changes caused primarily by changes in medical practice, by changes in the scope of medical practice. Fifty years ago and before, the medical practice and equipment brought to the sick man ordinarily was largely the doctor with his eyes and his ears, his hands and his brain, and perhaps a stethoscope, and, where surgery was needed, a blood-letting lancet or scalpel. Hospitals took care only of indigents. Surgery was done in the home, even major surgery; but the amount of major surgery was limited by many things—limited by a lack of knowledge of asepsis, by limited anesthesia, and by many other factors.

Since medical practice was so simple and its scope so limited, medical costs were comparably low and people had on the whole not much difficulty in meeting them. Now, with the advances of medicine, now with the doctor himself demanding, and quite properly, that the serious cases be treated in hospitals, with expensive equipment and with all of the new and fine things that have come into medicine, the cost to the patient has risen very, very greatly. It has reached a point where even to the middle income groups it is a difficult cost to bear when it strikes suddenly.

In the early days of this state, in the early days of this country, people built cabins of logs. That was their home. If disaster overtook that home in the shape of fire or wind and the home was destroyed, there was not much material loss. The man himself, and with the help of his neighbors, could erect a similar home within two, three or four days, and there was little money expended. Now, as homes have become better and as houses have become expensive through the introduction of equipment that adds to comfort, if a man's house burns down now, it is a loss that few of us like to bear, even though we can bear it. I have no doubt that with the present incomes of physicians, the great majority of you gentlemen own your own homes. I have no doubt that you could replace them if they burned overnight, and yet I have not the slightest doubt that all of you carry insurance on those homes, not for the reason that you could not replace them if they burned down but because that sudden cost would be a great blow; and so you spread the cost of this new home over a period of years in the form of insurance.

So far as I know, medical care is the only absolute necessity in life the costs of which cannot be predicted. We know even with rising costs what food for ourselves and our families will cost in the next few months, in the next year. We know how much clothing will cost. We know how much rent will be within reason, and yet the other great necessity for existence, the necessity of medical care, no one can predict how much it is going to cost him next week, next month, or next year. It stands in the same position as a home in respect to insurance.

Whether or not the prepayment of health costs is a proper thing in our economy is no longer a decision of the medical profession. It is no longer a decision of anyone, because it has been decided by a very large and an increasing segment of our population that they will pay their medical costs in that way. The question now is, how? We have commercial carriers. Many people in our population do not like indemnity insurance. I shan't go into the shortcomings of indemnity, except to say that the American working man today realizes that a \$20 bill is only worth a fraction of a cent of what it formerly was and that its value is only what it can be exchanged for. He, in his negotiations with management for wages, is taking that into consideration. He has received in the past three or four years the greatest lesson in economics that he has ever had in our history.

It has been argued that the consumer himself should form a mutual association for the prepayment of medical care, such as there are, especially in the Middle West, large cooperative fire insurance associations. These mutual cooperatives have the great advantage of low cost. The cost of such cooperative insurance with selected risks rarely exceeds 60 per cent of the cost of insurance carried by commercial carriers. So there is a great advantage to the consumer in such a mutual cooperative. However, there is a great disadvantage to him and to medicine in that such a mutual cooperation would have no medical direction, and it must be accepted that eventually whatever agency pays for the cost of medical care—I am not talking about the individual, but the agency through which he operates—will have a great and profound influence upon medical practice. So that, I think, is the reason why the only solution acceptable to medicine, the only solution which will advance the future of medicine, is one of a medically sponsored plan. A medically sponsored plan is a medically controlled plan.

I can see no basic objection to physicians themselves organizing a plan for the public. I think that medicine has a responsibility not only to furnish the highest class of medical care but also to see that it is made available to the greatest possible number of people. In one way or another, medicine has always assisted the patient in paying his bills. My grandfather's account books show entries of corn and of hogs. His farmer patients back 104 years ago, when he started to practice medicine, unable to pay in cash and wanting to pay, paid their bills that way. Their bills were cheap because those books are full of entries such as "To one office visit, one bit"—twelve and one-half cents, and that probably included the medicine, too.

They also have assisted their patients to pay by accepting installments on their bills. I can see little difference in taking installments from a patient after his medical care has been rendered and in permitting him to pay his money into a physicians' controlled plan before the need for medical care arises.

However, quite recently, a new factor has arisen in prepayment insurance. The National Labor Relations Board has recognized this in a decision that health and welfare funds are a proper item for negotiation between labor and management, and that shows the pressure of large organized groups of working men in this country for such funds that will give them protection against disease and some assurance against unemployment.

Mr. Oscar Ewing's recent National Health Assembly report, which many of you have seen, is obviously faulty in many, many things. He did say something, however, with which millions of people in this country

who are now organized agree: The voluntary prepayment plans are not doing a full job. Everyone recognizes that within their limitations they are doing a good job, but it is not good enough for the future with these great groups of employed persons coming into the field for them.

What is wrong with them? I shan't bore you with a long dissertation; you will all have, if you have not had, a copy of the proposals for the correction of this.

I want to tell you what is happening right now in negotiations with the United Automobile Workers for protection of Ford employees across the country. There are more than 200,000 such employees. Proposals have been made to us to enroll everyone of the Ford employees across the country. The Michigan Medical Service and Michigan Hospital Service benefits are fully acceptable to all of their employees nation wide, but there are places in the country—specifically Memphis and Louisville where there are many Ford employees—where they are writing in to the automobile workers and saying, "We want no part of this. We want the same benefits the Ford employees have in Michigan. We are perfectly satisfied with the benefits in Michigan, but we are not satisfied with the benefits offered in this area."

Many plans are not in a position to increase either their premiums or their benefits. There is a great necessity for some organization that can coordinate these without in any way interfering with the autonomy of any plan.

There have been objections raised against this national plan, but I have yet to hear a specific one. The objections are couched in such vague generalities that they are very difficult to answer. One is "there is no need in my county or in my state—it won't benefit my state or my county." While I hope devoutly that forestalling the socialization of medicine is not the principal objective of prepayment medical insurance on a voluntary scale, I do think that it is something that cannot be overlooked. I would point out that in no county of the United States is there a demand for socialization within the county. In very few states has there been a demand which has ever reached the state legislature; California is one exception. They have had to fight it on a state level in California. But the threat is national, and if it succeeds nationally, it backs up into the state and into the county. So whether or not any such plan would be of direct benefit to a county or a state is not the whole problem because the threat to medicine is national.

Another objection is that we are going out after labor and labor will dictate. Well, that is absurd. Labor will never dictate to medicine. Medicine will listen to the demands of labor and then tell labor how much prepayment is feasible and what is not feasible.

It is obviously impossible to give complete medical care at any price anyone can pay. The Saskatchewan Plan with its funny system of bookkeeping, as near as we can make out, charged families \$15 per month and then lost sixty million dollars last year, which was made up in taxes.

There are many people who run to the office, whether or not they even have a pain, just to talk to the doctor. And when you talk about complete coverage for all medical costs, you are getting into astronomical figures. Labor has demanded that, but labor can't get that except through a government plan in which the great bulk of the money is contributed from taxes.

It has been said that if this plan works, it will in-

crease the demand for socialization of medicine. I am completely unable to understand that argument. To me it seems to say that if a baker bakes better bread, wholly satisfactory to his customers, it will increase their demand for hardtack.

It is also said that the plan will create a bureaucracy as bad or worse than that of a government, but the plan proposed for the national organization is one completely controlled by local plans, and when they get tired of the direction in which it is going, they only have to pull on the reins, set it back on its haunches and back on the track. But nobody has any intention of getting out of line.

Not a Merger

Finally, it has been said that there is a merger of Blue Cross and Blue Shield. There is no merger at all. It is the kind of an association that competitors in industry organize for their mutual benefit. It is the kind of an association that the fire underwriters have organized whereby one laboratory works out the problems common to all fire insurance companies, or like the National Canners' Association which supports a laboratory to improve methods of canning which all of the members use.

The proposals do not make a perfect document, but they are as perfect as the people who prepared them could make them. They include many compromises. The objection offered in the past was that all compromises tend to weaken documents. This plan is a splendid starting point. It can be changed as experience indicates and it is controlled at the grass roots of these local, state, and other local service plans. It is not a document that is binding for ten years, twenty years, or five years; it is binding for only one year, so we can't go very far astray.

I have been associated with the Blue Shield Commission, which you people elect, for about six months now. I never hoped to be associated with men of more honesty and more integrity. You must have confidence in the people whom you elect to these commissions.

My own interest in this matter is primarily and fundamentally as a physician. I wouldn't say this to any other group because it might be misunderstood. I am primarily concerned with the future of medicine in this country. It is the greatest medicine in the world, and nothing can be permitted to happen which will check its progress. As a human being I am obviously interested in better distribution of medical care, but my primary interest here is the advancement of medicine.

I would point out to you that I get letters from many friends in England, and English medicine is in a sad, serious state today. They all tell me that the only reason medicine is socialized today in England is that the British Medical Association had no alternative plan. All they did was say, "No, no; we don't like this. We don't like that." They have never come up with an alternative plan. I would point out to you that the people who are fighting Associated Medical Care Plans have yet themselves to come up with an alternate plan. If they have something better, let's say it is better and let's do something; but you can't fight socialization of medicine by saying no.

I have talked recently to many friends of medicine in Congress, both in the Senate and the House. I am sure if Dr. Fenton is in the room, he will agree with what they say. They say, "We don't want socialization of medicine, but we must have a weapon to fight it. We must have something to offer that is better than the socialization of medicine."

We can't continue to say, "No, no; we just don't want it," because the public demand for better distribution of medical care is becoming too intense to be ignored by our representatives in Congress. They must have something better to offer.

As an individual, at this time and before this body, I renew my pledge of loyalty to the best interests of medicine, and if ever I discover any trend in this movement which is not in the best interests of medicine or which is an effort to evade the wishes of the practitioners of medicine, you may rely on me to quit immediately. Thank you!

SPEAKER BUCKMAN: Thank you, too, Dr. Hawley.

We have here a representative of the Board of Trustees of the American Medical Association. I will ask Dr. Borzell to present him to the Chair and to the House.

DR. FRANCIS F. BORZELL (Philadelphia): Mr. Speaker, Fellow Delegates of The Medical Society of the State of Pennsylvania: It gives me unusual pleasure to have this opportunity to present to you on the occasion of our centennial the official representative of the Board of Trustees of the American Medical Association in the person of Dr. James R. Miller, who, as you heard, was one of the delegates from the United States to the World Medical Association, of which Congressman Fenton spoke. Dr. Miller is a member of the AMA Board of Trustees.

I met Dr. Henderson, chairman of the Board, at Chicago Saturday morning. He regrets exceedingly that he cannot be here, but Dr. Miller has flown in this afternoon so that he may present the official greetings of the Board of Trustees of the American Medical Association.

Dr. Miller!

DR. JAMES R. MILLER: Mr. Speaker, Mr. President, General Hawley, Congressman Fenton—if he is here, I would like to address him, too, because I came to admire him and respect his judgment and accomplishments recently in Geneva: I do bring you the hearty greetings of the Board of Trustees. We had a meeting only three or four days ago, and from early morning until late at night—and I mean late at night—we were laboring, we hope, in your behalf. Dr. Henderson, Dr. Sensenich, and others might well be with you, but they have been going about the world tending to your business.

As Dr. Fenton has said, American medicine is in a strategic position in the world today. At the meeting in Geneva of the World Medical Association I am told that the delegates from medical associations, men and women such as you, with one accord laid out a program of twelve points, which will shortly appear in the *Journal*, which might well have been drafted by our own House of Delegates. They are not happy under the circumstances in which they find themselves. Many other common grounds were explored.

Our AMA delegates are recently back from Japan. With the exception of the World Medical Association, all of these trips are not at the expense of the American Medical Association; they were paid for by the United States Government in one form or another. I take it as a good omen that a representative of the American Medical Association was desired as a full delegate, one of the three official delegates of the World Health Organization. I was not specifically chosen at first. I think they wanted Dr. George Lull. Dr. Tom Routley, whom many of you know and who is execu-

utive secretary of the Canadian Medical Association, has been in the World Health Organization from the start and is one of its most effective members. He told me recently that he was glad I was there as a practicing physician because he had been rather lonesome. He is not truly a practicing physician, but does represent them. Being a staunch Rotarian for many years, he said that recently, in addressing the Rotary Club in London, he was introduced by his opposite, Dr. Charles Hill, of the British Medical Association. Dr. Hill said, "Dr. Routley is recently back from a meeting of the Interim Commission of the World Health Organization in Paris. He represents there his country as its official representative. Such a state of affairs in this country" (that is in England) "would be unthinkable. The Health Ministry wouldn't trust me to post a letter for them."

That, of course, was at the height of the fight between the British Medical Association and the Health Ministry. It points up, however, the fact that I as a member of the official family was one of the official delegates and not an observer sitting on the sidelines. I think there is hope and recognition of the part that practicing physicians must play in public health work. I personally look forward to the day when every public health officer is a physician and every physician discharges to the full limit of his ability his obligations to the public health. Thank you!

SPEAKER BUCKMAN: Thank you, Dr. Miller. We appreciate these greetings and good words from the Board of Trustees of the American Medical Association.

It is always a pleasure to welcome a representative of our neighboring state to the north. I would ask the House now to hear a few words from Dr. J. Stanley Kenney, of the Medical Society of the State of New York. Dr. Kenney!

DR. J. STANLEY KENNEY: Mr. Speaker, Dr. Hess, Distinguished Guests and Members of the House of Delegates: It was my privilege a year ago to represent New York State at your meeting in Pittsburgh, which I enjoyed thoroughly and which gave me a great many good thoughts which I tried to translate into action in New York County, if not in New York State.

I am here as a pinch-hitter today, gentlemen. Dr. Leo Simpson, the president of our state medical society, had fully intended to be here. He will be here before your meeting is over. Also, Dr. Walter Anderton, our secretary, intended to be here. Dr. Anderton was called to Rochester rather suddenly yesterday and asked me if I would represent him here and convey to you the greetings from both the president and the secretary of the Medical Society of the State of New York. I wish to take this occasion to do so. I know you have a great deal to accomplish in the short time at your disposal. I was greatly impressed this morning by the remarks of your president, Dr. Hess, particularly with the story of his stewardship and his recommendations for more activity, more responsibility, and more initiative at the county level. We have sixty-two counties in our state, many of them rural. To accomplish the purposes of the state society, those of us on the Council in New York and directors of the various bureaus find it very difficult sometimes to get the cooperation needed from the county societies. I want to add my few words to what Dr. Hess has said in that particular regard.

I realize this is a very momentous occasion for Pennsylvania, celebrating its hundred years of achievement

and progress, and that you all look to the future with great hopes, despite the disruption, the chaos and unhappiness that prevail in the world today.

We have many joint problems as neighboring states. New York and Pennsylvania are large states. Maryland, Delaware, and New Jersey are important states, if not so large. I just venture to express my own personal opinion—nothing official—that a little more co-operation and more conferences might follow if representatives of these five states met occasionally to discuss problems that definitely overlap state lines. You know what many of them are—the problem of which Dr. Hawley spoke, the blood banks, the workmen's compensation, Veterans Administration affairs, and many others. I believe such a conference group exists in New England. I am sure that much could be accomplished along such lines.

You saw me walk up here with a great sheaf of papers. I find among these papers copies of five or six rather important addresses that I heard in Chicago about three weeks ago at the National Conference of the Professions. They bring out very clearly and very philosophically as well as realistically the problems that confront us in the field of medical care programs, and especially the socialized medicine bugaboo which Dr. Hess reminded you was not dead. If any of you care to get copies of these papers, all you need to do is write to the offices of the National Physicians Committee, 75 E. Wacker Drive, Chicago (1), Ill. They will send you the whole group without any cost to yourself. They are well worth a postal card to get, particularly the talk by Dr. Lexeson Jones, of New Zealand, who has lived eleven years under the socialized sickness service program there; the talk of Mr. Cannon, the editor of the *Christian Science Monitor*; of Congressman Busby, and of Mr. Stuart Hayden, who is or was the foreign relations editor of the *Scripps-Howard* newspapers in Washington.

Gentlemen, with these remarks I again felicitate you on your hundred years and I wish you the greatest success in the days to come, when I know we all have so many mutual problems to solve and to resolve in the interests of the public.

SPEAKER BUCKMAN: Thank you, Dr. Kenney! I think I will not be out of order if I suggest to Dr. Borzell that he send Dr. Kenney an invitation to attend the Middle Atlantic States Conference in Philadelphia this winter.

SPEAKER BUCKMAN: Gentlemen, it is nearly twelve-thirty. There are others who are our guests here, but I really feel that we should adjourn now for lunch. Before we adjourn, I will announce the meeting places of the several reference committees.

Are there any other announcements before adjournment?

Will someone offer a motion to adjourn, designating the hour and the first order of business?

DR. E. ARTHUR WHITNEY (Delaware): I move that we adjourn until two o'clock this afternoon to receive at that time the report from the Medical Service Association of Pennsylvania.

[The motion was seconded by Dr. Walter S. Cornell, of Philadelphia, was put to a vote, and carried.]

SPEAKER BUCKMAN: We are adjourned.

[The meeting adjourned at twelve-thirty o'clock.]

LEWIS T. BUCKMAN, *Speaker*,

WALTER F. DONALDSON, *Secretary-Treasurer*.

Monday Afternoon, Oct. 4, 1948

The House of Delegates convened at two-ten o'clock.

SPEAKER BUCKMAN: The Chair recognizes Dr. Wilson of the Committee on Credentials.

DR. FRED B. WILSON: Mr. Speaker, there is a quorum present.

SPEAKER BUCKMAN: There being no objection from the floor, we will dispense with the roll call and with the minutes of this morning's meeting.

The first business under the motion at the morning session was the reception of the report from Dr. Daugherty, president of the Medical Service Association of Pennsylvania. This is presented on recommendation of the Board of Trustees through the request of MSAP. The Chair recognizes Dr. J. Arthur Daugherty.

Report of MSAP (see Appendix E, page 294)

SPEAKER BUCKMAN: What is the pleasure of the House in regard to this report from a sponsored organization?

DR. GUY H. MCKINSTRY [Washington]: I move that the report be received.

[The motion was seconded by Dr. Roy W. Mohler, of Philadelphia, put to a vote, and carried.]

SPEAKER BUCKMAN: The report is received and referred to the Reference Committee on Reports of Officers and Standing Committees insofar as it refers to statistical matter on the return of funds to our society, and to the Reference Committee on New Business insofar as it refers to the enrollment of participating physicians.

It is the purpose of the Chair, as the first item under new business this afternoon, to call for a report from Dr. Bates' Committee on Revision of the Constitution and By-laws. If that is acceptable to the House and if we enter into that part of the business, it will immediately throw that proposed revision into amendment and debate.

I make these remarks to warn the House members that the opponents or proponents of the proposed revisions should be present at this time.

To revert to the order of the day, this morning at adjournment we were still receiving supplemental reports. The Chair will ask if there are any other supplemental reports to be received from committees, commissions, or officers.

Resolutions to be offered must be prepared and presented in triplicate. We are now ready to receive any resolutions.

DR. WALTER S. CORNELL [Philadelphia]: The Philadelphia County delegation has approved this resolution for presentation to this House of Delegates:

Resolution (1)

WHEREAS, There is ample evidence in the radical literature, supplemented in particular by research in hospitals, indicating that penicillin acts as a specific in the treatment of gonococcal infections in the eyes of the newborn; and

WHEREAS, Similar experience indicates that penicillin used locally in the eyes of the newborn is very effective in the prevention of ophthalmia neonatorum; and

WHEREAS, There was published in the *Journal of the American Medical Association* recently a statement by the United States Public Health Service that penicillin is probably better than silver nitrate in the prevention of ophthalmia neonatorum; and

WHEREAS, A Special Committee on the Prevention of Ophthalmia Neonatorum of the Philadelphia County Medical Society has recorded in its minutes that 1 per cent silver nitrate has very little or no value in the prevention of ophthalmia neonatorum; and

WHEREAS, A report made at a meeting of the Section of Ophthalmology of the British Medical Association at Cambridge, July 1 and 2, 1948, records that "it would appear that silver nitrate has little or no prophylactic value"; therefore, be it

Resolved, That the House of Delegates of The Medical Society of the State of Pennsylvania go on record as strongly favoring modification of previous resolutions of the Advisory Council of the Department of Health of the Commonwealth of Pennsylvania concerning ophthalmia neonatorum now in force to the end that modern proved antibiotic measures may be used against ophthalmia neonatorum as an alternative to the mandatory use of silver nitrate; and be it further

Resolved, That the Board of Trustees of The Medical Society of the State of Pennsylvania be instructed to so inform the Secretary of Health of the Commonwealth of Pennsylvania; and be it further

Resolved, That a copy of these resolutions be forwarded to the Secretary of the American Medical Association and that the delegates of The Medical Society of the State of Pennsylvania to the American Medical Association be instructed to present at the next session of the American Medical Association a resolution looking towards encouraging similar action in other states.

SPEAKER BUCKMAN: This is referred to the Committee on New Business.

DR. JOSEPH W. POST [Philadelphia]: The Philadelphia delegation desires me to submit the following resolution for your consideration:

Resolution (2)

WHEREAS, The Medical Practice Act of Pennsylvania, Section 410, states that the "Board of Medical Education and Licensure may for a definite or indefinite time . . . revoke or suspend the right to practice medicine and surgery in this State for any or all of the following reasons, to wit: the conviction in a State or Federal court of a crime involving moral turpitude . . ."; and

WHEREAS, It was publicly stated in the *Philadelphia Inquirer*, March 28, 1940, that Dr. Henry J. Schireson was convicted on or about March 28, 1940, in the United States District Court on charges of concealing assets in bankruptcy proceedings and making false oath to bankruptcy statements; and

WHEREAS, It was publicly stated in the *Philadelphia Evening Bulletin* of May 8, 1940, and also in the *Philadelphia Inquirer* of May 9, 1940, that Dr. Schireson was sentenced to two concurrent terms of eighteen months each in the Lewisburg Penitentiary; therefore, be it

Resolved, That the House of Delegates of The Medical Society of the State of Pennsylvania call the attention of the State Board of Medical Education and Licensure to these facts; and be it further

Resolved, That the House of Delegates urge the State Board to consider immediate steps towards the revocation of the medical license of this physician.

SPEAKER BUCKMAN: This is referred to the Reference Committee on New Business.

Are there any other resolutions?

DR. JOSEPH V. M. ROSS [Columbia]:

Resolution (3)

WHEREAS, The American Medical Association has condemned by formal resolution the practice of medicine by closed staff institutions which employ physicians on a salary basis, exploiting their services, and which thereby do practice medicine as institutions, the Columbia County Medical Society of the State of Pennsylvania hereby urges the adoption by The Medical Society of the State of Pennsylvania of a similar resolution so that such institutions as exist in this state might be informed that their practices are opposed to the efforts and policies of organized medicine and not contributory to the public weal; therefore, be it

Resolved, That whereas the American Medical Association has condemned by formal resolution the practice of medicine by closed staff institutions which employ physicians on a salary basis, exploiting their services, and which thereby do practice medicine as institutions, The Medical Society of the State of Pennsylvania reaffirms its endorsement of the policies of the American Medical Association in condemnation of institutions engaging in such practices.

SPEAKER BUCKMAN: This is referred to the Board of Trustees.

Are there any other resolutions? Any correspondence?

SECRETARY DONALDSON: None.

SPEAKER BUCKMAN: Which brings us to new business.

The Chair recognizes Dr. Bates, chairman of the committee created by the House of Delegates last year for the revision of the Constitution and By-laws. The Chair takes the position that the formal action of the House last year, ordering the revision of the Constitution and By-laws and creating a committee for the specific purpose of doing that, brings that project before us now definitely as an item of new business and not necessarily as amending the existing Constitution and By-laws. Therefore, it will be necessary for Dr. Bates to read only the articles, chapters, and sections of his committee's proposed revision as would stand as our future Constitution and By-laws, unless later amended, if adopted as he reads them. On that basis it is not necessary for him to read all the old parts, but at any time we can stop and explain the old parts and connect them up to the proposed revisions at the request of anyone from the floor.

At the close of each section or paragraph or article, he will stop and we will ask for any question or any further amendment from the floor. No ballot will be taken on this until the entire material has been read and presented to you and then moved for adoption by the committee or others.

Report of Committee on Revision of Constitution and By-laws

DR. WILLIAM BATES [Philadelphia]: Before taking this up, I want to express my appreciation for the help that was given in the committee's deliberations. Apparently we found a function for the Society's past presidents. Ex officio on this committee were past presidents Buckman and Donaldson. They didn't miss a meeting; they didn't miss a sentence or a comma. Past president Petry, who last year activated this study report, was also present at every meeting. The current president stimulated part of this work and the incoming president gave us some ideas. A lot of the changes are based on the Constitution and By-laws of the AMA recently adopted as a result of two years' work by our past president, Dr. Borzell. The committee that was named, with one exception, attended every meeting. I have never worked with a finer committee.

DR. BATES: You will find by following in the August PENNSYLVANIA MEDICAL JOURNAL or the printed Transactions distributed to all of you the old paragraphs and sections from which we are taking this material.

CONSTITUTION

ARTICLE I.—NAME

The name and title of this organization is The Medical Society of the State of Pennsylvania.

ARTICLE II.—PURPOSES OF THIS SOCIETY

The purposes of this Society shall be to federate the medical profession of the Commonwealth of Pennsylvania; to unite with similar state medical societies to form the American Medical Association; to extend medical knowledge and to advance medical science; to elevate and maintain the standards of medical education; to advocate and support the enactment of such legislation as will accrue to the health and well-being of the public; to enlighten and direct public opinion in regard to health and hygiene.

In Article III we have made a change; it will read as follows:

ARTICLE III.—COMPONENT SOCIETIES

Component societies shall be those county medical societies whose several constitutions and by-laws have been approved by this Society, and such approval shall continue unless further amendments to the county society constitutions and by-laws should conflict with provisions of the Constitution and By-laws of this Society.

SPEAKER BUCKMAN: Are there any questions or amendments to that proposed revision?

Proceed, Dr. Bates.

DR. BATES: In the new Constitution, Article IV, under Membership, Section 1, is entirely new.

ARTICLE IV.—MEMBERSHIP

SECTION 1.—The active members of this Society shall be citizens of the United States licensed to practice medicine in the Commonwealth of Pennsylvania, members in good standing in the component county medical societies, and whose annual assessments in this Society have been paid.

SPEAKER BUCKMAN: Are there any questions or amendments to that proposed revision?

DR. BATES: In Section 2 appears a new designation of our governing board—Board of Trustees and Councilors. Before, on a state level, they were known as trustees and locally they were known as councilors. On a state level, they were known as councilors only when they sat as a judiciary committee. The term was confusing and we have, therefore, combined the terms "Board of Trustees and Councilors."

DR. BATES:

SECTION 2.—Upon certification in due form of the office of the Secretary-Treasurer and elected by the Board of Trustees and Councilors, a member of this Society who has been a member for a continuous term of fifteen years, who is not less than sixty-five years of age, on request of his component county medical society, may be made an associate member provided he holds like membership in his component society as shall relieve him from the payment of annual assessment in his component society.

Let me pause there for an explanation. Don't get this confused now because it was formerly the description of an affiliate member. In the new Constitution of the American Medical Association they have reversed the terms Associate and Affiliate membership, and we have altered ours to correspond with it, which means that as you members go back to your county societies, you should advise them to change their local constitution and by-laws to correspond with those of the state and national societies.

[Dr. Bates continued the reading of Section 2 of Article IV, as follows:

An active member of this Society who is prevented from the practice of medicine by reason of illness or disability may, on annual certification by the component county medical society, be elected to associate membership by the Board of Trustees and Councilors in regular meeting. A component county society shall not be required to pay any annual assessment for an associate member. Associate members shall be privileged to participate in the scientific discussions of this Society; they shall receive the JOURNAL of The Medical Society of the State of Pennsylvania; they shall be eligible to the benefits of the Medical Benevolence Fund, but they shall not be entitled to the benefits of the Medical Defense Fund.]

SPEAKER BUCKMAN: Any questions or amendments to that proposed revision?

DR. EDWARD LYON, JR. [Lycoming]: It was the intent of the committee, I believe, that these associate members named first should have completed a continuous term of at least fifteen years immediately preceding application for associate membership.

DR. BATES: Making that read "a member of this Society who has been a member for a continuous term of fifteen years immediately preceding, who is not less than sixty-five years of age." It means whether or not the House wants to add the words "immediately preceding" to those fifteen years.

SPEAKER BUCKMAN: Dr. Lyon, do you offer that as an amendment?

DR. LYON: I do.

[The amendment was seconded by Dr. Francis F. Borzell, Philadelphia.]

SPEAKER BUCKMAN: The question is on insertion of the words "immediately preceding." Are you ready for the question?

[The motion was put to a voice vote, followed by a standing vote, and was carried.]

DR. BATES: In Section 3 may I call your attention again to this revision of terms; this concerned the former associate member section.

SECTION 3.—Affiliate members may be elected by the Board of Trustees and Councilors upon recommendation of the component society of the county in which they are located. They shall be chosen from those doctors of medicine who are citizens of the United States engaged in Pennsylvania in teaching, public health, research work, or holding positions in the Federal Service, or serving hospital residencies. They shall be doctors of medicine not holding license to practice in Pennsylvania and such membership shall end with termination of such status within Pennsylvania. Affiliate members shall have all the rights and privileges of active members except the right to vote, to hold office, and to benefits of the Medical Defense and Benevolence Funds. The annual assessment of affiliate members shall be one-half the annual assessment of active members.

SPEAKER BUCKMAN: Are there any questions or amendments to be offered?

DR. BATES: In Section 4 we have changed the first line; instead of the original word "physician" we use the term "doctor of medicine."

SECTION 4.—Any doctor of medicine not a resident of this state but a member of his own state or territorial medical association may be elected an honorary member of this Society by the House of Delegates by a three-fourths vote at any annual session. Not more than two may be thus elected in any one year.

SPEAKER BUCKMAN: Any amendment or addition to this section? Proceed!

DR. BATES: The next has to do with a change of dates.

SECTION 5.—Members whose annual assessments are received by the Secretary-Treasurer of this Society on or before March 1 shall be entitled to all the privileges of this Society for the current year. One whose assessment is received after March 1 shall not be entitled to any benefit from the Medical Defense Fund from January 1 to the date of the receipt by the Secretary-

Treasurer of this Society of his name and assessment. The assessment of new members, elected and reported between July 1 and November 1, shall be one-half the annual assessment. Assessments received for new members elected and reported in November or December shall be the full annual assessment, which shall cover the assessment for the following calendar year.

SPEAKER BUCKMAN: The effect of this change is to move the date up from March 31 to March 1. Any other change or amendment? Any question? Proceed!

DR. BATES: Section 6 remains as Section 6 in the printed notice.

SECTION 6.—Each member in attendance at the annual session of this Society shall enter his name on a registration blank, indicating the component county medical society of which he is a member. When his right to membership has been verified by the official Roster of this Society, he shall have a right to all the privileges of membership at that session. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section.

In Section 7 we have some changes.

SECTION 7.—Any person who is under sentence of suspension or expulsion from a component county medical society, or whose name has been dropped from its roll of members, or whose license to practice medicine has been revoked, shall not be entitled to any of the rights or benefits of this Society, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.

We have added this paragraph:

Any member who has been convicted by a court of an offense making liable the revocation of his medical license may be dropped from the roll of members of this Society by action of the Board of Trustees and Councilors (acting as judicial council) even though such possible revocation has not yet been accomplished.

SPEAKER BUCKMAN: Are there any questions or further amendments? Proceed!

DR. BATES: In Section 8 there is one word substituted in the last line—"activities."

SECTION 8.—Delegates to this Society from any state society entitled to representation in the American Medical Association shall, by presenting certificates of delegation duly signed, be entitled to seats and to participate only in the scientific activities of this Society.

SPEAKER BUCKMAN: It is a change of the word, "business" to "activities." Any other change or question? Proceed!

DR. BATES: Section 9 is changed; "doctor of medicine" is the only change.

SECTION 9.—Any doctor of medicine of reputable standing, not a resident of Pennsylvania, but a member of his own state or territorial medical association, after an introduction by a member present, may by vote of a general meeting or of a section be accorded the privilege of participating in the scientific discussions.

SPEAKER BUCKMAN: Any other change or question?

DR. BATES: Now we have some structural changes in Article V on the House of Delegates, changes in addition to those which are published.

ARTICLE V.—HOUSE OF DELEGATES

The House of Delegates shall be the legislative and policy-making body of this Society and shall be com-

posed of: (1) delegates elected by the component county medical society in the proportion of one delegate for every 100 or fraction thereof of its active members, as of June 1 preceding the annual session, and who shall be certified to the office of the Secretary-Treasurer of this Society by June 1;

(2) is eliminated; (3) is changed to (2), and reads: "(2) the secretaries of the component county medical societies;" that is a very drastic change.

(4) is changed to (3):

"(3) ex-officio, the President and President-elect of this Society, the trustees and councilors, Secretary-Treasurer, Assistant Secretary-Treasurer, ex-presidents of this Society, and the presidents of the component county medical societies, but without the right to vote. In the absence of its secretary, the president of that component county medical society may be seated with the right to vote."

At the end is added: "The county medical society when electing delegates shall also elect two alternates-at-large for each delegate, who shall also be certified to the office of the Secretary-Treasurer of this Society by June 1.

"If any component county medical society is without representation at any session of the House of Delegates, then the members registered in attendance from that county may select from their number one delegate who shall be the representative of that county and who shall serve in the place of an accredited delegate. If but one member is registered, he shall be seated as a representative of that county. When any delegate is once seated, no change may be made in his status during the session. No individual member shall be entitled to more than one vote. The voting membership shall be the delegates duly seated, alternates duly seated as delegates, and the secretaries of the component county medical societies in attendance or their presidents acting as their alternates.

"No individual occupying an ex-officio membership in the House of Delegates shall be seated as a delegate with vote, except that, when an ex-president of this Society, who is not at the time a trustee and councilor or other officer, is a regular delegate of his county medical society duly elected to represent it in the House of Delegates, he shall be received as an accredited member of the House of Delegates, and shall have all the privileges of an accredited member during the term for which he was elected."

SPEAKER BUCKMAN: Are there any questions on that proposed revision?

DR. WILBUR E. FLANNERY [Lawrence]: In the section that would become No. 3, previously numbered (4), in view of the discussion that it might seem wise to elevate the positions formerly held by vice-presidents, I would like to suggest the amendment that this section read: "ex-officio the president, president-elect, and vice-presidents of this Society."

SPEAKER BUCKMAN: Dr. Flannery would insert the words "and vice-presidents of this Society," which would have the effect of making them also ex-officio members of the House of Delegates.

[The amendment was seconded by Dr. Joseph A. Parrish, Centre County.]

SPEAKER BUCKMAN: The question is on the insertion of the words "and vice-presidents of this Society"; are you ready for the question?

[The Speaker of the House put the amendment to a vote.]

SPEAKER BUCKMAN: On the question raised by Dr. Flannery's amendment, the vote being in the affirmative, the amendment is adopted.

Dr. Cornell!

DR. CORNELL: In this new procedure the alternates are all alternates-at-large. Should one delegate not appear, there may be ten alternates-at-large. Which one should be seated? Where the alternates-at-large are provided for, I would amend by this clause, "with relative seniority as certified by their respective county societies."

[The amendment was seconded by Dr. Frederick C. Smith, Philadelphia.]

DR. FRANCIS F. BORZELL [Philadelphia]: I raise the question as to the propriety of that provision in the State Society constitution. The determination of seniority and the manner of determining seniority are functions of the county medical society and not the State Medical Society. When such an alternate-at-large appears before the Credentials Committee, he presents proper credentials from his county society. I do not believe that it is the function of this body to tell any county society how it shall determine the eligibility of an alternate.

SPEAKER BUCKMAN: The question is on the insertion of the words "according to seniority as provided by the respective county societies." Are you ready for the question?

[The amendment was put to a vote.]

SPEAKER BUCKMAN: The "noes" seem to have it.

[A standing vote was called for and taken.]

SPEAKER BUCKMAN: There were 13 for, 54 against; the amendment is defeated.

DR. BATES:

ARTICLE VI.—SECTIONS

The House of Delegates may provide for a division of the scientific work of this Society into appropriate sections.

We have some additions to Section 1 of Article VII.

ARTICLE VII.—SESSIONS AND MEETINGS

SECTION 1.—This Society shall convene in annual session at such place as may be determined by the House of Delegates, at such time as may be determined by the Board of Trustees and Councilors, and each session shall continue for three days, or longer if required by the business of the Society. In case of strikes, governmental regulations, or unavoidable catastrophes, the Board of Trustees and Councilors shall have the power to cancel or change the date or the place of meeting of the annual session of The Medical Society of the State of Pennsylvania.

SPEAKER BUCKMAN: Any questions or further amendments?

DR. BATES: In Section 2 there is a change in addition to those included in the JOURNAL.

SECTION 2.—Special meetings, either of this Society or of the House of Delegates, shall be called by the President on petition of forty delegates or two hundred members, or by nine members of the Board of Trustees and Councilors.

SPEAKER BUCKMAN: Are there any questions or amendments to this proposed revision?

DR. BATES:

ARTICLE VIII.—OFFICERS

SECTION 1.—The officers of this Society shall be a president, a president-elect, two vice-presidents, a secretary-treasurer, an assistant secretary-treasurer, a speaker and a vice-speaker of the House of Delegates, trustees, who are also councilors (one from each councilor district who must be in the active practice of medicine), and as many district censors as there are component county medical societies.

SPEAKER BUCKMAN: Are there any questions?

DR. WILBUR E. FLANNERY [Lawrence]: It may seem rather unnecessary to debate this point, but it seems to me there is some value in maintaining the four vice-presidents. Knowing three individuals in our own county who at one time or another have held this office, I am reminded that when they did hold the office, they had some recognition from the local doctors; they also had some recognition from the local press, and in some way or other the local county society felt that it was tied in a little tighter with the state organization. True, it was an empty honor, but at the same time it seemed to have some value in my mind. I think we should continue with a couple of other members over the State who are officially connected with the administration of State Society affairs. Perhaps vice-presidents will be more useful in the future. In any event, I would like to make the motion for the retention of four, instead of two, as here stated.

SPEAKER BUCKMAN: Dr. Flannery moves that the word "four" be substituted for the word "two" before vice-presidents.

[The motion was seconded by Dr. Irwin J. Ober, Westmoreland.]

SPEAKER BUCKMAN: The question is on the substitution of the word "four" for the word "two" before the word "vice-presidents."

DR. BATES: I am asked to explain why this change was made. I have rarely, if ever, known a function in this Society to have been extended down beyond the first vice-president.

To have four vice-presidents attend all the meetings adds to the expense of the Society in an unnecessary way, and it seems to me that there will be more concrete honors to two vice-presidents than to four. We felt that in keeping with other structures in our government and elsewhere the lesser number would add more dignity to the post.

DR. FLANNERY: May I speak again? For a couple extra vice-presidents to travel from one section of the State to another to attend some of these meetings might be well worth while. If more thought were given to their selection, I still think they would be useful officers, and the offices provide a place to put somebody else to work in our state organization.

DR. GEORGE L. LAVERTY [Dauphin]: Several years ago in the course of nomination for vice-presidents, there was a moment of hesitation and it occurred to me to place in nomination the name of a young member from one of the rural counties. He was elected. Then I learned that was the first time any member of that county medical society had been recognized in a state society office.

DR. EDGAR S. BUYERS [Montgomery]: Mr. Chairman, I am about to retire as fourth vice-president of

this Society. By all means give my successor something to do! [Laughter.]

DR. JAMES J. MONAHAN [Schuylkill]: I want to endorse the opinions of Dr. Flannery and Dr. Laverty. I am of the same opinion they are.

SPEAKER BUCKMAN: The question is on the change of the word "two" to the word "four" before "vice-presidents."

Are you ready for the question?

[The amendment was put to a vote and carried.]

DR. BATES: In Section 2 the only change is the change in the official name of the Board, adding the words "and councilors" at the end of the first line.

SECTION 2.—The officers, except the trustees and councilors, shall be elected annually by the House of Delegates to serve for one year, or until their successors are elected and installed.

SECTION 3.—A full complement of the Board of Trustees and Councilors shall be maintained by election each year in the House of Delegates, each trustee and councilor to serve for a period of five years. No trustee and councilor shall be eligible to succeed himself after he has served two consecutive terms. Each councilor district shall be entitled to one trustee and councilor. A trustee and councilor must be a member of one of the component societies of the councilor district which he represents.

Now, before the changes there are considered, may I finish this next section which ties in with it?

SECTION 4.—In the event of a vacancy in the Board of Trustees and Councilors, the Board shall fill the vacancy within ninety days by the appointment of a member from that councilor district, such appointee to serve until the next regular meeting of the House of Delegates.

At the next meeting of the House of Delegates, the remainder of the unexpired term created by the vacancy shall be filled by election. This shortened period in office shall constitute a term within the meaning of Article VIII, Section 3.

Which states that a man may have served only two full periods. In other words, we are trying to prevent a member serving a short term and then two full elected terms, which might possibly put him in office for four years and nine months. That has happened.

SPEAKER BUCKMAN: Are there any questions or amendments to this proposed revision?

DR. E. ROGER SAMUEL [Northumberland]: I would suggest the addition of these words after Section 3: "and that the trustee and councilor be elected by his own district." I think we have nominations for councilor in this House of Delegates of unknown members. Every district knows its own membership and should have the privilege of electing a trustee and councilor from its own district.

SPEAKER BUCKMAN: Do you offer that as an amendment?

DR. SAMUEL: I do.

DR. BATES: In the First Councilor District, where there is only one county (Philadelphia), it would be the only place where this could be done rapidly and safely. It would mean in some of the districts where there are seven counties that a separate district meeting would have to be held. The recommended provision would maintain a complete board by naming the man

from the affected district to serve only until the next meeting of the House of Delegates, when the House of Delegates elect, on nomination presumably from that district, for the unexpired term. We felt that this was the way to keep our board intact without calling separate meetings of the district.

SPEAKER BUCKMAN: Is there further discussion?

DR. SAMUEL: My suggestion comes at the wrong place. It should be up in the third line instead of at the end of the sentence. You know what I mean.

SPEAKER BUCKMAN: The Chair will ask for a motion to lay on the table the proposed revision of Article VIII, Section 3, and Article VIII, Section 4, until Dr. Samuel has had time to perfect his amendment.

DR. JOHN H. HARRIS [Dauphin]: I so move.

[The motion was seconded by Dr. Walter S. Cornell, of Philadelphia.]

SPEAKER BUCKMAN: The question is to lay on the table until Dr. Samuel has had time to perfect his amendment.

[The motion was put to a vote and carried.]

DR. BATES: In Article IX in reference to funds, there is a change over the printed form.

ARTICLE IX.—FUNDS

SECTION 1.—Funds shall be raised by annual assessment payable by each active and each affiliate member of the several component county medical societies. The amount of the annual assessment is to be fixed by the House of Delegates annually. Funds may also be raised by voluntary contributions and in any other legal manner approved by the House of Delegates. The House of Delegates may recommend the appropriation of funds to defray the expenses of this Society for publication and for such other purposes as will further the interests of this Society.

That clarification was made because the House cannot appropriate money. We elect the Board of Trustees, but the Board of Trustees spends our money. We may make recommendations, but we can't do the appropriating. Therefore, this change is in conformity with our actual practice.

SPEAKER BUCKMAN: Are there questions, or is there any amendment to this proposed revision?

DR. LYON: The word "publication" should be plural, should it not?

SPEAKER BUCKMAN: The correction is accepted by the chairman.

The question was raised whether the word "publication" should not be plural—publications. Dr. Bates, on behalf of this committee, accepted the correction. It is not necessary to ballot on it.

Are there any other corrections, or are there amendments to the revision?

DR. BATES: In Section 2 in reference to funds, we are changing over to Board of Trustees and Councilors wherever it is mentioned and adding the word "active" before "member" in the third line.

SECTION 2.—Each year, out of the funds of this Society, the trustees and councilors may appropriate a sum not to exceed \$1.00 for each active member, to be set aside by the Secretary-Treasurer as a special fund to be known as the Medical Defense Fund. This fund shall be kept separate from other moneys and may be

invested by the Secretary-Treasurer under the direction of the Board of Trustees and Councilors and shall be used only for the legitimate expenses of members threatened with or prosecuted for alleged malpractice; provided, however, that no member of this Society shall be entitled to the benefits of this fund who was not in resident practice in the State of Pennsylvania when the alleged act of malpractice was committed.

SPEAKER BUCKMAN: Any other corrections or suggestions for this proposed revision?

DR. BATES:

SECTION 3.—Each year, out of the funds of this Society, the trustees and councilors shall appropriate a sum not to exceed 15 per cent of the annual dues for each active member, to be set aside by the Secretary-Treasurer as a special fund to be known as the Medical Benevolence Fund. This fund shall be kept separate from other moneys and may be invested by the Secretary-Treasurer under the direction of the Board of Trustees and Councilors, and shall be used (a) for the relief of pecuniary distress of sick or aged members or the parents, widows, widowers, or children of deceased members, and (b) for the relief of pecuniary distress of members resulting from catastrophic natural emergencies.

SPEAKER BUCKMAN: Does the assembly have any changes that it wishes to make?

DR. BATES: In Section 4 the purists got to work and it now reads as follows:

SECTION 4.—The Endowment Fund (established as an Endowment Fund of this Society in 1917) may be sustained and maintained by any surplus revenues, gifts, and interest from investments which the Board of Trustees and Councilors shall in its discretion set aside for that purpose. The Endowment Fund and its accumulations shall be used by order of the House of Delegates in annual meeting assembled for any purpose devoted to instructional and educational purposes that may be reflected in improved service to humanity under medical auspices.

Now, may I call your attention to the fact that this is one fund over which the House of Delegates has the sole right of control.

SPEAKER BUCKMAN: Are there questions regarding this proposed revision?

DR. BATES: Under Section 5 an entirely new section is provided:

SECTION 5.—Each year out of the funds of this Society, the trustees and councilors with the approval of the House of Delegates may appropriate a sum not to exceed \$2.00 for each active member to be set aside by the Secretary-Treasurer as a special fund to be known as an Educational Fund. This fund shall be kept separate from other funds and may be invested by the Secretary-Treasurer under the direction of the Board of Trustees and Councilors, and shall be used to assist in the underwriting of the expenses of continuing the education in high school, college, or medical school of the children of members of this Society if and when said training is about to be discontinued for lack of family financial support following the death, or incapacitating illness, or injury of the physician parent member of this Society.

SPEAKER BUCKMAN: Are there any questions to be raised as to this proposed revision?

DR. IRWIN J. OBER [Westmoreland]: Is this the \$500,000 Dr. Hess talked about?

DR. BATES: He supplied the motive. We have the *modus operandi* here.

SPEAKER BUCKMAN: Any further question? Any amendment of it?

DR. THOMAS ST. CLAIR [Westmoreland]: We took that question up in our county society and didn't approve it. We felt that it was getting into big money, that it was a complicated thing requiring a lot of work, a lot of people to work it out, and in this country there are not many members of the society of doctors who can't in some way finance the education of their children.

SPEAKER BUCKMAN: Dr. St. Clair, of Westmoreland County, announces to the House that his county society considered this subject and went on record as opposing the idea because (trying to quote him) it carries us into big money. They feel that the average physician's family is able to carry on the education of his children beyond the death or incapacity of the father. I forgot other reasons. Am I fair, Dr. St. Clair, in interpreting that to the House?

DR. ST. CLAIR: Yes.

DR. CHARLES L. FACKLER [York]: Our county society similarly rejected that proposal, so I think we should have a separate vote on the floor now, even if only to record these two negative votes. There may be negative votes from other county medical societies.

SPEAKER BUCKMAN: The Chair will entertain a motion from any county society in opposition to this to strike out the proposed new section—Section 5, Article IX—as proposed by the committee. I think that is the only way we can bring this subject to a vote.

DR. FACKLER: I so move—that we strike out the section.

[The motion was seconded by Dr. Thomas St. Clair, Westmoreland.]

SPEAKER BUCKMAN: The question is on striking out the proposed new Section 5 of Article IX which would set up the educational fund.

SECRETARY DONALDSON: I want to ask Drs. St. Clair and Fackler if their county medical societies took this unfavorable action on the proposed new section for our Constitution, or was it on the plan as proposed in 1947 by Dr. Hess, which, unfortunately, immediately developed the belief that it required a fund of \$500,000? I would like them to answer that question.

DR. ST. CLAIR: Our action was taken on that original idea—not on this new section. It was taken on the whole proposition of this paternal type of legislation. Our opposition was taken because that gets into something like socialized medicine, where the government takes charge for individuals possibly capable of doing it, if they would. It wasn't exactly like this, but it was an assessment from each member of the county society, as I understood the other proposition.

SPEAKER BUCKMAN: The question is on striking out the proposed new Section 5 of Article IX.

DR. JOHN H. HARRIS [Dauphin]: I would like to remind the members here that this section is permissive and not obligatory. It is entirely in the hands of the trustees whether they will or will not and how much of it they will carry out and operate.

DR. DOMINIC S. MOTSAÏ [Bradford]: I would like to ask a question before the vote is taken. Would someone explain whether or not the Medical Benevolence Fund might do exactly this for the families of such physicians who may be incapacitated or who may have died?

SPEAKER BUCKMAN: The Medical Benevolence Fund does not. Since Dr. Hess enunciated his revolutionary idea a year ago, it came out at a meeting of the Board of Trustees that there had been one or two instances in the past where the Benevolence Fund had been drawn upon for some such purpose as this and the then current Board of Trustees felt that that was a wrong thing to have done. Therefore, the answer to your question is that the money of the Medical Benevolence Fund cannot be used for this purpose.

DR. FACKLER: Before the members vote on this amendment, I wish they would take into consideration the amount of money this is going to build up. I understand it is \$2.00 out of each member of the State Society annually, which will mean considerable moneys within a space of four or five years. Actually, how many widows or dependent members in the last five or ten years have appealed to the State Society to assist their children through medical school? There will be some cases, yes; but certainly in my mind there will not be a sufficient number to entail the accumulation of a large amount of money.

I think that was the purpose of the York County Medical Society in rejecting the initial proposal.

DR. THOMAS W. MCCREARY [Beaver]: I think \$2.00 a year is a very, very small amount of money for us to contribute annually toward such a fund. If we were in some organizations, they would ask us for \$100. I don't think this fund is going to grow too big at all. There are no statistics to show how often such a fund could be used. I personally would dislike to see it stricken from the record.

DR. ELWOOD T. QUINN [Montgomery]: Both of our youngsters are educated, so I don't have to worry about the fund, fortunately. I am afraid the fund won't get big enough soon enough. I would like to see the money appropriated each year from an assessment of \$2.00 each.

DR. THOMAS R. GAGION [Luzerne]: Thank you for the privilege of the floor. I think the word "may" is opportune. There is nothing mandatory as to the \$2.00. There is a limit of \$2.00. Should the fund grow too large, the Board and the House can reduce the allotment. I think that word "may" will protect the fund from growing too large.

DR. NORMAN K. BEALS [Venango]: We today live in a democracy; I hope we do. I think that we consider education the foundation of democracy. I know of two young men who expected to become doctors, but could not go on with their medical training because their fathers became incapacitated. I feel that we should definitely make this our goal and not oppose it.

DR. JOSEPH J. TOLAND [Philadelphia]: The Medico-Chirurgical College alumni have been administering a fund for the education of such beneficiaries as are considered in this section. We have had cases every year. Now, although the college has been out of existence since 1918, we are still educating boys from our fund. It is very important, in my opinion, that this fund carry on because there is much good to be done.

DR. WILBUR E. FLANNERY [Lawrence]: I would like to speak for the passing of this proposed new section in the Constitution. I think that many of us can think of instances of doctors' children to whom something has happened. Had they had a little help, it might have been a great benefit. I think this is a benevolent thing to do and I am sure the judgment of those in charge will be exercised so that the fund will certainly not be developed beyond the amount that is needed. I certainly am in favor of it.

SPEAKER BUCKMAN: The question is on striking out the proposed new Section 5 of Article IX. Are you ready for the question? An affirmative vote will strike it out.

[The motion was put to a vote and lost.]

SPEAKER BUCKMAN: The "noes" have it; the motion is defeated. The House accepts the recommendation of the Committee on Revision.

DR. BATES: We have modernized the wording under Article X a bit.

ARTICLE X.—SEAL

This Society shall have a corporate seal which shall contain the monogram "A.M.A." and "1847" within a circle on a keystone, at the sides of which shall appear: "Organized 1848: Chartered 1890," and the whole surrounded by a double circle containing the words, "Medical Society of the State of Pennsylvania."

The archaic language which followed was eliminated.

In Article XI there is only one change and that was suggested previously. That is in the third sentence of the article.

ARTICLE XI.—AMENDMENTS

Proposals for amendments or alterations to this Constitution may be offered at any annual session or during the interim, provided such proposal or proposals be signed by fifteen active members of this Society. If offered during the interim, such proposals must be sent to the Secretary-Treasurer of this Society at least four months before the next annual session. All proposals for amendments or alterations must appear either in the published minutes of the preceding annual session or must be published in the JOURNAL of this Society at least three months before the next annual session; and all such proposals for amendments or alterations must appear in the official call for the next annual session. If these conditions have been fulfilled, then the House of Delegates may adopt such proposals by a two-thirds vote of the delegates present at the next annual session.

SPEAKER BUCKMAN: Are there any questions as to this proposed revision? Any amendment of it?

Dr. Samuel has returned to the room. We are ready to consider changes in Article VIII, Section 3, which have been laid on the table. The Chair recognizes Dr. E. Roger Samuel.

DR. SAMUEL: The action that I proposed infringes upon the Constitution of The Medical Society of the State of Pennsylvania under which we are incorporated. The trustees handling the funds of the Society shall be elected by the Society and, therefore, my proposal is out of order.

Mr. Chairman, I move that this be taken from the table.

[The motion was seconded by Dr. Walter S. Cornell, Philadelphia, put to a vote, and carried.]

SPEAKER BUCKMAN: It opens that question up to any further question or any further revision; otherwise, we accept it for the moment as read by Dr. Bates. Are there any questions on that particular article and section?

Now, then, in your hands in the Transactions you have this printed and presented to you together with the old form. Some of that old form is not changed and some is deleted as whole articles. Consequently, it is necessary for us to read those parts which are not changed and read those parts which are deleted. Dr. Bates had his material prepared by the printer without those old forms. Consequently, the Chair will read this:

The first two articles of the old Constitution remain unchanged as printed in the Transactions: Article I—Name and Article II—Purposes of This Society.

Article IV, Section 3, of the old Constitution will be changed to Article IV, Section 6, of the revision; that will remain unchanged.

The present Article IV, Section 8, of the present Constitution is deleted.

[Speaker Buckman read Section 8, Article IV, of the old Constitution.]

SPEAKER BUCKMAN: Article VI of the old Constitution will remain unchanged.

[Speaker Buckman read Article VI of the old Constitution.]

SPEAKER BUCKMAN: Article VIII, Section 2, of the old Constitution will remain unchanged and will read as follows:

[Speaker Buckman read Section 2, Article VIII, of the old Constitution.]

SPEAKER BUCKMAN: The present Article X of the old Constitution will be deleted; that had to do with referendum.

Now, the question is on the adoption of the revised Constitution.

DR. WILBUR E. FLANNERY [Lawrence]: I move that we adopt the revised Constitution as presented.

[The motion was seconded by Dr. Francis F. Borzell, Philadelphia.]

SPEAKER BUCKMAN: The entire instrument is open to further revision or amendment, if there are any to be offered. If not, the question is on the adoption of the revised Constitution. Are you ready for the question?

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: The revised Constitution is adopted.

The House will rise and recess for two minutes.

[Recess]

SPEAKER BUCKMAN: The House will be in order.

We will proceed with further consideration of the report of Dr. Bates' Committee on Revision of the By-laws. Dr. Bates!

DR. BATES:

BY-LAWS

CHAPTER I.—MEETINGS

SECTION 1.—At the annual session there shall be three types of meetings: (1) general meetings, (2) scientific assemblies, and (3) scientific sections.

SECTION 2.—The general meeting shall be presided over by the President, or a vice-president, or a dele-

gated chairman. All registered members and friends may attend. The program may include: (1) introduction of invited special guests, (2) report of Committee on Necrology, (3) reports of Committees on Scientific Work and Exhibits, (4) an address by the incoming president, and (5) appropriate entertainment.

SECTION 3.—The Scientific Assembly shall be presided over by the Chairman of the Committee on Scientific Work, or Chairman of the Committee on Scientific Exhibits, or a delegated substitute. Registered members and friends may attend. Discussion shall be limited to registered members.

SECTION 4.—Scientific sections shall be divided into two general groups: (1) Medicine, and (2) Surgery.

SECTION 5.—The scientific assembly or either of the sections in session may recommend to the House of Delegates the appointment of commissions for scientific investigations of special interest and importance to the profession and the public.

SPEAKER BUCKMAN: Members of the House, this first chapter has five sections. Are there any questions about Section 1?

Any question or amendment about Section 2?

Any question or amendment on Section 3?

Any question or amendment of the proposed new Section 4?

DR. ROY W. MOHLER [Philadelphia] Mr. Chairman, may I ask if there are to be no special sections at all?

SPEAKER BUCKMAN: That is right. The effect of the passage of this proposed revision would be immediately to write off all scientific sections in the State Society except that on Medicine and that on Surgery.

DR. MOHLER: May I have an expression of the rationale for that?

SPEAKER BUCKMAN: Certainly. Dr. Bates!

DR. BATES: We are in the day of trying to emphasize the importance of the general practitioner. We feel that the specialist has been overemphasized and that too much attention has been paid to special sections not only in the state society but in the county society and in the A.M.A. The state society meeting is for the advancement of the medical profession as a whole. It is the national trend and will we think, prove a benefit to a greater number of members of the State Society.

In addition, we feel that every specialist belongs to some one special society, if not six, where he may compete with his equals in a show of erudition, whereas this society is for the education of the general practitioner.

DR. DANIEL RITTER [Cambria]: Mr. Speaker, in view of the favorable action in the supplemental report by Chairman Deckard of the Board of Trustees, this morning, recommending that a Section on Anesthesiology be added, and also in view of the favorable report of the Committee on Scientific Work to that effect, I would like to amend this Section 4 to read as follows:

(A) A new scientific section shall be added to be known as Section on Anesthesiology.

(B) Scientific sections shall be divided into two general groups: (1) medicine, and (2) surgery.

The reason I make the motion for this amendment is that when we get all of our meetings and all of our scientific programs into the one big room that Dr. Bates speaks of, possibly the program committee won't forget to put a symposium on anesthesiology in the program.

SPEAKER BUCKMAN: The Doctor proposes that the committee's recommendation shall be amended in this manner:

Section 4 (A).—A new scientific section shall be added to be known as a Section on Anesthesiology.

(B) leaves Section 4 as it is.

Is there a second?

DR. RITTER: As I say, the benefit to anesthesiology will be that the program committee will not forget to include a symposium on anesthesiology.

SPEAKER BUCKMAN: Is there a second to the motion to amend?

DR. MOHLER: you asked for the floor to discuss this or to raise a question.

DR. MOHLER: I was wondering about the terms, medicine and surgery, and whether diagnosis and therapy wouldn't divide the sections up better. All forms of therapy would be under the head of what ordinarily we think of as surgery and diagnostic or other types of therapy, for instance; and then diagnostic work rather than medicine and surgery. I don't like those terms anyway.

DR. WALTER S. CORNELL [Philadelphia]: I don't suppose any of us can follow all the implications of this new recommendation, but I would say that having been engaged in public health work for some thirty years it seems to me there is a great value in getting the members of the Society together in large meetings to hear what the other man has to say. There is a corresponding disadvantage in going off into our own particular sections, where we listen to what we want to hear by people we know already. I rather feel with Dr. Bates that the general effect on the thinking of the whole membership will be improved by our gathering together in a sort of postgraduate institute each year.

SPEAKER BUCKMAN: You understand, Doctor, I did not put your question for lack of a second.

DR. RITTER: I don't know whether the membership really understood what I wanted to accomplish in that motion. If I may, I would like to repeat it.

SPEAKER BUCKMAN: Certainly.

DR. RITTER: I am fully in favor of the revision committee's recommendation. I think the attendance at meetings will be improved and I think everybody will be better satisfied, but I also believe that before that happens, anesthesia is entitled to be recognized along with the eleven other specialties as a new section. We have sections for almost everything else in this society except anesthesiology and I would like to see that recognized as a section, as it is in the A.M.A. and in many other state societies.

SPEAKER BUCKMAN: You understand, Doctor, that adoption of the recommendation of the committee, or the adoption of their recommendation as amended by yours will mean in either case that all sections presently existing would pass out of existence?

DR. RITTER: That is right, including anesthesiology.

SPEAKER BUCKMAN: But your amendment would create a new, separate Section on Anesthesiology; that would be the effect of it.

DR. RITTER: I don't think it would, Doctor.

DR. EDWARD LYON, JR. [Lycoming]: In Article VI of the Constitution, which we have just accepted, it

says that the House of Delegates may provide for division of scientific work of this Society in appropriate sections, which of course, we are doing now. I don't believe this discussion of anesthesiology or the Section on Anesthesiology belongs in this paragraph.

SPEAKER BUCKMAN: Really, Dr. Lyon, the Doctor offered an amendment to the committee's proposed revision and perhaps the Chair is wrong in entertaining any discussion, but in fairness to the doctor who offered it, I allowed discussion. I can't put the question: we can't ballot on it unless somebody offers a second.

DR. RITTER: If that is the feeling, I will be glad to withdraw it.

SPEAKER BUCKMAN: That is not necessary; it is lost for want of a second—which brings us to Section 5. [Speaker Buckman read Section 5 of Chapter I.]

SPEAKER BUCKMAN: Are there any questions regarding Section 5? If there are no further questions or any other amendments to be offered to these five sections, we will proceed to the next chapter. Dr. Bates!

DR. BATES: What happened to Dr. Mohler's suggestion of a change of name under Section 4, namely, that the scientific session be divided into two general groups, diagnosis and therapy, in preference to medicine and surgery?

SPEAKER BUCKMAN: Does Dr. Mohler wish to offer that as an amendment?

DR. MOHLER: I offer that as an amendment, Mr. Chairman.

SPEAKER BUCKMAN: Dr. Mohler moves that we substitute for the word "Medicine" the word "Diagnosis" and for the word "Surgery" the word "Therapeutics" in Section 4, Chapter I. Do I hear a second?

[The motion was seconded by Dr. S. Meigs Beyer, Jefferson.]

SPEAKER BUCKMAN: The question is on substituting the word "Therapeutics" for "Surgery," and—

DR. BATES: May I record that I polled my original committee and they are agreeable to that change?

CHORUS [from Philadelphia]: Why?

DR. BORZELL: Do I understand that the proposed amendment has been seconded and is open to discussion?

SPEAKER BUCKMAN: Yes.

DR. BORZELL: I think that we are limiting those two groups more than we really intend to if we adopt those two words. I don't wish to belabor the subject from the standpoint of semantics. I think we all understand the intent of the proposed amendment, but I cannot help feeling that the original terms, Medicine and Surgery, would be broader from the standpoint of intent than Diagnosis and Therapy, because the latter, if we stick to the wording as given, would eliminate physiology. They would probably eliminate preventive medicine, also some other phases that definitely do not come under diagnosis and therapeutics but which might come under medicine and surgery.

DR. CHARLES L. SHAFER [Luzerne]: I like the words Medicine and Surgery. In the Commonwealth of Pennsylvania you are licensed to practice medicine and surgery. I think that is a good way to express it.

DR. CONSTANTINE P. FALLER [Dauphin]: Medicine and Surgery are much more comprehensive. Medicine

is more than diagnosis. The practice of medicine is both diagnostic and therapeutic. Therefore, I think Dr. Bates' idea is much the better one.

SPEAKER BUCKMAN: Are you ready for the question?

[The motion was put to a vote and lost.]

SPEAKER BUCKMAN: The amendment is defeated.

DR. BATES:

CHAPTER II.—HOUSE OF DELEGATES

SECTION 1.—The House of Delegates shall meet on the morning of the day before that fixed as the first day of the annual session. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the scientific programs. The order of business shall be arranged as a separate section of the program.

SECTION 2.—Each delegate, before being seated, shall deposit with the Committee on Credentials a certificate signed by the President and Secretary under seal of the component county medical society, stating that he has been legally and regularly designated as a delegate to this Society.

SECTION 3.—Forty delegates shall constitute a quorum. The number of delegates is changed from twenty to forty.

SPEAKER BUCKMAN: Any change or question about continuing Sections 1 and 2 of Chapter II? Any question about the change in the number of delegates that constitute a quorum?

DR. BATES:

SECTION 4.—The House of Delegates shall receive reports of officers, committees, and commissions authorized by the House of Delegates at each annual session. All reports of committees and commissions not previously published shall be limited to ten minutes in verbal presentation before the House of Delegates. Any report of greater length shall be printed or mimeographed and a copy furnished each delegate. The pertinent or argumentative features of a report shall then be presented in the allotted ten-minute period.

In unusual cases this amendment may be suspended by a two-thirds vote of the House of Delegates, each exception to this rule to be voted upon separately.

DR. EDWARD LYON, JR. [Lycoming]: Mr. Chairman, I believe that was copied directly from the amendment which was adopted last year. Should it now not read "This rule"? It is no longer an amendment.

The second suggestion I would like to make is this. Basically, this is a deliberative or a business group. We are honored to have guests appear before us. However, are we not justified in asking those who do appear before us to restrict their remarks to a reasonable length of time? In addition to reports, are we not justified in requesting that those remarks be limited to ten, twenty, thirty minutes, or whatever we feel is right?

SPEAKER BUCKMAN: The Chair will undertake to answer that, because in all good faith it is a reflection on the Chair, whoever may be occupying it. It is a fact that two of the speakers this morning were asked to limit the duration of their remarks to twenty minutes. They knew that. On the other hand, it is difficult to interrupt people while they are speaking, and it hap-

pened that I could see the sheets being turned and I knew the end was coming, although they had run over the twenty minutes. I don't think any one of you would have stopped a speaker under those circumstances. Ordinarily the guests who come here don't overrun their time; they haven't in my experience. I see Dr. Lyon's point, but I myself feel that it would be entirely inappropriate to write that into our by-laws.

Are there any other questions? Let us proceed with consideration of Section 5.

DR. BATES:

SECTION 5.—It shall consider and advise as to the interests of the public, wherein it is dependent upon the profession, and shall use its influence to secure proper medical and public health legislation and to diffuse popular information of an educational nature in relation thereto.

SECTION 6.—It shall make careful inquiry into the condition of the profession in each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such component county medical societies as already exist, and for organizing the profession in counties where societies do not exist. It shall specially and systematically endeavor to promote friendly intercourse among physicians of the same locality, and shall continue these efforts until every legally qualified physician in every county of the State who is reputable has been brought under organized medical society influence.

SECTION 7.—It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body, these delegates so elected to assume office on January 1 following their election.

SECTION 8.—The House of Delegates shall meet in open session to which any person may be admitted, except as it shall move into closed session restricted to members of this Society and attaches of this Society and component county medical societies, and except as it shall move into executive session restricted to members of the House of Delegates.

I would like to speak just a second on the whys and wherefores of that. We have here attempted to cut out a long debate when it is moved that we go into executive session. With the open session, the press is present; with a closed session, the press and the visitors are out, but members, fellows, attaches and so forth, of the state and county societies are admitted. But when it comes to an executive session, there will not be somebody rise on this side and say, "I move that we permit the executive secretaries, I move that we permit the editors of county journals, I move that the publicity man of thirteen counties be admitted." The membership in the executive session will be limited to the members of the House of Delegates.

SPEAKER BUCKMAN: While you are considering that, I will ask Dr. Bates to read Sections 5, 6 and 7, which remain unchanged but weren't read.

DR. ROY W. MOHLER [Philadelphia]: I think the Philadelphia County Medical Society suggested a change in Section 7 of Chapter II:

"The delegates shall be remunerated by their society for travel expenses and maintenance expenses while attending meetings, such maintenance expenses not to exceed \$15 per day."

Isn't that in this section? They shall elect representatives to the House of Delegates of the American Medical Association. The delegates shall be remunerated by this Society for travel expenses and maintenance expenses while attending meetings.

SPEAKER BUCKMAN: We will ask Dr. Bates first to read Sections 5, 6, and 7, which the committee have offered unchanged.

[Dr. Bates read Sections 5, 6 and 7 of Chapter II (see above).]

DR. BATES: In Chapter II, Section 7, I read as follows:

"It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body, these delegates so elected to assume office on January 1 following their election."

Now, Philadelphia County has a new paragraph to add to Section 7, which reads as follows:

"Delegates to the American Medical Association shall be remunerated by this Society for traveling expenses and maintenance expenses while attending meetings, such maintenance expense not to exceed \$15 per day."

SPEAKER BUCKMAN: Dr. Mohler wishes to amend: "Delegates to the American Medical Association shall be remunerated by the Society for traveling expenses and maintenance expenses while attending meetings, such maintenance expense not to exceed \$15 per day."

Dr. Mohler moves the adoption of this amendment, seconded by Dr. Walter E. Wentz, of Delaware County. Are you ready for the question?

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: The amendment is adopted.

DR. BATES: May I ask for information now on the adoption of this? The Board of Trustees is in charge of our finances. Can we make it mandatory on our Board of Trustees to do this, or shall we say the delegates to the A.M.A. shall be remunerated by this Society for traveling expenses and maintenance expenses while attending meetings, such maintenance expense not to exceed \$15 per day?

According to action by the Board of Trustees, or in the judgment of the trustees, or what do you want to do? Because they are the spending body.

DR. MOHLER: Can't you recommend to the Board of Trustees that they pay these expenses?

DR. BATES: Yes.

DR. EDWARD LYON, JR. [Lycoming]: Mr. Chairman, for my clarification, is the term of the delegates of the A.M.A. stated in that Constitution, that is, the length of time they hold office?

DR. FRANCIS F. BORZELL [Philadelphia]: Mr. Chairman, may I help to answer Dr. Lyon? It is a requirement of the By-Laws of the American Medical Association that delegates be elected for a term of two years. My interpretation of the paragraph would be that where it says "in accordance with the Constitution and By-Laws of that body," it would automatically mean two years.

SPEAKER BUCKMAN: Later on in a proposed Section 8, Chapter VI (you will find it on page 1278 of the JOURNAL), it says: "All resolutions or recommendations of the House of Delegates pertaining to the ex-

penditure of money must be approved by the Board of Trustees and Councilors before the same shall become effective."

I think that is the only restriction on the purse strings so far as we are concerned. We can say in the by-law that the delegates must be paid by the Board of Trustees and Councilors; if they turn around and say no, we will not pay.

DR. GEORGE L. LAVERTY [Dauphin]: Mr. Speaker, I am not exactly familiar with the procedure, but I believe that Dr. Donaldson can inform us concerning the present procedure.

When I was a member of the delegation to the American Medical Association some years back, no expenses were paid at the regular sessions of its House of Delegates. When a special session was called, the American Medical Association paid the expenses of the delegates somewhat as our state society has repaid those attending the Secretaries and Editors Conference. I believe that during recent years our State Society has paid some expenses of the delegates at the regular sessions.

SECRETARY DONALDSON: If I may answer, Mr. Speaker, it would be to the effect that there has been but one special meeting in my recollection of the House of Delegates of the American Medical Association and delegates' expenses were paid by the A.M.A. Three or four years ago our Board of Trustees began to pay the expenses of our delegates to the interim meetings of the American Medical Association, not to the regular June meetings; but in the past year with the great rise in the cost of serving as a delegate, they have paid expenses at both interim and regular annual meetings. That is not a fixed policy; the Board takes action before each A.M.A. session.

SPEAKER BUCKMAN: Just one moment. The action of the House was to adopt the amendment offered by Dr. Mohler to the proposed revision offered by the committee and the vote has been announced. Any further discussion is out of order.

DR. BORZELL: May I present an amendment to this amendment, sir?

SPEAKER BUCKMAN: Yes, you may amend Dr. Bates' proposed revision further so far as it doesn't change the amendment or the sense of the amendment that has already been adopted.

DR. BORZELL: Then I would like to propose that the amendment read: "Delegates may be remunerated by this Society for traveling expenses and maintenance expenses while attending meetings, at the discretion of the Board of Trustees."

That would authorize the Board of Trustees to do that officially and they would know the feeling of the House of Delegates on it.

SECRETARY DONALDSON: I think the Board of Trustees would appreciate that.

SPEAKER BUCKMAN: That amendment is out of order because we have adopted an amendment that they shall be remunerated. You can change the wording and simply add a phrase or clause, providing that the Board of Trustees—

DR. BORZELL [interrupting]: I will accept, "subject to the approval of the Board of Trustees and Councilors."

SPEAKER BUCKMAN: You have already adopted an amendment to Dr. Bates' recommendation, the commit-

tee's recommendation. That amendment reads as follows:

"Delegates to the American Medical Association shall be remunerated by this Society for traveling expenses and maintenance expenses while attending meetings, such maintenance expenses not to exceed \$15 per day."

Now, Dr. Borzell offers an amendment, "provided such remuneration is approved by the Board of Trustees and Councilors." In one sense you say shall and then you end up by saying provided the Board of Trustees approves it.

DR. LAVERTY: Mr. Speaker, I move to reconsider.

[The move was seconded by Dr. Walter S. Cornell, Philadelphia.]

SPEAKER BUCKMAN: The question is on reconsidering your action on the amendment as recommended by Dr. Mohler.

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: The question now is on Dr. Mohler's amendment: Delegates to the American Medical Association shall be remunerated by this Society for traveling expenses and maintenance expenses while attending meetings, such maintenance expenses not to exceed \$15 per day.

It was seconded by Dr. Wentz, of Delaware County. It is now open for further amendment.

DR. BORZELL: In order not to delay longer and to get this program through, I move that this section be laid on the table temporarily in order to provide wording which will meet the apparent sense of the House.

[The motion was seconded by Dr. Mohler, of Philadelphia.]

SPEAKER BUCKMAN: The question is on laying this amendment to the proposed revision on the table.

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: The amendment to the proposed revision is laid on the table.

It is now a little beyond half past four. I think there has been a little confusion in the last five minutes, which is perhaps indicative of the fact that some of us are tired. Before we adjourn for the afternoon, I would like the permission of the House to ask our old friend, Dr. Joseph Lawrence, of Washington, to speak a few minutes. If I hear no objection, Dr. Lawrence has the floor.

Then I would suggest in the motion for adjournment that we specify the time we are going to meet tomorrow and perhaps make as the first order of business further consideration of Dr. Bates' report (see page 246).

DR. LAWRENCE: Mr. Speaker, Members of The Medical Society of the State of Pennsylvania: I am pleased to have the opportunity of talking to you.

I was delighted this morning that you had an opportunity to hear Congressman Fenton. I wanted to tell you that you have a very friendly delegation in Congress all the way around, but you are also fortunate in having two doctors among your Congressmen—Dr. Fenton, and Dr. Morgan from the western part of your state. They are both very much interested in our work and are close friends of yours.

Dr. Fenton could have told you this morning of a very interesting study he made last summer of the Hopi Indians and the health conditions of the Hopis. He

was quite exercised over the unsanitary conditions he found there and was instrumental during the winter in having money appropriated for their better health care.

I have nothing but commendation for your patience in considering this revision of your constitution and by-laws. It is important and must be done carefully. It is hard work. We have a lot of that sort of thing in Washington at times, and we are going to have more this year. Regardless of how the election comes out, we can expect three things that I would like you to think over after you get through with the revision. There will be several bills that will propose to liberalize medical service and provide for more readily available facilities, and there will be increased interest in medical education with certain legislation in regard to hospitalization.

Such things are sure to come and are indicative of the progress that medicine is making.

One of the first bills that will be presented no doubt will be one calling for medical examination of children of school age. When those bills are introduced, they will be sent to your committee headed by your efficient Dr. Palmer. I hope that you will all seek an opportunity to read the bills, give him your opinion as to their merit and pass it on to me. We will greatly need it.

Washington is going to be a very interesting place and it becomes more interesting as interest increases among the physicians back home. I wish that we had more Congressmen who are doctors. We have eight in the House of Representatives, but none in the Senate. At least two are sons of doctors. Several others have doctors as brothers or brothers-in-law. So much for the medical profession in Congress, but it needs stimulation from back home. You in Pennsylvania have done nobly in the past. I know you will do it again in the future.

I thank you very kindly for your recognition.

SPEAKER BUCKMAN: A motion to adjourn until two o'clock Tuesday afternoon is in order.

DR. THEODORE R. FETTER [Philadelphia]: I so move.

[The motion was seconded by Dr. Francis F. Borzell, Philadelphia, put to a vote, and carried.]

[The meeting adjourned at four-forty o'clock.]

LEWIS T. BUCKMAN, *Speaker*,

WALTER F. DONALDSON, *Secretary-Treasurer*.

Tuesday Afternoon, Oct. 5, 1948

The House of Delegates convened at two-ten o'clock, Speaker Buckman presiding.

SPEAKER BUCKMAN: The House will be in order, Dr. Wilson having reported a quorum present.

If there be no objection from the floor, we will dispense with the roll call and with the reading of the minutes of yesterday's meeting.

At the close of yesterday afternoon's meeting, we were in the midst of discussing Chapter II, Section 7, of the By-laws.

DR. FRANCIS F. BORZELL [Philadelphia]: Mr. Speaker, I move that we take from the table Section 7.

[The motion was seconded by Dr. Walter S. Cornell, Philadelphia.]

SPEAKER BUCKMAN: Are you ready for the question?

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: The Chair recognizes Dr. Bates.

Report of Revision Committee (continued)

DR. BATES: Chapter II, Section 7, reads: "It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body, these delegates so elected to assume office on January 1 following their election."

And this amendment:

"The Board of Trustees and Councilors are hereby authorized to reimburse delegates to the A.M.A. for travel expenses and maintenance while in attendance at the sessions of the American Medical Association."

SPEAKER BUCKMAN: Is there any question or further amendment of that section?

DR. JOSEPH A. PARRISH [Centre]: Didn't that read \$15 a day?

SPEAKER BUCKMAN: It is not necessary to take a ballot on it because that is a recommendation offered by the revision committee.

Is there any question on Section 8? Proceed to the next.

DR. BATES: CHAPTER III.—COMMITTEES OF THE HOUSE OF DELEGATES.

A word of explanation here. Our committee and commission system sort of grew up like Topsy and if we had tried to find the function and the origin of certain committees, it would have meant a period of research. With the memory of Dr. Donaldson available and the workings of committees known by Dr. Buckman as they were, we tried to put together in this chapter and in a later one the appointing power and functions and limitations. It is pretty much stereotyped, but we will go over it for the next few minutes.

SECTION 1.—The reference committees of the House of Delegates shall be as follows, the appointments to be made annually by the President-elect prior to July 1 from the members already reported as members of the House of Delegates for the coming session of this Society:

A Committee on Credentials.

A Reference Committee on Reports of Officers.

A Reference Committee on Reports of Standing Committees.

A Reference Committee on Reports of Commissions.

A Reference Committee on Scientific Business.

A Reference Committee on New Business.

A Reference Committee on Hospital Relations.

A Reference Committee on Revision of the Constitution and By-laws.

DR. BORZELL: For the sake of clarity I raise the question as to whether that should not read a Reference Committee on Amendments to the Constitution and By-laws, instead of revision.

I offer that as an amendment.

[The amendment was seconded by Dr. Willbur E. Flannery, Lawrence.]

SPEAKER BUCKMAN: The question is on changing the word "Revision" to "Amendment." Are you ready for the question?

[The amendment was put to a vote and carried.]

DR. BATES:

SECTION 2.—The Committee on Credentials of the House of Delegates shall consist of three members of the House of Delegates for the coming session of this Society, to which shall be referred all questions regarding the registration and credentials of the delegates.

SPEAKER BUCKMAN: No question here? Proceed.

DR. BATES:

SECTION 3.—The Reference Committee on Reports of Officers shall consist of five members of the House, and to it shall be submitted all reports of officers.

DR. BATES:

SECTION 4.—The Reference Committee on Reports of Standing Committees shall consist of five members of the House, and to it shall be submitted reports of all committees not otherwise specifically referred to other committees.

DR. BATES:

SECTION 5.—The Reference Committee on Reports of Commissions shall consist of five members of the House, and to it shall be submitted reports of all commissions not otherwise specifically referred elsewhere.

DR. BATES:

SECTION 6.—The Reference Committee on Scientific Business shall consist of five members of the House, and to it shall be referred all new business of a scientific nature, not otherwise specifically referred to other committees before action may be taken by the House.

SPEAKER BUCKMAN: Are there any questions, then, on Chapter III, Sections 3, 4, 5 and 6? Proceed!

DR. BATES:

SECTION 7.—The Reference Committee on New Business shall consist of five members of the House, and to it shall be referred resolutions introducing ordinary new business, not specifically referred to other committees, before action may be taken by the House.

DR. BATES:

SECTION 8.—The Reference Committee on Hospital Relations shall consist of seven members of the House, and to it shall be referred all matters pertaining to the relationship between the profession and hospital administration.

SPEAKER BUCKMAN: This is an entirely new section. Any question? Proceed!

DR. BATES:

SECTION 9.—The Reference Committee on Revision of the Constitution and By-laws shall consist of five members, and the President, Secretary-Treasurer, and Speaker of the House of Delegates as ex-officio members. To it shall be referred all proposals for additions, revisions, and modifications concerning the Constitution and By-laws.

That word "Revision" was changed to "Amendment" by previous action, and I think we should make that change here.

SPEAKER BUCKMAN: Is there a question here?

DR. BATES: Are we in error in including in our last sentence "to it shall be referred all proposals for additions, revisions, and modifications?" Should we again change that word "revisions" to "amendments"?

SPEAKER BUCKMAN: It would be the interpretation of the Chair that we should not, for the reason that an addition or a change which is either revision or modification is accomplished by amendment and in no other manner.

DR. WALTER S. CORNELL [Philadelphia]: Mr. Speaker, I will ask Dr. Borzell whether or not the present comprehensive revision was referred to his Committee on Revision of the By-laws.

DR. BORZELL: Mr. Speaker, it was not, for the very reason that under Robert's Rules of Order this body authorized a committee to bring about a complete revision of the Constitution and By-laws and, consequently, did not take the same status as an amendment, according to Robert's Rules of Order.

DR. CORNELL: We want to make it an amendment right now. That is the point.

DR. BORZELL: There would need to be an original motion by the House calling for a committee to be established to bring about a complete revision, and I think a discussion of that motion itself is perhaps advisable to be referred to the reference committee; but once the House has authorized a Committee on Revision, then that committee and its deliberations would take the proper status according to Robert's Rules of Order.

I don't think it has any reference at all to this committee, because this committee was properly authorized by this House to bring about a complete revision, and under Robert's Rules of Order a complete revision takes exactly the same status as the adoption of a new constitution and by-laws.

SPEAKER BUCKMAN: Is there further question regarding the use of the word "amendments" as against "revisions?"

Proceed with the next.

DR. BATES:

SECTION 10.—The proceedings of the House of Delegates at the annual meeting, or any special meeting, shall be published in this Society's publication, in the first possible issue following said meeting of the House of Delegates.

SPEAKER BUCKMAN: This is the old section, eliminating the words "in full." Any question on it? Proceed!

DR. BATES: I want to thank the gentlemen, first, for passing on this, because what we have attempted to do is lighten your own work by having more reference committees. By spreading the work a little wider the committees can make their reports without staying up all night. So we labored on this in your behalf.

We have eliminated Section 6 of the old By-laws.

SPEAKER BUCKMAN: Any question about eliminating that? Proceed!

DR. BATES: We decided to try to eliminate Section 7.

SPEAKER BUCKMAN: Do you require an explanation as to why that should be deleted?

We will proceed with Chapter III.

DR. BATES: Chapter III in the old By-laws becomes Chapter IV. The first paragraph, plus the geographic distribution of counties remains unchanged.

CHAPTER IV.—COUNCILOR DISTRICTS

SECTION 1.—The State of Pennsylvania shall be divided into twelve councilor districts, and each district shall be entitled to one councilor. The councilor districts shall be composed of the following counties:

First Councilor District—Philadelphia County.

Second Councilor District—Berks, Bucks, Chester, Delaware, Lehigh, and Montgomery Counties.

Third Councilor District—Carbon, Lackawanna, Monroe, Northampton, Pike, and Wayne Counties.

Fourth Councilor District—Columbia, Montour, Northumberland, Schuylkill, and Snyder Counties.

Fifth Councilor District—Adams, Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, Perry, and York Counties.

Sixth Councilor District—Blair, Centre, Clearfield, Huntingdon, Juniata, and Mifflin Counties.

Seventh Councilor District—Cameron, Clinton, Elk, Lycoming, Potter, Tioga, and Union Counties.

Eighth Councilor District—Crawford, Erie, Forest, Mercer, McKean, and Warren Counties.

Ninth Councilor District—Armstrong, Butler, Clarion, Indiana, Jefferson, and Venango Counties.

Tenth Councilor District—Allegheny, Beaver, Lawrence, and Westmoreland Counties.

Eleventh Councilor District—Bedford, Cambria, Fayette, Greene, Somerset, and Washington Counties.

Twelfth Councilor District—Bradford, Luzerne, Sullivan, Susquehanna, and Wyoming Counties.

SPEAKER BUCKMAN: Any questions? Proceed!

DR. BATES: Section 2 of Chapter III becomes Section 2 of Chapter IV, and remains unchanged.

SECTION 2.—Each councilor district shall have a separate board of censors. The board shall be formed by the House of Delegates of this Society electing one censor from each component county medical society in the councilor district. Each component county medical society is requested to present to the House of Delegates for its consideration the name of a suitable member for district censor.

SPEAKER BUCKMAN: Is there any question?

DR. BATES: Section 3 has several changes in wording.

SECTION 3.—The district censors of each councilor district shall sit under the chairmanship of the councilor of the district who shall not have the right to vote. They shall consider every case of appeal from the decision of a component county medical society by a member who has been censored, suspended, or expelled, provided that the appeal is made within three months after the censure, suspension, or expulsion. They shall report in writing their decision thereon to the county medical society, and also to the trustees and councilors of this Society. They shall consider and dispose of all questions affecting the principles of medical ethics that may be referred to them, either by a component county medical society or by this Society. The decision of the censors in every case must be signed by a majority of the board. Any appeal or judicial question arising in a district comprised of less than three county societies shall be referred directly to the judicial council of this Society.

DR. BATES: To this Section 3 is added:

A. In instances wherein the censors or judicial board of a component society suppress without a proper hear-

ing, or deny appeal from board decision on charges of unethical conduct formally brought against a member of this Society, the complainant may bring such alleged conduct or such decision, through the Board of Trustees and Councilors of this Society, to the consideration of a grievance committee composed of the district censors of the complainant's councilor district. The findings of the grievance committee shall be reported to the Board of Trustees and Councilors, seated as a Judicial Council, for disposition.

SPEAKER BUCKMAN: Is it thoroughly understood just what the implication is in this new subsection A?

DR. BATES: A new subsection B:

B. In hearing appeals the district censors may admit oral or written evidence as in their judgment will best and most fairly present and record the facts.

After giving at least thirty days' notice to the appealing member and his component county society, the Board of Trustees and Councilors sitting as a Judicial Council shall hold a hearing on the appeal. The Board shall review the record of the original proceedings and may obtain additional evidence. Its decision shall be final except that within the next ninety days a further appeal may be made to the Judicial Council of the American Medical Association.

SPEAKER BUCKMAN: Is there any question on this subsection B? Proceed!

DR. BATES:

SECTION 4.—Each councilor district shall hold one or more district meetings each year for the purpose of increasing acquaintanceship, good fellowship, and organization among the physicians of the district. All physicians residing in the district who are eligible to membership in a component county medical society shall be invited to the meetings.

SPEAKER BUCKMAN: Proceed with Chapter V.

DR. BATES:

CHAPTER V.—ELECTION OF OFFICERS

SECTION 1.—All elections shall be by ballot of the House of Delegates and a majority of votes cast shall be necessary to elect.

SECTION 2.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the morning of the second day of the annual session. This order of business may be postponed to a definite time and place by a two-thirds vote of those present. The Speaker of the House of Delegates shall appoint three members as tellers, who shall count the ballots under the supervision of the Secretary-Treasurer. At the election of officers of this Society, such election shall be preceded by roll call of the members of the House of Delegates under the supervision of the Secretary-Treasurer.

SECTION 3.—Any person known to have solicited votes for, or sought after, any office within the gift of this Society shall be ineligible for any office for two years.

SPEAKER BUCKMAN: Proceed with Section 4.

DR. LOUIS W. JONES [Luzerne]: I would like to make a motion that Section 3 be stricken from the By-laws.

[The motion was seconded by Dr. Charles I. Shaffer, Somerset.]

DR. EDWARD LYON, JR. [Lycoming]: I question the wisdom of striking that out entirely. There may be flagrant cases which need disciplinary action and it might well be the function of this House to determine when and if those flagrant cases arise. I think we should have some disciplinary power.

DR. FRANCIS F. BORZELL [Philadelphia]: Mr. Speaker, may I speak in favor of the retention of that? I recall very distinctly a situation which occurred not too many years ago, in which I feel that the dignity of the medical profession and our State Medical Society was very much impaired by the obvious solicitation by one of our own members.

SPEAKER BUCKMAN: The question, then, is on the deletion of Section 3 of Chapter V.

Are you ready for the question? As many as favor the question, which is the deletion of this section, will say, "aye"; contrary, "no."

I am going to ask for a division.

[A standing vote was taken and the motion was lost, 59 to 44.]

DR. JOHN N. SNYDER [Fayette]: Could we have an interpretation of the section?

SPEAKER BUCKMAN: One of the members of the House has asked for an interpretation of this section. We will interrupt the proceedings to give the chairman of the Board of Trustees a chance to offer his interpretation. If any question arose under this section, it would be laid before the Board of Trustees acting as a Judicial Council. Dr. Deckard!

DR. DECKARD: I still can't see why we should question supposedly honest men and women. The section has been voted in, but just the same it can be interpreted either way.

SPEAKER BUCKMAN: Ladies and gentlemen of the House, you have an explanation from the chairman of the Board of Trustees who would ordinarily sit as the head of the Judicial Council in deciding such a case. The Chair will give its parliamentary interpretation of this section.

Any member known to say, "I want this or that office," and who seeks votes in behalf of himself for such office would be a flagrant offender under this section; but one accused of having become subject to the efforts of his friends to solicit votes for him could not be justly accused under this section.

Dr. Cornell!

DR. WALTER S. CORNELL [Philadelphia]: This section should specify—any member known to have solicited votes for himself. It may be practically impossible to keep your friends from campaigning for you, but they are not in any position to make commitments or promises for a candidate.

SPEAKER BUCKMAN: The situation in regard to this section is this: The chairman of the committee has offered it to you for correction or amendment. The amendment to strike it out was defeated. It is still open for any amendment, and if you wish to insert the words "for himself," now is the time to do it.

DR. SNYDER: I offer such an amendment.

SPEAKER BUCKMAN: Dr. Snyder offers the amendment inserting the words "for himself" after the word "votes."

[The motion was seconded by Dr. Francis F. Borzell, Philadelphia; put to a vote, and carried.]

DR. BATES:

SECTION 4.—The chairmen and secretaries of sections provided for by these By-laws or future action of the House of Delegates shall be elected by the sections at executive meetings held on the second day of the annual session.

This is Section 4 as our committee offers it.

[Dr. Bates re-read Section 4 of Chapter V.]

SPEAKER BUCKMAN: Is there any question? Proceed!

DR. BATES:

SECTION 5.—INSTALLATION OF OFFICERS.—The officers of this Society, except the President, shall assume their duties at the close of the last meeting of the annual session at which they are elected.

DR. BATES:

SECTION 6.—INSTALLATION OF THE PRESIDENT.—The President-elect shall be installed as President at the first general session of the next annual meeting following that at which he was elected. In the event that circumstances beyond the control of the Society prevent the holding of the regular meeting of the Society or of its House of Delegates, he shall assume the office of President at the previously announced time for the annual meeting of the Society.

DR. BATES:

SECTION 7.—No member of this Society shall be elected by the House of Delegates to serve simultaneously in more than one office, as specified in the Constitution, Article VIII, Section 1.

SPEAKER BUCKMAN: Are there any questions about Sections 5, 6 or 7 of Chapter V of the By-laws? If not, we will proceed to Chapter VI of the By-laws.

DR. BATES:

CHAPTER VI.—DUTIES OF OFFICERS

SECTION 1.—The President shall preside at all general meetings of this Society. At the first general meeting of the annual session following his election he shall deliver an address on such matters as he may deem of importance to this Society. He may at any time make suggestions in writing to the House of Delegates or to any committee or commission and shall close his term with a report to the House of Delegates. He shall be ex-officio a member of the Board of Trustees and Councilors. He shall be ex-officio a member of all committees and commissions.

SPEAKER BUCKMAN: For the sake of the record, I will point out to you that I am holding in my hand the August, 1948 number of THE PENNSYLVANIA MEDICAL JOURNAL. A typographical error there lists this as proposed Chapter IV. Dr. Bates is actually reading Chapter VI. I don't know how it appears in the copy you may hold in your hand. Is there any question?

DR. S. MEIGS BEYER [Jefferson]: I would like to go back to Section 7. It says:

"No member of this Society shall be elected by the House of Delegates to serve simultaneously in more than one office, as specified in the Constitution, Article VIII, Section 1."

In Article VIII, Section 1, it specifies, among other officers, if I read this correctly, the district censors. I wonder if those 60 members should be eliminated from

holding other office besides that of district censor. Is that what is intended?

SPEAKER BUCKMAN: I think the committee must have intended that. I do not recall in the discussions that the question was raised.

DR. BEYER: It seems a little drastic if the district censors, one from each county society, are eliminated from holding any other office.

DR. EDWARD LYON, JR. [Lycoming]: One could always resign if elected to another office and another be elected district censor.

DR. BEYER: As district censor?

DR. BATES: Dr. Tom Stites resigned as a district censor when he was elected a vice-president of this society.

SPEAKER BUCKMAN: It happens not infrequently.

(SECRETARY'S NOTE: Interestingly enough, the member elected the following day as president-elect promptly resigned as district censor representing his county society.)

DR. BORZELL: For the sake of clarity and correct interpretation, should not the term "without the right to vote" or "without vote" be added after ex-officio. Ex-officio of itself means that by the right of his office he is a member of a particular committee or body. But unless it is so specified, he has the right to vote.

SPEAKER BUCKMAN: That is correct. Do you wish to deprive an ex-officio member of any committee of the right to vote?

DR. BORZELL: I believe that for the sake of good organization they should not have the right to vote under those circumstances. I move that in this Section 1 wherever the term ex-officio appears, the words "without the right to vote" be added.

SPEAKER BUCKMAN: Is there a second to this proposed amendment?

[The amendment was seconded by Dr. Roy W. Mohler, Philadelphia.]

SPEAKER BUCKMAN: The question is on the insertion of the words "without the right to vote" following "ex-officio" wherever it occurs in this section.

[The amendment was put to a vote and carried.]

SPEAKER BUCKMAN: The proposed section is amended, and the words "without the right to vote" are inserted in two places.

DR. BATES:

SECTION 2.—The President-elect shall appoint the reference committees of the House of Delegates at least sixty days in advance of the next annual session of the House. He shall as far as possible select his committee appointees, with the exception of those that must be approved by the Board of Trustees and Councilors, at least thirty days in advance of the next annual session in order that meetings of such committees may be planned to be held during the annual session. He should attend all meetings of the Board of Trustees and Councilors during his term of office as President-elect and shall assist the President in the performance of his duties. In the event of his death, removal, refusal to serve, or for any other cause a vacancy exists, his successor shall be elected by the House of Delegates as a special order of business on the morning of the

first day of the annual session next succeeding such vacancy.

DR. LYON: For clarification, Chapter III, Section 1, stated that the appointments should be made annually by the President-elect prior to July 1. The first sentence as now read states at least sixty days in advance. Shouldn't they conform?

SPEAKER BUCKMAN: Dr. Lyon offers an amendment to strike out the words "at least sixty days in advance of the next annual session of the House" and to substitute the words "prior to July 1."

[The amendment was seconded by Dr. Walter S. Cornell, Philadelphia, put to a vote, and carried.]

DR. BATES:

SECTION 3.—The Vice-presidents shall assist the President and President-elect in the performance of their duties. In case of the death, resignation, or removal of the President, the vacancy shall be filled by the ranking Vice-president.

DR. E. ARTHUR WHITNEY [Delaware]: Mr. Speaker, the Delaware County delegates would like to offer this amendment: "The Vice-presidents shall constitute the Program Committee for the next annual session of the Society."

This would mean that this House would use great care in the selection of the vice-presidents. It would also require a change later in Chapter VII, Section 2.

[The amendment was seconded by Dr. Dennis T. Sullivan, Delaware.]

DR. THOMAS W. MCCREARY [Beaver]: I wish to call the attention of the House to Dr. Engel's resolution yesterday in which he asked that more responsibility be delegated to the first vice-president.

DR. LEONARD D. FRESCOLN [Philadelphia]: I would like to ask whether it is "vice-president" or "vice-presidents."

SPEAKER BUCKMAN: Vice-presidents—plural. My recollection is that yesterday's action retained the number at four.

The question, then, is on the addition of the words: "The Vice-presidents shall constitute a program committee for the next annual session of the Society." Are you ready for the questions?

SECRETARY DONALDSON: May I speak to the question?

SPEAKER BUCKMAN: Dr. Donaldson!

SECRETARY DONALDSON: Having served for thirty years with the Committee on Scientific Work in arranging annual programs and having listened yesterday to the appeal that four vice-presidents be elected in order that a good proportion of them might come from outlying counties, I question the wisdom of limiting the selection of a program such as will be offered this year to the judgment of four vice-presidents. That is no reflection on any past vice-presidents or any in the future. I will grant you that they could seek advice and help. While I want to see good members chosen as vice-presidents, with something for them to do, I rather hesitate to express approval of this proposition.

DR. S. MEIGS BEYER [Jefferson]: The way the section stands the responsibility is on the president and president-elect for putting the vice-presidents to work. I think if there has been any failure in the past, it must

have been in that direction. If the members elected to the office of President and President-elect would utilize the services of the vice-presidents, perhaps they would have enough duties to perform.

[The amendment was put to a vote and lost.]

DR. BATES: Still under Chapter VI:

SECTION 4.—The Secretary-Treasurer shall attend the general meetings of this Society, the meetings of the House of Delegates and of the Board of Trustees and Councilors. He shall have no vote in the Board of Trustees and Councilors nor in the House of Delegates. He shall keep the minutes of their respective proceedings in separate record books. He shall be custodian of all record books and papers belonging to this Society. He shall receive and receipt for the annual assessments from the component county medical societies. He shall provide for the registration of the members and the delegates at the annual session. He shall aid the trustees and councilors in the organization and improvement of component county medical societies, and in the extension of the influence and usefulness of this Society. He shall conduct the official correspondence, notifying members of meetings, officers of their election, and committees of their appointment and duties. He shall employ such assistance as may be ordered by the trustees and councilors, and shall make an annual report to the House of Delegates. He shall supply each component county medical society with the necessary receipts and blanks for making its report. Acting with the Committee on Scientific Work, he shall prepare and issue all programs.

The only change in this section is simply that of changing the name of our governing board and giving it its new official name—Board of Trustees and Councilors—on three different lines.

SPEAKER BUCKMAN: This is the old Section 3 of Chapter V. It now becomes Chapter VI, Section 4, with the change indicated. Is there any other change or question?

DR. BATES:

SECTION 5.—The Assistant Secretary-Treasurer shall act as an aid to the Secretary-Treasurer, especially during annual sessions, and may take his place when necessary as a temporary secretary. In case of vacancy in the office of the Secretary-Treasurer on account of death or otherwise, the vacancy shall be filled by the Assistant Secretary-Treasurer until the next annual session of the House of Delegates.

SPEAKER BUCKMAN: Is there any question on this?

DR. BATES:

SECTION 6.—The Secretary-Treasurer shall hold all funds of this Society together with bequests and donations and deposit the same in such banks or trust companies as may be designated as depositories by the Board of Trustees and Councilors. He shall pay money out of the treasury only on written orders signed by the President and countersigned by the Chairman of the Finance Committee of the Board of Trustees and Councilors. He shall render annually to this Society a full account of the state of funds. He shall give bond of a surety company, in an appropriate amount, for the faithful performance of his duties.

The wording there is changed only to give the official name for the Board of Trustees and Councilors on line 5.

SPEAKER BUCKMAN: This is the old Section 5 of Chapter V, which now becomes Chapter VI, Section 6, with that change. Any question?

DR. BATES: Section 7 has a change necessitated by bringing it in line with legal phraseology.

SECTION 7.—At the first meeting of the Board of Trustees and Councilors after the annual session of this Society, it shall organize by electing a chairman. The Board of Trustees and Councilors shall have charge of the financial affairs of this Society, including the right to borrow money, and shall have charge of all properties including the authority to purchase, sell, lease away or otherwise dispose of any real estate. It shall recommend to the House of Delegates the amount of the annual assessment. It shall be the duty of the Board of Trustees and Councilors to provide for and superintend the publication of a medical journal and of all proceedings, transactions, and memoirs of this Society. It shall have full discretionary power to omit from the medical journal, in part or in whole, any paper or advertisement that may be referred to it for publication. It shall appoint an Editor of the JOURNAL and such assistants as may be necessary, and shall determine the salaries and the terms and conditions of their appointment.

It shall exercise general supervision over the conduct of all committees and commissions in the interval between sessions.

It shall be empowered to appoint an Executive Secretary, who shall perform such executive duties as the Board may designate, and who shall receive such salary and serve for such period and under such conditions as the Board may determine.

It shall be empowered to employ such administrative representative or representatives for the Society as shall be needed to conduct the work outlined by the Committee on Public Relations, or any other constituted or appointed committee.

These representatives' activities shall be only of an executive nature, since all policies of this Society shall originate within the House of Delegates, the Board of Trustees and Councilors, or within appointed or constituted committees. The term of employment of such representatives shall not exceed one year; the salary and conditions of their employment shall be determined by the Board of Trustees and Councilors.

a. The chairman shall appoint a finance committee of three members of the Board.

b. The chairman shall appoint a committee of three members of the Board to supervise the publication of a medical journal.

SPEAKER BUCKMAN: This is the old Section 6 of Chapter V, now to become Section 7 of Chapter VI with the changes read by Dr. Bates.

DR. E. ROGER SAMUEL [Northumberland]: Mr. Speaker, as a matter of clarification, it says that they shall elect a chairman. Is it determined in that section whether the chairman has to be a member of the Board of Trustees and Councilors or can they elect any member of The Medical Society of the State of Pennsylvania to be chairman of the Board?

SPEAKER BUCKMAN: Will anyone offer an answer to Dr. Samuel's question? The Chair would reply to that by saying that the implication is and always would be that the chairman must be a member of the Board.

DR. SAMUEL: The explanation I would make, Mr. Speaker, is this: Having been chairman of the Board

of Trustees for several years, I feel that some time it may be desirable to elect someone outside who would have a fine knowledge, as yourself, of the proceedings in a body of that kind. It may not always be to the advantage of the Board to elect one of its own members. Having felt my own deficiency in this matter, I think it should either be clarified, or else be left as it is, that a man from outside could be invited to be the speaker or chairman of the board.

SPEAKER BUCKMAN: To bring the question to a decision, Dr. Samuel, are you seated as a member of the House?

DR. SAMUEL: I am.

SPEAKER BUCKMAN: Will you offer an amendment by inserting the words "from its own membership" after "chairman?"

DR. SAMUEL: I would prefer to leave it the way it is.

DR. FRANCIS F. BORZELL [Philadelphia]: Mr. Speaker, I am afraid that Dr. Samuel is raising a question which would result—if the Board of Trustees should even think of electing anyone outside of its own body—in violating the Articles of Incorporation and Charter of the Society, because the Board of Trustees is definitely a part of the corporate body and, consequently, someone outside of that body could not be a chairman of the Board of Trustees. I think it is quite obvious that the chairman must be a member of the Board of Trustees and Councilors.

DR. WALTER S. CORNELL [Philadelphia]: Apparently the trustees have power to purchase or sell and "lease away or otherwise dispose of any real estate."

DR. BATES: I said before reading this section that that phraseology was used on legal advice.

SPEAKER BUCKMAN: Proceed!

DR. BATES:

SECTION 8.—The Board of Trustees and Councilors shall have full control of all arrangements for the annual session. It may employ a Convention Manager, who shall carry out all the business details incident to the annual session of this Society. He shall provide suitable accommodations for the meeting places of this Society, Board of Trustees and Councilors, and the House of Delegates and their respective committees. He shall report an outline of the arrangements to the Secretary-Treasurer for publication in the program and in the medical journal, and make such additional announcements during the session as occasion may require. He shall render to the Board of Trustees and Councilors a full itemized account of all receipts and expenditures on account of the annual session, and he shall, from time to time, remit moneys received to the Secretary-Treasurer. All items of expense in connection with the annual session shall be paid out of the treasury on written orders signed by the President and approved by the chairman of the Finance Committee of the Board of Trustees and Councilors, excepting such small items as may be paid from a "Revolving Petty Cash Fund," which may be provided for this purpose. He shall receive a salary to be fixed annually by the Board of Trustees and Councilors. He shall give a bond of a surety company in the sum of \$1,000 for the faithful performance of his duties.

The Board of Trustees and Councilors may, at their discretion, combine any of these designated positions in a manner which they may deem for the best interest of this Society.

All resolutions or recommendations of the House of Delegates pertaining to the expenditure of money must be approved by the Board of Trustees and Councilors before the same shall become effective. During the annual session of this Society, the Board shall hold meetings as often as may be deemed necessary and all matters referred to it by the House of Delegates shall be reported on within twenty-four hours if so requested by the House of Delegates. The Board of Trustees and Councilors shall have the accounts of the Secretary-Treasurer and the officers of the JOURNAL audited annually or oftener if deemed desirable and shall make an annual report on the same to the House of Delegates. This report shall specify the character and cost of all publications of this Society during the year and the amount of all properties belonging to this Society.

The Board of Trustees and Councilors shall designate the salary of the Secretary-Treasurer.

Regular meetings of the Board shall be held immediately after the conclusion of the annual meeting of the House of Delegates, and at least quarterly thereafter. Special meetings of the Board may be called at any time by the chairman or by three members of the Board. Seven members of the Board shall constitute a quorum. During the intervals between the sessions of the House of Delegates, the Board of Trustees and Councilors shall supervise the action of committees and commissions constituted by the action of the House of Delegates.

SPEAKER BUCKMAN: Is there any question? Chairman Bates has just read the five paragraphs of the old Section 7, Chapter V, now becoming the five paragraphs of Section 8, Chapter VI, with the changes indicated.

DR. BATES:

SECTION 9.—BOARD OF TRUSTEES AND COUNCILORS.—Each councilor shall be judicial representative of this Society for his district consisting of certain counties. He shall visit the component societies in his district at least once a year and make a report of such visit at the next meeting of the Board of Trustees and Councilors. It shall be his function to help organize component county medical societies where none exist; to inquire into the condition of the profession, and to improve and increase the zeal of component county medical societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district at the annual session of the House of Delegates. Members of the Board of Trustees and Councilors shall be reimbursed for their travel expenses in attendance at Board meetings, and for any official business of this Society.

SPEAKER BUCKMAN: Dr. Bates has read old Chapter V, Section 8, with the changes indicated, now becoming Section 9, Chapter VI. Is there any question? Proceed!

DR. BATES:

SECTION 10.—The Board of Trustees and Councilors shall be the Judicial Council of this Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component county medical societies, or to the Society. All questions of an ethical nature brought before the House of Delegates or the General Meeting shall be referred to the Council without discussion. It shall decide all questions of discipline affecting the conduct of members or component county medical societies, on

which an appeal is taken from the decision of the Board of Censors, as provided in Chapter IV, Section 3a, of these By-laws. Its decision in all such matters shall be final, unless appealed to the Judicial Council of the American Medical Association.

SPEAKER BUCKMAN: Dr. Bates has read old Chapter V, Section 9, now becoming Section 10, Chapter VI, with the changes indicated.

DR. BATES: In Section 11 (old Section 10, Chapter V) there is a change, again, in which we refer to members as Doctors of Medicine.

SECTION 11.—In sparsely settled sections it shall have authority to organize the Doctors of Medicine of two or more counties into a society. Such societies, when organized and after their constitution and by-laws have been approved by this Society, shall be entitled to all rights and privileges provided for component county medical societies.

DR. BATES: In Section 12 the official name of the Board of Trustees and Councilors is used in the first line, and in the last line of the first paragraph we have added the words "these By-laws."

Paragraph "a" we have changed for the sake of better English.

In "b" we have the official name again of Trustee and Councilor; that is the only change. In "d" and "e" also, we have the official name, and in "f" the official name in two places.

SECTION 12.—The Board of Trustees and Councilors shall select a member of the bar of Pennsylvania as legal counsel of this Society, and is empowered to pay such counsel an annual retaining fee. To the legal counsel shall be submitted all suits for alleged malpractice brought against members of this Society and he shall be asked to endorse local counsel suggested by the trustee and councilor to defend such suits. To him also shall all proposed appeals to higher courts be submitted. The proper fees for defending members of this Society in suits for alleged malpractice shall be paid out of the Medical Defense Fund, provided that the member has placed his case in the hands of this Society in accordance with these By-laws.

a. A member sued or threatened with suit for alleged malpractice should at once fill out the application blank, which can be secured from the office of the Secretary-Treasurer of this Society. The Society will not undertake the defense of any member unless his application is made within seven days after service of summons.

b. Legal procedure requires that an appearance be made in court usually within fifteen days after service of summons. If deemed expedient by the Trustee and Councilor, he may, having ascertained from the Secretary-Treasurer of this Society that the member making application was in good standing at the time of the alleged malpractice, retain an approved attorney to make appearance in court in response to service of summons. The Society will not be responsible for attorney's fees incurred in behalf of any applicant, the defense of whom has not been approved by the Trustee and Councilor for the District.

c. Before other assistance than the service specifically provided for in paragraph "b" of this Section may be given, the application must be endorsed by unanimous vote of all the censors of his county medical society present at a special meeting called for the consideration of the applicant's standing in his society. It should be understood that the endorsement of the censors of a

county medical society carries with it not only moral support but their active participation in the conduct of the trial in any way they may best assist, and all without thought of pecuniary return.

d. Immediately after the application has received the endorsement of the censors of the county medical society, it shall be mailed to the Trustee and Councilor for the District.

e. After the application has received the endorsement of the county medical society censors and the Trustee and Councilor for the District, the management of the member's defense will rest with the Committee of Counsel—the Trustee and Councilor for the District, the President, the Secretary-Treasurer of this Society, and the necessary attorney or attorneys.

f. The Trustee and Councilor for the District or the Secretary-Treasurer of the State Society, or both, shall then arrange and conduct a conference with the legal representatives and other parties concerned, having in view the thorough discussion of all circumstances pertaining to the threatened suit and the possibility of its withdrawal. The Trustee and Councilor or Secretary-Treasurer, or both, upon approval by the Board of Trustees and Councilors shall be paid for their time expended in this particular service and be refunded their legitimate expenses.

Note the spelling of Counsel in "g"; it is not a mistake. There was confusion before.

g. The applicant shall sign a contract vesting in the Committee of Counsel sole authority to conduct the defense of his suit, and he shall agree to make no compromise or settlement of the case without the written consent of the Trustee and Councilor of his District.

h. The State Society will not undertake the defense of any member who, after investigation by the censors and Trustee and Councilor for the District, is believed guilty of criminal abortion, feticide, homicide, or any criminal act, or who has not conformed to the recognized ethical laws in regard to these cases. It will only defend suit brought in the course of legitimate professional work.

i. The State Society will not pay any expenses for serving subpoenas nor the expenses of witnesses residing within the county, nor will it pay judgment or fine awarded or imposed by the jury or court.

In "h" the official name appears again; in "i" there is no change.

In Section 13 we have the official name again.

SECTION 13.—The actions taken by the Board of Trustees and Councilors shall be published in this Society's publication in the first issue possible following the said meeting of the Board of Trustees and Councilors.

SPEAKER BUCKMAN: Dr. Bates has read, in the first place, old Section 11, Chapter V, which now becomes Section 12, Chapter VI, with the changes earlier indicated.

He also referred to the old Section 12 of Chapter V, now to become Section 13 of Chapter VI.

Are there any questions? This has covered the mechanism of applying for assistance from The Medical Society of the State of Pennsylvania in the event of threatened suit for alleged malpractice.

DR. STEPHEN I. DODD [Juniata]: Mr. Speaker, in reference to paragraph "g," how would that affect such a member's relationship with any commercial indemnity insurance that he might have outside of the Society? Would he have help from one or the other?

SPEAKER BUCKMAN: Dr. Donaldson!

SECRETARY DONALDSON: Section g: The applicant shall sign a contract, etc. Is that what you have in mind?

DR. DODD: Yes.

SECRETARY DONALDSON: For many years we have had perfectly harmonious relations with the commercial indemnity companies selling in Pennsylvania, and it has meant this much to the Society: when an applicant member holds such insurance, he formally agrees that he will not settle suit, no matter how much pressure is brought to bear upon him by his commercial insurance company, without the approval of the trustee and councilor for his district.

Harmonious relations with these companies result in the State Society being relieved of the payment of attorneys' fees. We cooperate just the same as if their attorneys were actually retained by us and their attorneys must always be approved by our own legal counsel. So it works advantageously to the member, to the Society, and to the indemnity company.

The Committee of Counsel is composed of the trustee and councilor for the district, the president of the Society, and its secretary-treasurer.

SPEAKER BUCKMAN: Those are the three whose signatures are necessary on his application blank for defense.

DR. CORNELL: Are they identified anywhere in the paper?

DR. LYON: Yes, in paragraph "e."

SECRETARY DONALDSON: It is understood that defense will be undertaken only after approval of the member's application for defense by the Board of Censors of his county society.

SPEAKER BUCKMAN: Any other question?

DR. BATES: May I diverge to add this to Dr. Donaldson's remarks? The premiums that we pay for commercial insurance in the State of Pennsylvania are so low as compared with the rates paid in other states that the difference would more than pay our county and state dues.

I think that is a very concrete example of the effectiveness of our harmonious system of handling suits for alleged malpractice.

Now, Chapter VII.—Commissions and Committees. Much of this is new. Previously, a presidential appointee to a committee served one year. A commission appointment might last for three years. We have divided our committee and commission structures on the basis that commissions are to handle scientific assignments and committees are to take care of the ordinary administrative, social, economic, and legislative affairs of the Society. Consider the changes from that angle.

CHAPTER VII.—COMMISSIONS AND COMMITTEES

SECTION 1a.—A Commission shall be defined as a group under a chairman, authorized by the House of Delegates and appointed by the President, to undertake scientific investigations and promulgate the instruction of the profession and the public. Such a commission shall be automatically discharged unless annually continued by the House of Delegates. Continued membership on a commission shall be contingent upon faithful performance of duty and attendance at a majority of called meetings. Commissions shall submit annually a

written report to the House of Delegates to be delivered to the office of the Secretary-Treasurer before July 1.

SPEAKER BUCKMAN: Any question on Section 1a?

DR. BATES:

b.—A Standing Committee shall be defined as a group under a chairman, authorized by these By-laws or by the House of Delegates and appointed annually by the President-elect at least thirty days prior to his installation as president, except as further provided for by these By-laws. They shall be responsible for other activities of the Society in the interim between annual sessions not specifically delegated to the Board of Trustees and Councilors. They shall submit annually a written report to the House of Delegates to be delivered to the office of the Secretary-Treasurer before July 1.

DR. BATES:

c.—A Special Committee shall be defined as a group under a chairman authorized by the House of Delegates or the Board of Trustees and Councilors, in the interim between sessions of the House of Delegates, for the purpose of expediting any other business of the Society. The membership of these committees will be appointed by the President and the committee report will be given to the House of Delegates by submitting annually a written report to the office of the Secretary-Treasurer prior to July 1.

SPEAKER BUCKMAN: Any question on Section 1 b or c?

DR. BATES:

SECTION 2 a. — STANDING COMMITTEES — membership to be appointed by the President:

- Committee on Scientific Work.
- Committee on Scientific Exhibits.
- Committee to Nominate Delegates and Alternates to the House of Delegates of the American Medical Association.
- Committee on Archives.
- Committee on Medical Benevolence.
- Committee on Educational Fund.
- Committee on Necrology.
- Advisory Committee to Woman's Auxiliary.
- Committee on Hospital Relations.
- Committee on Military Affairs.
- Committee on Psychiatric Services to Criminal Courts.
- Committee on Rural Medical Service.
- Committee on Telephone Directory.
- Committee on Workmen's Compensation Laws.

SPEAKER BUCKMAN: Is there any question?

DR. ROY W. MOHLER [Philadelphia]: The difference between commission and committee isn't very clear.

DR. BATES: When we are dealing with a specific subject, such as diabetes, cancer, dietetics, or tuberculosis, for the benefit of the public and the profession, we have named such groups commissions; but if appropriate information for the public and the profession is to be worked out along social, economic, service and legislative lines, we have named such study groups committees.

DR. MOHLER: Under the head of standing committees we have Scientific Work and Scientific Exhibits.

DR. BATES: May I repeat the words of Speaker Buckman? These are committees appointed annually to arrange programs and exhibits for our convention.

DR. JOHN T. FARRELL, JR. [Philadelphia]: Does this mean that annually the president shall reappoint all committees and commissions? Is there any provision for continuing membership?

DR. BATES: Later, the by-laws discuss the term for which they shall serve, and in Section 1a of Chapter VII, under the commission description, appears "Individual membership on commissions shall be contingent upon faithful performance of duty and attendance at a majority of called meetings."

All of you who have lived through the formations of committees realize the firecracker potentialities of removing members from committees who haven't done any work on such committees for many years and yet want their names continued there. You can appreciate what we are trying to do for the good of the Society, and particularly as a kindness to the reappointing power. The president has the right to appoint any member, but can't reappoint one who has not been active.

SPEAKER BUCKMAN: To answer Dr. Farrell's question, the Chair would give the interpretation that the membership of a committee ceases to exist at the end of the year for which it was appointed, unless we find hereafter that it is specifically provided that the terms of membership shall be staggered.

The personnel of the Committee on Public Relations, as we shall find later, is staggered, with nine members, three appointed annually to serve for three years.

However, if we adopt Section 1a, Section 1b, and Section 1c, as written here, it will be in line with ex-President Petry's plea to the House last year that we do something about defining commissions and committees and about giving the presidents of our Society the opportunity to put life into the committees by dropping those members who really could not work or who did not show interest.

Finally, in answer to Dr. Farrell's question again, most of these would be constituted for only one year for that very purpose.

Is there another question? Do you wish to offer an amendment to what has just been read—to Section 2a, which simply lists the standing committees?

DR. CORNELL: There is a question in my mind (it may be imaginary) about this. The general intent is, of course, that the standing committees are paramount. The standing Committee on Public Relations is a very important committee. Would it be worth while to strengthen the paragraph on commissions, which states very plainly that we have scientific work, to add after "promulgate the education of the profession and the public" the words "regarding the subject matter of their respective commissions"? It may be superfluous or superfluous, but at least it holds the commission down to specific subject matter, whereas now it says they can promulgate the education of the public, which might overlap the standing Committee on Public Relations.

SPEAKER BUCKMAN: I still maintain, Dr. Cornell, unless the House questions the ruling, that much of this is out of order; it is not germane to the point we have reached in our consideration of these proposed by-laws. We simply read a list of the proposed standing committees. Unless you wish to eliminate one of them or unless you wish to add one, it would seem to me at the

moment no other discussion is germane until we reach the identifying by-law describing such committees.

DR. CORNELL: Have we passed Section 1a?

SPEAKER BUCKMAN: Section 1a has not been passed, but it was opened for amendment and suggestion. You can change it again; you can amend it yet.

DR. CORNELL: I will make a motion, just to bring it to a yes or no vote, that Section 1a as it reads here be amended to add these words: After "promulgate the education of the profession and the public" add the words "regarding the subject matter of their respective commissions."

SPEAKER BUCKMAN: Dr. Cornell offers the amendment that after the word "public" in the fifth line, the words "regarding the subject matter of their respective commissions" be added.

DR. BATES: Assigned to?

DR. CORNELL: Yes; all right.

SPEAKER BUCKMAN: Would you accept the words "identifying their commission"?

DR. CORNELL: Yes.

SPEAKER BUCKMAN: He offers the words, "regarding the subject matter identifying their commission." Do I hear a second?

[The amendment was seconded by Dr. Wilbur E. Flannery, Lawrence.]

[The amendment was put to a vote and carried.]

SPEAKER BUCKMAN: Do you wish to correct 1b, which defines a standing committee?

DR. FARRELL: I still think some provision should be made for staggered appointments. I agree that the dead wood on committees should be thrown off. On the other hand, it takes a year to find out what a committee is all about, and to have them changed each year and no provision made for continuing the membership is wrong, I think. I don't know just how it should be worded or where it should be put in.

SPEAKER BUCKMAN: The question would be, Dr. Farrell, whether to introduce the words in this definition or whether to introduce them when each committee comes up for identification later.

DR. FARRELL: Whichever you decide is agreeable to me.

SPEAKER BUCKMAN: No, it is up to you. If you want to offer an amendment or if you want to await the opportunity to amend these several ones as they come up later, or at the end, if you wish to go back, not being satisfied at that time, you still can do it.

DR. FARRELL: I'll wait until then.

SPEAKER BUCKMAN: Any other question on 1c?

DR. LOUIS W. JONES [Luzerne]: In regard to paragraph 1c, I would request a little clarification. The last line says, "The membership of these committees will be appointed by the President and the committee report will be given to the House of Delegates." Does that imply, if the Board of Trustees appoints a special committee to investigate some matter, that it does not report back to the Board but to the House of Delegates?

SPEAKER BUCKMAN: It requires that the report must be given annually to the House of Delegates, but it does

not forbid interim reports to the Board of Trustees, because it does not specifically say they should not.

DR. BORZELL: In connection with paragraph 3, I am wondering about something else. In order to bring it formally before the Society, I would like to move the amendment of paragraph c by striking out the sentence beginning: "The membership of these committees will be appointed by the President and the committee report will be given to the House of Delegates by submitting annually a written report to the Secretary-Treasurer prior to July 1."

This is my reason—this is my interpretation of it at least as it is presented. We are defining commissions and standing committees and then special committees. I know very well, and everyone knows, that the Board of Trustees, for instance, in its interim activities finds it necessary to appoint a special committee for some special specific purpose of either expediting or furthering the business of the Society and the functions of that committee are probably limited both as to time and extent and reporting back to the Board of Trustees. Would it not be burdening the activities of this House to require that all such special committees bring a report annually back to the Society on matters which are probably largely minor?

At the same time I can understand very well that there might be situations in which the chairman of the Board of Trustees and Councilors would be much better prepared to name a special committee than the president. It would seem to me that with that last paragraph we are limiting and defining the functions of special committees a bit farther than would be necessary for good functioning.

I move, therefore, the deletion of that last sentence, as indicated.

SPEAKER BUCKMAN: Do I hear a second?

[The motion was seconded by Dr. Constantine P. Faller, Dauphin.]

SPEAKER BUCKMAN: The question is on striking out: "The membership of these committees will be appointed by the President and the committee report will be given to the House of Delegates by submitting annually a written report to the Secretary-Treasurer prior to July 1."

The effect of striking out those words would be to create a special committee for a certain purpose. It would be authorized by the House of Delegates or by the Board of Trustees and Councilors if the House of Delegates were not in session. The committee would not be obliged to make any report unless by general consent to do so.

DR. CORNELL: Couldn't you fix the whole thing by changing the title of the whole chapter to "Commissions and Committees of the House of Delegates"? Then we would be confining it to what I think Dr. Bates was driving at.

SPEAKER BUCKMAN: The Chair would point out to Dr. Cornell that these are commissions and committees of The Medical Society of the State of Pennsylvania and not of the House of Delegates.

DR. CORNELL: Not the Board of Trustees; that is what I was trying to get away from.

SPEAKER BUCKMAN: The question is on striking out the final sentence of paragraph 1c.

DR. E. ARTHUR WHITNEY [Delaware]: This calls for committees from the House of Delegates or the

Board of Trustees and Councilors. Shouldn't the committee report back to the organization which creates the committee?

SPEAKER BUCKMAN: Any further discussion?

DR. B. FRANK ROSENBERY [Carbon]: If that is all deleted, by whom will the committee appointments be made?

SPEAKER BUCKMAN: No, Dr. Rosenberry, the question is on striking out only the final sentence.

DR. ROSENBERY: No.

SPEAKER BUCKMAN: That is right. Dr. Rosenberry points out that if you strike out the entire sentence, you will be taking out the identification of the appointive power. Are you ready for the question?

[The motion was put to a vote and lost.]

SPEAKER BUCKMAN: The sentence is retained. The section is now open for further amendment.

The House will stand in recess for two minutes only.

[Recess]

SPEAKER BUCKMAN: The House will be in order.

Ladies and gentlemen of the House, Clinton County has been without representation up to this time. It is our understanding that none of their delegates are present, but the secretary is in attendance and the members of Clinton County have caucused and elected Dr. Edward E. Hoberman as their representative and asked that he be seated as a delegate. If there is no objection from the floor, he is accepted as a delegate representing Clinton County.

The Chair recognizes Dr. Bates.

DR. BATES: Do we go on to Section 2 b?

SPEAKER BUCKMAN: Yes, 2 b.

DR. DEHAVEN HINKSON [Philadelphia]: I still think we could clarify this section instead of striking it out, as Dr. Borzell suggested, if we would change it to read: "The membership of these committees shall be appointed by the president and the committee reports shall be given in writing to the organization authorizing said committee."

If the House of Delegates authorizes the committee, it shall be made to them; if it is the Board of Trustees, it shall be made in writing to the Board of Trustees.

SPEAKER BUCKMAN: Are you referring to the standing committees?

DR. HINKSON: No; I am referring to special committees, Section 1 c. As it stands now, the last sentence remains in. It would just be amended to read, "The membership of these committees shall be appointed by the President and the committee reports shall be made in writing to the body authorizing said committees." In other words, a report would be made to the group that authorizes the committee and not to—someone raised the question that the Board of Trustees might appoint a committee for its own use, so why should it bring in its report to the House of Delegates. If the Board of Trustees authorizes a committee, it would report to the Board; if the House of Delegates authorizes one, it would report to the House.

SPEAKER BUCKMAN: The Doctor offers the amendment that the words "to the House of Delegates" be stricken out and that the words "to the body authorizing such committees" be substituted.

The Chair would point out to the House that by do-

ing that it would possibly be renouncing all control of certain committees that may be created during the interim between the meetings of the House. The Board of Trustees and Councilors, charged with conducting the affairs of the Society between the meetings of the House, felt that authority of The Medical Society of the State of Pennsylvania lies in the House of Delegates. If you wish to renounce authority over committees that have been created in the interval between meetings of the House, this amendment would accomplish that purpose. That would be the effect of it.

Do I hear a second?

[The motion was seconded by Dr. E. Arthur Whitney, Delaware.]

DR. WHITNEY: The beginning of Section 1 c states: "A Special Committee shall be defined as a group under a chairman authorized by the House of Delegates or the Board of Trustees and Councilors."

SPEAKER BUCKMAN: In the interim between sessions of the House.

The question is on striking out the words "to the House of Delegates" and substituting the words "to the body authorizing such committees." Any discussion?

SECRETARY DONALDSON: I share the speaker's sentiments about the possibility of robbing the chairman of the Board of Trustees and Councilors of the power of appointing a committee that has been authorized by the Board. I would also call the attention of the House to the fact that the annual report of the Board through its chairman to the House of Delegates embodies actions taken by committees that have been appointed by the Board in the interim. So it scarcely seems necessary to define that such committees should report to the House of Delegates, because their actions are always embodied in the report of the Board of Trustees and Councilors to the House of Delegates.

DR. CORNELL: You are in favor of this proposed amendment?

SECRETARY DONALDSON: I am not.

DR. WALLACE E. HOPKINS [York]: I think Dr. Donaldson's statement substantiates the thought of the delegate who offered the amendment. He wants the committee created by the Board of Trustees and Councilors to report back to it and not to the House of Delegates. That is perfectly reasonable, and, as Dr. Donaldson stated, the work of such a committee would come through to the House of Delegates in session in the report from the Board of Trustees and Councilors.

SPEAKER BUCKMAN: Are you ready for the question?

The question is to strike out the words "to the House of Delegates" and substitute the words "to the body authorizing such committees."

[The motion was put to a vote.]

SPEAKER BUCKMAN: The Chair will call for a division.

[The motion was put to a standing vote and lost, 38 voting for it and 45 against it.]

SPEAKER BUCKMAN: The words "to the House of Delegates" remain in. This section is open for further amendment.

DR. HERMAN A. FISCHER, JR. [Luzerne]: Since this is a special committee, I believe the word "annually" isn't necessary, and I believe that "prior to July 1" should be deleted. This committee may be started any

time during the year. I would amend it to read, "be given to the House of Delegates or the Board of Trustees and Councilors by submitting a written report to the office of the Secretary-Treasurer at the conclusion of its work."

SPEAKER BUCKMAN: Let us consider your offered amendment as to what should be stricken out first. You move to strike out the words "annually" and "prior to July 1."

[The motion was seconded by Dr. Cornell.]

SPEAKER BUCKMAN: Any discussion?

SECRETARY DONALDSON: Before the members vote on this, I think they should be cognizant of one of the reasons why we like to receive such reports early. The reports considered by your reference committees each year, except the supplemental reports, have been in the hands of the members of the reference committees for three or four weeks, giving them ample time for study before they go to the convention. If this proposed amendment is adopted, there might be any number of annual reports that wouldn't be received by anybody until they are introduced at the opening meeting of the House of Delegates, thereby encouraging inadequate study and subsequent reports to the House of Delegates by its reference committees.

SPEAKER BUCKMAN: The question is on striking out the words "annually" and "prior to July 1." Are you ready for the question?

[The motion was put to a vote and lost.]

SPEAKER BUCKMAN: Dr. Fischer moved to amend the section by inserting the words "or to the Board of Trustees and Councilors" after the word "Delegates."

[The motion was seconded by Dr. E. Arthur Whitney, Delaware.]

[The motion was put to a vote.]

CHAIRMAN BUCKMAN: The Chair will call for a division.

[The motion was put to a standing vote and was lost, 24 voting in favor and 40 against.]

SPEAKER BUCKMAN: The words are not inserted.

Any further amendment to the remainder of the section? Dr. Bates, proceed with 2 b.

DR. BATES:

b.—STANDING COMMITTEES—membership to be appointed by the President and approved by the Board of Trustees and Councilors:

Committee on Medical Economics.

Committee on Public Health Legislation.

Committee on Public Relations.

SPEAKER BUCKMAN: Any question here? Proceed!

DR. BATES:

SECTION 3.—It shall be the function of the President to name the chairman of any commission or committee, except as hereinafter provided by these By-laws. In case a vacancy occurs, the committee shall elect one of its own members as chairman until the next meeting of the House of Delegates. No member of this Society shall serve as an appointed member simultaneously on more than two commissions or standing committees.

(SECRETARY'S NOTE: After prolonged debate and repeated attempts to modify or delete the last sentence in Section 3, no alteration resulted.)

DR. BATES:

SECTION 4.—The Committee on Scientific Work shall consist of the President, Secretary-Treasurer, Editor, Convention Manager, Chairmen and Secretaries of the Sections, Chairman of the Finance Committee of the Board of Trustees and Councilors, Chairman of the Committee on Scientific Work, and Chairman of the Scientific Exhibit Committee. It shall determine the character and scope of the scientific proceedings of this Society for each session, subject to the instructions of the House of Delegates. At least ninety days previous to each annual session it shall prepare a program to be issued by the office of the Secretary-Treasurer, announcing the order in which papers and discussions shall be presented.

(SECRETARY'S NOTE: A motion to add the four vice-presidents to the Committee on Scientific Work was lost, as was a motion to add the word "a" before the words "Chairman of the Committee on Scientific Work.")

DR. BATES:

SECTION 5.—The Committee on Scientific Exhibits shall consist of a chairman appointed by the President and four additional members appointed by the chairman. It shall be their function to cooperate with the Committee on Scientific Work and the Convention Manager to develop for the next annual session instructive and educational exhibits of progress in the science of medicine.

SPEAKER BUCKMAN: No question?

DR. BATES: In Section 6, the first, second and third sentences are unchanged, then we have added a sentence. It is in reference to the Committee to Nominate Delegates.

SECTION 6.—The Committee to Nominate Delegates and Alternates to the House of Delegates of the American Medical Association shall consist of five members.

It shall be the duty of the committee, after careful consideration, to submit to the House of Delegates a list of nominees for delegates and alternates to the House of Delegates of the American Medical Association. These nominations shall not preclude nominations from the floor of the House of Delegates. To conform to the requirements of the House of Delegates of the American Medical Association, each nominee must have been a Fellow in the American Medical Association for at least two years prior to his nomination.

DR. BATES: In Sections 7 and 8 there are no changes except in reference to Trustee and Councilor.

SECTION 7.—The Committee on Archives shall consist of three members. They shall have charge of, and be custodians of, the records of this Society, written property, the Secretary-Treasurer's books not in use, records of conventions, and all written records pertaining to this Society and its functions.

SECTION 8.—The Committee on Benevolence shall consist of the Secretary-Treasurer and three members to be selected annually by the Trustees and Councilors, at least one of whom shall be a Trustee and Councilor. This committee shall select its own chairman, secretary, and treasurer, and shall have absolute and confidential jurisdiction over the distribution of such part of the Medical Benevolence Fund as may be placed in its hands. No money shall be paid from its treasury except on warrant signed by the chairman and secretary

of the committee, and an annual audit of its accounts shall be made by a committee of the Trustees and Councilors, the names of the beneficiaries being omitted. All beneficiaries shall be designated by number, and after each annual audit all communications tending to show the personality of the same shall be destroyed. This committee may solicit subscriptions, donations, and legacies to be added to the principal of the Medical Benevolence Fund. It may also receive subscriptions to be used for the relief of members in distress from the effects of any special catastrophe. It may also draw upon its treasury for the relief of members in distress from the effects of a special catastrophe of nature, giving due consideration to equitable recommendations from the president and the secretary of the distressed member's component county medical society and from the district councilor concerned.

SPEAKER BUCKMAN: Any question?

DR. JAMES Z. APPEL [Lancaster]: Section 6, Chapter VII, the Committee on Medical Benevolence.

SPEAKER BUCKMAN: We are not on that.

DR. APPEL: I understood you to say that you are.

DR. BATES: I am, in the new By-laws. If you look at the change of number, I am reading Chapter VII, Section 6, having to do with the nomination of delegates and alternates to the House of Delegates.

SPEAKER BUCKMAN: Proceed, Dr. Bates, with the reading of the new Chapter VII, Section 7. Dr. Appel raised a question.

DR. BATES: Section 7, sir, is on archives.

SPEAKER BUCKMAN: Are you ready for Section 8?

DR. BATES: We were on Section 7, which had to do with the Committee on Archives and which has no change. Then we came to Section 8, and the only thing I want to change there is the official name of the body.

DR. APPEL: I request clarification. In the section it states that the Committee on Benevolence shall consist of the Secretary-Treasurer and three members to be selected annually by the Trustees. In Section 2a of the same chapter, in the listing of standing committees, it mentions membership to be appointed by the President. I should like to know who will do the appointing.

SPEAKER BUCKMAN: Dr. Appel raises this question. In Section 2a after the words "Standing Committees," there is a dash and then the words "membership to be appointed by the President." In the revised list under that section appears Committee on Medical Benevolence, and when a little later the Committee on Medical Benevolence is defined, we find that it is to be selected annually by the Trustees. Dr. Appel fears that confusion may develop by allowing the words "membership to be appointed by the President" to stand in Section 2a, Chapter VII. Dr. Appel, would you like to introduce an amendment at this time to the heading of Section 2a, membership to be appointed by the President, adding "except as hereinafter provided by these By-laws"?

DR. APPEL: I will be glad to offer that amendment.

SPEAKER BUCKMAN: Dr. Appel offers that amendment.

[The amendment was seconded by Dr. Wilbur E. Flannery, Lawrence.]

DR. THOMAS W. MCCREARY [Beaver]: Isn't that answered in Section 3, the first sentence?

DR. BATES: That refers only to the chairman and not to the members.

SPEAKER BUCKMAN: Dr. Appel points out that we have made a mistake by not qualifying the words "membership to be appointed by the President" after we list the standing committees. We are not free to appoint a committee created otherwise. As a matter of completing the form of this, he offers his amendment to be inserted.

[The amendment was put to a vote and carried.]

SPEAKER BUCKMAN: We have inserted the words "except as hereinafter provided by these By-laws" after the word "President" under the heading "Standing Committees."

Dr. Bates offers on behalf of his committee the insertion of the word "Medical" before "Benevolence" in the first line of the new Section 8, Chapter VII. It is accepted.

DR. BATES:

SECTION 9.—The Committee on Educational Fund shall consist of the Secretary-Treasurer and three members to be selected annually by the Trustees and Councilors, at least one of whom shall be a Trustee and Councilor. This committee shall select its own chairman, secretary, and treasurer, and shall have jurisdiction over the distribution of such part of the Educational Fund as may be placed in its hands. No money shall be paid from its treasury except on warrant signed by the chairman and secretary of the committee, and an annual audit of its accounts shall be made by a committee of the Trustees and Councilors. When considering requests for educational assistance, this committee may consult members of the component society of the county from which the request is received and may consult also teachers and pertinent school records in their efforts to determine (1) the need for financial assistance and (2) the qualifications for the absorption of higher education of those for whom assistance is sought. This committee may solicit donations, legacies, and repayments to be added to the Educational Fund. All expense for the administration of this Fund shall be met from the Society's general checking account.

That is all new.

SPEAKER BUCKMAN: Is there a question or an amendment?

DR. THOMAS ST. CLAIR [Westmoreland]: We acted upon this Educational Fund before, and did not fix an assessment of \$2.00 per member. Is that where the finances come from? That will be \$20,000 a year.

DR. BATES: From Article IX, Section 5, of the Constitution, regarding the new fund approved yesterday, I read:

"Each year out of the funds of this Society the Trustees and Councilors, with the approval of the House of Delegates, may appropriate a sum not to exceed \$2.00 for each active member to be set aside by the Secretary-Treasurer as a special fund to be known as an Educational Fund."

The Board recommends and the House approves the allotment.

SPEAKER BUCKMAN: Is there any further question?

DR. BATES:

SECTION 10.—The Committee on Necrology shall consist of the Secretary-Treasurer of this Society and four members. They shall prepare and present a report at the opening general meeting of each annual session of this Society, and shall publish in the annual Membership List the names of members deceased from July 1 to July 1.

There are no changes in Section 10 except deletion of the words "appointed annually by the President," to which change Speaker Buckman called attention.

SECTION 11.—The Advisory Committee to the Woman's Auxiliary shall consist of three members. They shall act in an advisory capacity to the Woman's Auxiliary, and shall hold meetings whenever it is necessary to furnish advice to the Woman's Auxiliary on any debatable question regarding the change in their constitution or other functions.

There are no changes.

DR. LOUISE C. GLOECKNER [Montgomery]: Dr. Buckman, may I refer back to the section on the Educational Fund? In that paragraph, "When considering requests for educational assistance, this committee may consult members of the component society of the county from which the request is received and may consult also teachers and pertinent school records in their efforts to determine," and so forth. I move that "may" be changed to "shall." We should have reassurance from persons in close contact with school records of such boys and girls that indicate them to be good material for college before we spend our money on them.

SPEAKER BUCKMAN: Dr. Gloeckner moves the substitution of the word "shall" for the word "may" before "consult also teachers," also after "this committee."

DR. GLOECKNER: Yes.

[The motion was seconded by Dr. Thomas St. Clair, Westmoreland, put to a vote, and carried.]

DR. BATES:

SECTION 12.—The Committee on Hospital Relations shall consist of seven members and it shall be its duty to confer with any recognized organization of hospitals or hospital management. It shall also concern itself with legislation affecting hospitals and the medical profession, and it shall at all times labor to improve relations between the medical profession and the hospitals in Pennsylvania. It shall strive to elevate the standards of all hospitals in Pennsylvania in conformity with the Principles of Ethics and Rules of Standardization of the American Medical Association.

SPEAKER BUCKMAN: This defines a new Committee on Hospital Relations which you are creating.

DR. BATES:

SECTION 13.—The Committee on Military Affairs shall consist of five members, with at least one member from each branch of the three medical reserve units of the Armed Forces. They shall concern themselves with the existence of reserve units of the Armed Forces in Pennsylvania, and shall serve as a liaison agent between this Society and the Office of the Secretary of Defense or subordinate officials. They shall inform themselves and our members of pertinent knowledge concerning all phases of military medicine.

SPEAKER BUCKMAN: Another new committee—is there any question?

DR. BATES:

SECTION 14.—The Committee on Psychiatric Services to Criminal Courts shall consist of five members and it shall confer with and advise courts and local Pennsylvania Bar Associations regarding the relation of psychiatry to the practices and operation of criminal courts.

SPEAKER BUCKMAN: Is there a question here?

DR. BATES:

SECTION 15.—The Committee on Rural Medical Service shall consist of five members whose duty it shall be to make a study of current needs for improved medical facilities in rural areas.

SPEAKER BUCKMAN: Is there a question here?

DR. BATES:

SECTION 16.—The Committee on Telephone Directory shall consist of three members whose function it shall be to cooperate with the several telephone companies operating in Pennsylvania, to secure completely accurate listing of all subscribers affiliated with the healing arts in conformity with the Principles of Ethics of the American Medical Association.

SPEAKER BUCKMAN: Is there a question here?

DR. BATES:

SECTION 17.—The Committee on Workmen's Compensation Laws shall consist of five members whose function it shall be to keep under constant review workmen's compensation laws; to cultivate cooperation between employer and employee while striving to improve the medical services to the workmen and the position of the Doctor of Medicine in the provisions of the Act.

SPEAKER BUCKMAN: Any question here?

DR. BATES:

SECTION 18.—The Committee on Medical Economics shall consist of seven members to be appointed by the President, contingent upon approval by the Board of Trustees and Councilors. This committee shall consider all questions dealing with proposals for the expansion of health and medical service in Pennsylvania by State or Federal bureaus or by lay organizations as they may be referred to the committee by the House of Delegates or the Board of Trustees and Councilors. It is a fact-finding body and shall report annually to the House of Delegates. Its chairman shall attend or be represented at regular meetings of the Board of Trustees and Councilors.

SPEAKER BUCKMAN: The interpretation of this would be that that committee is automatically disbanded every year to be reappointed by the president-elect every year.

DR. BATES:

SECTION 19.—The Committee on Public Health Legislation shall consist of a representative from each councilor district, a chairman, and the President and the Secretary-Treasurer. These appointments shall be subject to and contingent upon the approval of the Board of Trustees and Councilors. This committee shall represent the Society in securing legislation in the interest of public health and scientific medicine. It shall act under the direction of the House of Delegates, and in the interim between the meetings of the House of Delegates

it is authorized to undertake such activities as in its judgment will further the purpose it represents.

No one saw fit to change that, except the official name of the Board of Trustees and Councilors at the end of the second sentence.

SPEAKER BUCKMAN: That is the old Section 4 of Chapter VI. Is that right? Any questions? Proceed!

DR. BATES: In Section 20 we have changed the name of the official board in a couple of places and then made one change further down.

SECTION 20.—The Committee on Public Relations shall consist of nine members appointed by the President, three of whom are appointed annually to serve for three years, and ex-officio the President, the President-elect, the Chairman of the Board of Trustees and Councilors, the Chairman of the Finance Committee of the Board of Trustees and Councilors, and the Secretary-Treasurer. These appointments shall be subject to and contingent upon the approval of the Board of Trustees and Councilors. It shall conduct and direct campaigns of public education in matters of public health and hygiene. It shall assist the component societies in the conduct of similar campaigns and shall act as a source of information to individuals, press correspondents, or civic or state bodies, who seek enlightenment on matters of public health, medical legislation, or scientific medicine. The President may appoint committees to deal with special problems which may arise, such committees to work in conjunction with the Public Relations Committee.

We have enlarged that to definitely contact the press.

SPEAKER BUCKMAN: Any question?

DR. BATES: Now we come to Chapter VIII.—County Societies.

[Dr. Bates read old Sections 7 and 8 of Chapter VI to be deleted.]

CHAPTER VIII.—COUNTY SOCIETIES

SECTION 1.—All county societies now in affiliation with this Society are component county medical societies. Those which may hereafter be organized in this state, which shall have adopted principles of organization not in conflict with this Constitution or these By-laws, shall, on approval of the censors of the district, become component parts of this Society. Only one component medical society from any one county shall be affiliated with this Society.

Chapter VIII, Section 1, remains unchanged.

SPEAKER BUCKMAN: Any question?

DR. BATES: In Section 2 we have made a couple of changes.

SECTION 2.—Remembering that the component county medical society is the only portal to this Society and the American Medical Association, in considering the qualifications of applicants for active membership, using due diligence so that only reputable Doctors of Medicine licensed in Pennsylvania, citizens of the United States, may be admitted to membership, each component county medical society shall make formal inquiry regarding such applicants to the Biographic Department of the American Medical Association.

SPEAKER BUCKMAN: Any question?

DR. BATES: In Section 3 we change the word "physician" to Doctor of Medicine in the first line; otherwise, it remains unchanged.

SECTION 3.—Any Doctor of Medicine who may feel aggrieved by the action of a component county medical society in refusing him membership shall have the right to appeal to the censors of the councilor district for their decision.

SPEAKER BUCKMAN: Any question?

DR. BATES: In Section 4 we have made a change.

SECTION 4.—When a member in good standing in any component county medical society moves to another county in this State, he shall, on request, be recommended by his society for transfer to the component county medical society into whose jurisdiction he moves, for election without the delay attendant upon ordinary applications for membership.

SPEAKER BUCKMAN: Any question?

For the record, it is necessary to read the old Section 4 of Chapter VIII, which is now deleted. It is this: [Speaker Buckman read old Section 4, Chapter VIII.]

DR. BATES:

SECTION 5.—Any physician living near a county line may hold his membership in the county most convenient for him to attend, on permission of the councilor of his district, but no physician shall at the same time hold membership in more than one component county medical society.

SPEAKER BUCKMAN: Any question?

DR. LOUIS W. JONES [Luzerne]: Don't you think we had better be consistent and use Doctor of Medicine for "physician" there?

DR. BATES: You are right.

DR. DOMINIC S. MOTSA [Bradford]: Mr. Speaker, may I ask a question? In the case of a Doctor of Medicine living near a county line, that county line also being the state line, could he be allowed to hold membership in two county societies, one in each of the two states?

SECRETARY DONALDSON: The American Medical Association does not permit holding membership in two state associations.

SPEAKER BUCKMAN: Any other question?

DR. BATES:

SECTION 6.—Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral, and material condition of every Doctor of Medicine in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every qualified Doctor of Medicine in the county.

We changed the word "physician" to "Doctor of Medicine" in the middle and last sentences.

SPEAKER BUCKMAN: Any question?

DR. BATES:

SECTION 7.—At some meeting prior to June 1, each component county medical society shall elect a delegate and two alternates to represent it in the House of Delegates of this Society, in the proportion of one delegate and two alternates to each one hundred of its members and for each fraction thereof in good standing on June 1 preceding the session.

SPEAKER BUCKMAN: The effect of this change is to advance the date at which delegates and alternates are to be elected. Is that right?

DR. BATES: Yes, but should the words "and two alternates at large" be added for the sake of consistency?

SPEAKER BUCKMAN: Yes. The committee offers the insertion of the words "and two alternates at large" after the word "delegate." Any other question?

DR. BATES: We have no change to make in Section 8.

SECTION 8.—The secretary of each component county medical society shall keep a roster of its members in which shall be shown the full name, address, college and date of graduation, date of registration or license to practice in the State, and such other information as may be deemed necessary. In keeping such a roster, the secretary shall note any change in the personnel of the profession by death or by removal to or from the county; and in the event of the death of a member he shall fill out in duplicate the blanks supplied by the State Society, keep one on file as a permanent record of the county society, and promptly forward the other to the State Society Secretary-Treasurer for permanent filing in the archives of the State Society.

SPEAKER BUCKMAN: Any question here?

DR. BATES:

SECTION 9.—The secretary of each component county medical society shall remit to the Secretary-Treasurer of this Society, promptly upon receipt, the amount of the annual assessment of the members of his society, together with a copy of the receipt given to the members of his society. He shall promptly notify the Secretary-Treasurer of this Society of any change of address of the members of his society, and of losses in membership, giving the cause, such as death (with date), resignation, transfer, removal (with present address), or expulsion. He shall upon request furnish the Secretary-Treasurer of this Society with a list of the officers and members of his county medical society, and shall report new members as soon as they are qualified as members of his society, remitting at the same time the amount of the member's annual assessment.

SPEAKER BUCKMAN: Is there any question?

DR. KEICHLIN: I think somebody ought to help Dr. Bates out; his voice is getting bad.

SPEAKER BUCKMAN: Section 10 of Chapter VIII was old Section 11 of Chapter VIII.

SECTION 10.—Each component county medical society shall notify the Secretary-Treasurer of this Society of any new by-laws or rules that have been adopted, and furnish for publication in the JOURNAL of the State Society brief notes of its deceased members. Each component county medical society shall designate one of its members to act as reporter for the JOURNAL, who shall furnish such reports of the meetings of his society and such professional news as may be thought desirable for publication.

"Chapter IX.—Miscellaneous" remains unchanged.

CHAPTER IX.—MISCELLANEOUS

SECTION 1.—No address or paper before this Society, except those of the President and invited guests, shall occupy more than fifteen minutes in its delivery. In the

discussion of any papers, no member shall speak longer than five minutes, except by unanimous consent.

Is there any question?

SECTION 2.—All papers read before this Society or the sections shall become the property of this Society. Each paper shall be deposited with the section secretary when read.

Any question?

Section 3 will remain unchanged as follows:

SECTION 3.—The deliberations of this Society shall be governed by parliamentary usage, as contained in Robert's Rules of Order Revised when not in conflict with this Constitution or these By-laws.

Section 4 will remain unchanged, reading as follows:

SECTION 4.—The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relation to each other and to the public, and to this end each member shall conduct himself so as not to defeat or tend to defeat the purposes for which the Society is organized and is operating.

Section 5 of Chapter IX remains as follows:

SECTION 5.—At each annual session, a public reception shall be provided as part of the program in honor of the President of the Society. This function shall be under the direction of the Secretary-Treasurer and the Convention Manager, and shall be paid for by this Society.

Old Section 6 is changed to read as follows:

SECTION 6.—Any vacancy occurring in an appointive office shall be filled at once by appointment by the President for the unexpired term, except as otherwise provided for by these By-laws.

Any vacancy occurring in an elective office during the interim of the annual sessions shall be filled by the Board of Trustees and Councilors until the next regular session of the House of Delegates, unless otherwise provided by these By-laws.

Any question?

Section 7 remains the same as old Section 7, deleting only the final paragraph. It will now read:

SECTION 7.—It shall be required that The Medical Society of the State of Pennsylvania shall keep on file at all times at the offices of the Philadelphia County Medical Society a complete published list of membership of The Medical Society of the State of Pennsylvania and the annual report of this Society, including an unabridged copy of the minutes of the meetings of the Board of Trustees, with the full financial report.

Any question?

A new Section 8 to Chapter IX is to be added, reading as follows:

SECTION 8.—If anything in these revisions is contrary to any previous articles or chapters, then such previous articles or chapters shall be considered null and void.

Any question here?

[Chairman Buckman read old Chapter X of the By-laws, changed to read as follows:]

CHAPTER X.—AMENDMENTS

These By-laws may be amended at any annual session by three-fourths vote of the House of Delegates after lying over one day. If there be less than three-fourths favorable vote, the amendment shall lie over for one year and take the course of amendments to the Constitution.

Any question about this?

Up to the present hour one negative vote can postpone the revision of the By-laws. One vote this afternoon can defeat these efforts toward revision over which we have labored for two hours.

Dr. Bates, do you have a plea to make to the House?

DR. BATES: Mr. Speaker, with fear and trepidation the Revision Committee, consisting of Drs. Edward Lyon, J. K. Williams Wood, Thomas McCreary, and myself as chairman, move the adoption or the acceptance of our report as it has been corrected in this House.

[The motion was seconded by Dr. Wilbur E. Flannery, Lawrence.]

SPEAKER BUCKMAN: The question is on the adoption of the report of the Committee on Revision of the By-laws which covers the By-laws which were read yesterday afternoon and this afternoon with amendments. Are you ready for the question?

[The motion was put to a vote and carried unanimously.]

SPEAKER BUCKMAN: The "ayes" have it.

As Speaker for the House, Dr. Bates, the Chair can do no less than express its appreciation for the masterful way in which you have presented your report and for the patience which you have exhibited during this action.

DR. BORZELL: Mr. Speaker, may I follow the Speaker's words by a formal vote of grateful thanks to this committee for the work that they have performed so very well.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield.]

DR. WALTER E. WENTZ, JR. [Delaware]: Mr. Speaker, I would like very much to include the Speaker of the House.

SPEAKER BUCKMAN: That is out of order, Dr. Wentz. It is the duty of the presiding officer to do certain things, and he does them.

The question is on the vote of gratitude and confidence offered by Dr. Borzell to the Committee on Revision of the Constitution and By-laws.

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: Dr. Bates and his committee stand with a vote of thanks and confidence.

DR. BORZELL: Mr. Speaker, may I present another motion, discharging this committee of its duties and at the same time requesting the appointment of a committee of three, including the chairman and two members of the committee, to act as an editing committee for the publication of the revised Constitution and By-laws.

SPEAKER BUCKMAN: Dr. Borzell, I believe that Dr. Bates yesterday preceded his presentation by having an understanding with the House that his committee would be allowed to edit, crossing t's and adding commas, and so forth, where necessary. Is that right?

DR. BORZELL: That is all I want.

SPEAKER BUCKMAN: Dr. Bates, did you not request that?

DR. BATES: Yes, sir; I did.

SPEAKER BUCKMAN: Dr. Borzell, you are out of order.

Do not forget the announcement Dr. Donaldson made;

there is to be a reception here at five-thirty to which the members of the House are invited, of course.

SECRETARY DONALDSON: The chairman in a moment or two is going to ask you for a motion to adjourn and advice as to when we shall meet again. I want to remind you all that while you have remained here in conference, hundreds of your fellow members have been traveling out to Convention Hall for programs beginning at eight-thirty in the morning. I want to advise, with the extensive reference committee reports that are coming up tomorrow morning, that this House adjourn tonight to meet tomorrow morning at eight-thirty o'clock.

SPEAKER BUCKMAN: I would attest to the need for an early meeting and prompt arrival. It is your pleasure to set the hour. I would remind you the first order of business after roll call is the election of officers for the ensuing year. After that is done, we have the consideration of the lengthy reports from three reference committees. Other years at this stage we have been practically through. This year we had this voluminous report of revision to cover. Now, we must be ready to accept with deliberation these reports of the reference committees.

With that in mind, the Chair will entertain a motion to adjourn until Wednesday morning (tomorrow), stating the hour at which we shall meet.

DR. LEONARD D. FRESCOLN [Philadelphia]: Mr. Chairman, I move that we adjourn to reconvene at eight-thirty tomorrow morning.

[The motion was seconded by Dr. Charles L. Shafer, Luzerne, put to a vote, and carried.]

SPEAKER BUCKMAN: We will adjourn until eight-thirty tomorrow morning. The first order of business will be the election of officers.

[The meeting adjourned at five o'clock.]

LEWIS T. BUCKMAN, *Speaker*,

WALTER F. DONALDSON, *Secretary-Treasurer*.

Wednesday Morning, Oct. 6, 1948

The House of Delegates convened at eight forty-five o'clock, Speaker Buckman presiding.

SPEAKER BUCKMAN: The House will be in order.

Dr. Wilson, chairman of the Committee on Credentials, reports a quorum present.

The first order of business after roll call and the reading of the minutes at this morning's session is the election of officers. If those present feel that we should wait until others have arrived, we can postpone that order of business by a favorable vote of two-thirds. What is the pleasure of the House?

DR. IRWIN J. OBER [Westmoreland]: I move that we postpone the election.

[The motion was seconded by Dr. John W. Barr, Cambria.]

DR. FRANCIS F. BORZELL [Philadelphia]: I offer an amendment to the effect that in the judgment of the Speaker, we will revert to the regular order of business sufficiently soon, so that our elections may be completed this morning.

[The amendment was seconded by Dr. Ward O. Wilson, Clearfield.]

[The motion was put to a standing vote and was carried, 35 voting for and 24 against.]

SPEAKER BUCKMAN: The amendment is carried.

Now, the question is on the amended motion that we shall postpone the stated order of business, namely, the roll call and election, until such time during the morning as the Speaker may see fit to ask for action of the House. Are you ready for the question?

[The motion was put to a voice vote, and then to a standing vote.]

SPEAKER BUCKMAN: There were 62 voting; two-thirds of that would be 43. The ballot was 37 for, 25 against; consequently, the motion was not carried.

The first order of business, then, will be the calling of the roll.

[Secretary Donaldson called the roll.]

SPEAKER BUCKMAN: The next order of business is the consideration of minutes of yesterday's meeting. If there be no objection from the floor, we will dispense with any consideration of those minutes at this time.

That brings us, then, to the election of officers.

The first office to be filled is that of president-elect. The Chair is ready to receive nominations.

Election of Officers

DR. ROY DECK [Lancaster]: Mr. Speaker, Members of the House of Delegates: I wish to nominate for president-elect of this Society Dr. E. Roger Samuel, of Mt. Carmel, Northumberland County. I have a sentimental interest in this gentleman's early life. I have known him longer than most of you. The early part of our respective careers was strangely parallel. Pardon the personal element, but he was a coal-cracker up in Northumberland County. I was a coal-cracker from Carbon County. He was here in Philadelphia at the University while I too was studying medicine. I didn't know him then. A little later we joined the Medical Officers Reserve Corps at the same time, in that hot August of 1916. We went to England on the same boat. We both belonged to that so-called Lost Legion, that great number of military doctors who went over to the British, about whom very few people know anything. We served in sister battalions for the British.

After the war he came to Lancaster County for his wife, and I went to Lancaster County for my wife. He has been active all his life. He has worked hard for the medical profession. He has been a member of the House of Delegates of the A.M.A. for some years; for ten years he was a member of the Board of Trustees of this society, for two years serving as chairman. He has served his county medical society well in every capacity. He is a general practitioner, which today is of paramount importance. In his own community he has filled civic responsibilities in the American Legion, the church, social clubs, and fraternal organizations.

To finish the biography, he is 59 years of age and a graduate of the School of Medicine of the University of Pennsylvania in 1913.

I nominate Roger Samuel, of Mt. Carmel.

[The nomination was seconded by Allegheny, Somerset, Cambria, Blair, Jefferson, Lawrence, and Clearfield counties.]

SPEAKER BUCKMAN: Are there other nominations?

DR. PENROSE H. SHELLEY [Juniata]: I move that the nominations be closed.

[The motion was seconded by Dr. Charles L. Shafer, Luzerne.]

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: The nominations are closed. As there is only one nomination, this declares by acclama-

tion the election of Dr. E. Roger Samuel as president-elect.

I will ask Dr. Gass and Dr. Deck to escort Dr. Samuel later to the room.

Dr. Flannery, please take the chair.

[Vice-Speaker Wilbur E. Flannery assumed the chair.]

VICE-SPEAKER FLANNERY: It is now in order to proceed with nominations for the following offices: four vice-presidents, a secretary-treasurer, an assistant secretary-treasurer, a speaker of the House, a vice-speaker.

Nominations will be in order, then, for first vice-president.

DR. JOHN F. MCCULLOUGH [Allegheny]: Allegheny has a favorite son well known to many of you. His name is Harold B. Gardner, whom I wish to nominate for first vice-president.

[The nomination was seconded by Beaver, Washington, and Dauphin counties.]

DR. GEORGE L. LAVERTY [Dauphin]: I move that the nominations be closed.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield, put to a vote, and carried.]

VICE-SPEAKER FLANNERY: This being the only nominee, we will declare Dr. Gardner elected to the office of first vice-president.

Nominations for second vice-president.

DR. RALPH L. COX [Fayette]: I would like to place in nomination a man who has served faithfully in this House and on various committees of this organization—L. Dale Johnson, of Fayette County.

DR. JOHN N. SNYDER [Fayette]: I second the nomination.

VICE-SPEAKER FLANNERY: Any other nominations for second vice-president?

DR. WILLARD C. MASONHEIMER [Lehigh]: I nominate Dr. Robert L. Schaeffer, of Lehigh County, for second vice-president.

DR. WILLIAM J. CORCORAN [Lackawanna]: Lackawanna seconds the nomination of Dr. Robert L. Schaeffer.

[Dr. Norman K. Beals, Venango, and Dr. Frederick O. Zillessen, Northampton, seconded the nomination of Dr. Schaeffer.]

VICE-SPEAKER FLANNERY: There are two nominees for second vice-president—Dr. Johnson and Dr. Schaeffer.

DR. WALTER E. WENTZ, JR. [Delaware]: I move that the nominations be closed.

[The motion was seconded by Dr. Theodore R. Fetter, Philadelphia, put to a vote, and carried.]

VICE-SPEAKER FLANNERY: It will be necessary to distribute ballots.

We will ask Dr. McKee, Dr. Lucas, and Dr. McCreary to serve as tellers.

The ballots will be distributed.

[The ballots were collected and tabulated by the tellers.]

VICE-SPEAKER FLANNERY: Will the chairman of the Board of Tellers, the first named, Dr. McKee, come up and make the report?

DR. MCKEE: Dr. Schaeffer has been elected second vice-president.

VICE-SPEAKER FLANNERY: Dr. Robert L. Schaeffer is declared elected second vice-president.

Nominations are open for the office of third vice-president.

DR. WARD O. WILSON [Clearfield]: Mr. Chairman, I place in nomination the name of John W. Barr, of Cambria County for third vice-president.

[The nomination was seconded by Dr. Daniel Ritter, of Cambria County, and Dr. Charles I. Shaffer, of Somerset.]

DR. AUGUSTUS S. KECH [Blair]: I move that the nominations be closed.

[The motion was seconded by Dr. Joseph A. Parrish, Centre, put to a vote, and carried.]

VICE-SPEAKER FLANNERY: Dr. John W. Barr has been elected third vice-president. Without further nominations, we will declare him elected for this office.

Fourth vice-president.

DR. ELWOOD T. QUINN [Montgomery]: I nominate Louise C. Gloeckner, of Montgomery County.

[Dr. Norman K. Beals, Venango, seconded the nomination.]

DR. AUGUSTUS S. KECH [Blair]: I move that the nominations close.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield.]

[The motion to close the nominations was put to a vote and carried.]

VICE-SPEAKER FLANNERY: Dr. Gloeckner, the only nominee, we will declare elected to the office of fourth vice-president.

Nominations for secretary-treasurer.

DR. WILLIAM BATES [Philadelphia]: Philadelphia County takes great pleasure in renominating Walter F. Donaldson.

[The nomination was seconded by Dr. Frederick O. Zillessen, Northampton, and by Westmoreland County.]

DR. THOMAS W. MCCREARY [Beaver]: I move that the nominations be closed.

[The motion was seconded by Dr. Norman K. Beals, Venango.]

VICE-SPEAKER FLANNERY: It is moved and seconded that the nominations be closed, the nominee being Dr. Donaldson, and being the only nominee, he is returned to this office.

We now have before us nominations for the office of assistant secretary-treasurer.

DR. GEORGE L. LAVERTY [Dauphin]: Mr. Speaker, I wish to place in nomination as assistant secretary-treasurer the name of Dr. Park Berkheimer, of Hummelstown.

VICE-SPEAKER FLANNERY: Dr. Berkheimer is nominated as assistant to the secretary-treasurer. Any further nominations?

DR. LOUIS W. JONES [Luzerne]: I second the nomination.

DR. AUGUSTUS S. KECH [Blair]: I move that the nominations close.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield, put to a vote, and carried.]

VICE-SPEAKER FLANNERY: As we have but one nominee for this office, he will be declared elected.

Now, then, nominations for speaker of the House of Delegates.

DR. CONSTANTINE P. FALLER [Dauphin]: Dauphin County places in nomination Dr. Lewis T. Buckman.

[The nomination was seconded by Lehigh County.]

DR. KECH: I move that the nominations close.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield, put to a vote, and carried.]

VICE-SPEAKER FLANNERY: Dr. Buckman has been re-elected to the office of Speaker which he fills so well, and we would like to have him now return and carry on.

[Speaker Buckman resumed the chair.]

SPEAKER BUCKMAN: Thank you very much!

The House will be in order.

Nominations are now in order for the office of vice-speaker.

DR. THOMAS W. MCCREARY [Beaver]: I would like to renominate Dr. Wilbur E. Flannery.

[The nomination was seconded by Dr. McKee, Armstrong.]

DR. AUGUSTUS S. KECH [Blair]: I move that the nominations be closed.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield.]

SPEAKER BUCKMAN: The name of Dr. Flannery has been placed in nomination and there has been a motion to close the nominations.

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: The "ayes" have it, which closes the nominations and declares by acclamation the election of Dr. Flannery.

There is a trustee and councilor to be elected from the Fourth Councilor District.

DR. PETER B. MULLIGAN [Schuylkill]: Dr. Charles V. Hogan, the present incumbent, has served our district well for the past five years. He has given freely of his time and talent. Therefore, with great pleasure Schuylkill County renominates Dr. Charles V. Hogan, of Pottsville.

DR. HENRY F. HUNT [Montour]: The smallest county society takes pleasure in seconding the nomination.

DR. G. Paul Moser, Columbia County, and Dr. Mark K. Gass, Northumberland County, seconded the nomination.

DR. JAMES E. BRACKBILL [Northampton]: I move that the nominations be closed.

[The motion was seconded by Dr. Frederick O. Zillessen, Northampton, put to a vote, and carried.]

SPEAKER BUCKMAN: Since there is only one nominee, that elects by acclamation Dr. Charles V. Hogan, of Pottsville, for a second term of five years.

Now, we will receive nominations for a trustee and councilor for the Fifth Councilor District to succeed Dr. Park A. Deckard.

DR. CONSTANTINE P. FALLER [Dauphin]: I nominate Dr. James Z. Appel, of Lancaster.

[The nomination was seconded by York County.]

DR. NEWTON W. HERSHNER [Cumberland]: I move that the nominations close.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield.]

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: That closes the nominations and Dr. James Z. Appel, of Lancaster, is declared elected by acclamation.

We will now receive nominations for a trustee and councilor for the Sixth Councilor District to serve for one year to complete the unexpired term of Dr. Walter Orthner, deceased.

DR. AUGUSTUS S. KECH [Blair]: I wish to place in nomination the name of Dr. Joseph S. Brown, of Lewistown, who is now serving in the interim.

[The nomination was seconded by Cambria, Clearfield, Centre, and Huntingdon counties.]

SPEAKER BUCKMAN: Are there any other nominations?

DR. JOSEPH A. PARRISH [Centre]: I move that the nominations be closed.

[The motion was seconded by Dr. Theodore R. Fetter, Philadelphia, put to a vote, and carried.]

SPEAKER BUCKMAN: The nominations are closed. This declares by acclamation the election of Dr. Joseph S. Brown, which brings us to the slate of nominees for the delegates and alternates to the House of Delegates of the American Medical Association. The Chair recognizes Dr. Fetter.

DR. THEODORE R. FETTER [Philadelphia]: This committee places in nomination the following:

Report of Committee to Nominate Delegates and Alternates to AMA

<i>Delegates</i>	<i>Alternates</i>
William Bates, Philadelphia	T. Grier Miller, Philadelphia
Francis F. Borzell, Philadelphia	Edward L. Bortz, Philadelphia
Harold B. Gardner, Pittsburgh	C. L. Palmer, Pittsburgh
Charles L. Shafer, Kingston	Martin B. Finneran, Carbondale
Howard K. Petry, Harrisburg	Edgar S. Buyers, Norristown

Alternates-at-Large

Robert M. Alexander, Reading
J. Arthur Daugherty, Harrisburg
J. Hart Toland, Philadelphia
Robert D. Donaldson, Kane
George W. Hawk, Sayre
Louis W. Jones, Wilkes-Barre
John K. Covey, Bellefonte
Fred O. Zillessen, Easton
C. Irvin Stiteler, Chester
L. Dale Johnson, Connellsville
Wilbur E. Flannery, New Castle

SPEAKER BUCKMAN: You have heard the nominations by the Committee to Nominate Delegates and Alternates to the House of Delegates of the American Medical Association. Are there any nominations from the floor?

Will someone move that this report be received and these nominees be declared elected?

DR. T. CRAIG MCKEE [Armstrong]: I so move.

[The motion was seconded by Dr. E. Arthur Whitney, Delaware, put to a vote, and carried.]

SPEAKER BUCKMAN: These nominees are declared representatives in the House of Delegates of the American Medical Association.

[Drs. Deek and Gass escorted Dr. Samuel to the platform.]

SPEAKER BUCKMAN: Ladies and Gentlemen of the House: It is my privilege and pleasure to introduce to you your president-elect, Dr. E. Roger Samuel, of Mt. Carmel.

PRESIDENT-ELECT E. ROGER SAMUEL: Mr. Speaker, and friends of mine in the House of Delegates: This is a real occasion for me. You know what Mr. Shakespeare said in that great play of his, "The Tempest": "The epilogue is only the prologue; the end is only the beginning." We have finished a hundred years of notable history in the history of The Medical Society of the State of Pennsylvania. If I live one year, I will become your hundredth president.

My father was a physician. He practiced for fifty years, and one of the saddest things to me at the time of his death was that he died on exactly the fiftieth anniversary of his graduation from medical school. Before I studied medicine, my father was of the old school of medicine in the time we speak of as the horse and buggy days. After I came home from medical school, he talked to me one day for about an hour and a half. I thought, "Well, he has done his share and he has lived in this age and I am living in a different age."

I tell you all, and especially all of you men whose fathers were physicians will bear me out, that almost every day something comes into my mind that my father said to me that day. They were words of wisdom. I hope that I can be as worthy a member of this profession as he was.

We have completed our hundredth year. We are beginning a new century, and I hope that these next two years in which I will be more interested will be years of advancement in our planning and our accomplishment.

I have been in this House of Delegates for a number of years, and I have repeatedly told my friends that I know of no finer group of men in the world.

Last night as I was standing at the elevator, a man came up to me and, putting his arm around my shoulder, said, "Roger, I didn't know you had so many friends in the House of Delegates."

I want to thank you for this very high honor. I hope and pray that I may serve you in a manner worthy of your confidence.

Those who really do the work in this organization are in the House of Delegates and the Board of Trustees and Councilors. There has to be a presiding officer and I thank you from the bottom of my heart for the sincere feeling that has been expressed toward me in the last few days. I hope with God's help to discharge with credit the duties which you have assigned to me.

[Speaker Buckman pinned the President-elect's badge on Dr. Samuel.]

SPEAKER BUCKMAN: There is a list of nominees for district censor to be presented to the House by Secretary Donaldson.

Election of District Censors

SECRETARY DONALDSON: We have here the cards nominating a district censor from each of the component societies. If I may ask some delegate to move that these candidates for district censor be unanimously elected, we will save the time of the House.

DR. WARD O. WILSON [Clearfield]: I so move.

[The motion was seconded by Dr. Constantine P. Faller, Dauphin.]

SPEAKER BUCKMAN: The Chair is reminded that on this list is the name of E. Roger Samuel, who desires his name to be withdrawn. In due course, his county will send in another name, and if it is acceptable to the House, that name will be included as of this morning.

The question is on accepting this list as presented by Dr. Donaldson.

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: This declares the election of the following nominees for district censors:

Adams, Eugene E. Elgin; Allegheny, David P. McCune; Armstrong, Ellis C. Winters; Beaver, George B. Rush; Bedford, J. Reginald Myers; Berks, Philip D. Woodbridge; Blair, James W. Hershberger; Bradford, Willis A. Redding; Bucks, Allen H. Moore; Butler, Willis A. McCall; Butler; Cambria, Paul McCloskey; Carbon, Clinton J. Kistler; Centre, LeRoy Locke; Chester, Kenneth S. Scott; Clarion, Charles V. Hepler; Clearfield, George B. Kirk; Clinton, Saylor J. McGhee; Columbia, William C. Hensyl; Crawford, Thomas F. Collins; Cumberland, Newton W. Hershner; Dauphin, Edwin A. Nicodemus; Delaware, John B. Klopp; Elk, Joseph E. Madara; Erie, Orel N. Chaffee; Fayette, Othello S. Kough; Franklin, William B. O'Rear; Greene, Harry C. Scott; Huntingdon, Frederic H. Steele; Indiana, George C. Martin; Jefferson, Hollister W. Lyon; Juniata, Robert P. Banks; Lackawanna, Paul C. McAndrew; Lancaster, Mahlon H. Yoder; Lawrence, Charles F. Flannery; Lebanon, John D. Boger; Lehigh, William A. Hausman, Jr.; Luzerne, Herbert B. Gibby; Lycoming, Albert F. Hardt; McKean, Samuel R. Huff; Mercer, John M. Jamison; Mifflin, Joseph S. Brown; Monroe, William R. Levering; Montgomery, Elmer R. Place; Montour, Vincent J. Cassone; Northampton, Stephen E. Murray; Northumberland, Henry Ulrich; Perry, J. Edward Book; Philadelphia, William B. Odenatt; Potter, Robert H. Kazmierski; Schuylkill, Francis M. Dougherty; Somerset, Charles J. Hemminger; Susquehanna, James J. Grace; Tioga, Archibald Laird; Venango, Ford M. Summerville; Warren, William L. Ball; Washington, George W. Ramsey; Wayne-Pike, Robert C. Canivan; Westmoreland, D. Ray Murdock; Wyoming, William J. Llewellyn; York, Charles L. Fackler.

Election of Associate Members

SECRETARY DONALDSON: I think, Mr. Speaker, that we should read the names of those who have been duly nominated by their county medical society to affiliate membership, which now, under our new Constitution and By-laws, becomes associate membership. The following have first been elected to such membership in their county society and now are nominated by their respective counties, and if they are elected here, they will then become eligible to be elected to the same form of membership in the American Medical Association. These are members, as you understand, who are at least 65 years of age and previous to that were, for at least fifteen years immediately preceding, members of their respective county societies. Many of them no doubt were active members for forty or fifty years.

Adams: Harry M. Hartman, Gettysburg.

Allegheny: Howard Aber, Sydney S. Carrier, Roy C. Cooper, Richard L. Ertzman, E. Roy Gardner, Walter G. Gochring, J. McMaster Long, Harry C. Updegraff, Edward V. Weller, Pittsburgh; Uriah F. Rohm, Car-

negie; Charles K. Shanor, Sewickley; Jacob C. Smith, Tarentum; Charles G. Eicher, Ontario, Calif.

Berks: Walter M. Bertolet, William E. Fisher, Charles P. Henry, Homer J. Rhode, Marshall Stump, Samuel B. Taylor, Reading; George G. Wenrich, Wernersville.

Crawford: Glennis E. Humphrey, St. Petersburg, Fla.; Clyde L. Williams, Linesville; William H. Quay, Meadville.

Dauphin: John L. Burnite, Harry E. Klase, Harvey A. Stine, Harrisburg; Percy E. Deckard, Richfield.

Indiana: Medus M. Davis, Indiana.

Jefferson: Russell C. Gourley, Punxsutawney; Harry B. King, Reynoldsville.

Lackawanna: Milton I. Pentecost, Scranton.

Lawrence: Edwin C. McComb, New Castle.

Luzerne: William J. Davis, Herbert B. Gibby, Wilkes-Barre; A. Burton Smith, Wyoming.

McKean: William C. Hogan, Bradford.

Mifflin: James A. C. Clarkson, Lewistown.

Montgomery: J. Howard Cloud, Ardmore.

Northampton: Harvey O. Rohrbach, Danielsville; Edward S. Rosenberry, Stone Church; William G. Tillman, Easton.

Philadelphia: Joseph W. Anderson, Brooke M. Anspach, Frederick J. Voss, M. C. Edna Swalm-Laird, Philadelphia; Clifford B. Farr, Bryn Mawr.

Schuylkill: Lyman D. Heim, Thomas C. Rutter, Schuylkill Haven; Walter R. Rentschler, Ringtown.

Westmoreland: Edward G. Ankney, Pleasant Unity; Nathaniel E. Sisley, Scottsdale.

SPEAKER BUCKMAN: Will someone move that the members on this list of names be declared associate members?

DR. REYNOLDS M. GRIECO [Lycoming]: I so move.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield.]

SPEAKER BUCKMAN: The question is on the acceptance of this list of members to become associate members. Are you ready for the question?

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: These members are declared associate members from now on.

GENEROUS MINUTES

Secretary's note: The space occupied in this issue of the *Journal* for recording the minutes of the 1948 House of Delegates may seem unnecessarily generous unless it is remembered that they deal in large part with a nearly complete revision of the Society's constitution and by-laws, which touches the constitution and by-laws of our sixty component county societies and the obligations and responsibilities of the 10,750 members of the Society.

Many proposed alterations were freely discussed before acceptance or rejection by majority vote of the delegates in attendance, and in the preliminary discussions much information was doubtless imparted to many delegates which should stand in good stead for future discussions in their own county societies. By the same token, similar information for future guidance of members who did not attend the House of Delegates

meetings is to be found here on the printed page.

Note the great field of service to which \$2.00 of each member's annual dues will soon be applied under Article IX, Section 5, of the Constitution.

Note the creation of a new membership category under affiliate members and associate members in both Constitution and By-laws, and the changed process of their election.

Note new committees authorized with definite separation of all under three headings.

Note that the county society secretaries displace the county society presidents in the House of Delegates, and do not fail to read changes under the duties of district censors, in regard to discipline.

Study to become an understanding member of your own medical society.

I believe that this completes all the work on the election of officers, etc. We have received our president-elect. There is a guest from Chicago whom Dr. Borzell would like to introduce to the House, yet the Chair feels that the House is entitled to go on with some of its new business because we have postponed this so long.

The Chair recognizes Dr. McCreary.

Report of Reference Committee on Reports of Officers and Standing Committees

DR. THOMAS W. MCCREARY: Mr. Speaker, the report of the Reference Committee on Reports of Officers and Standing Committees will be read in two different parts, the first being the report of the reference committee on the printed material and the second part being the report of your reference committee on supplemental reports.

Chairman of Board of Trustees: It is very gratifying to note that 90 per cent of the entire cost of the Graduate Education Institute was defrayed by the money realized from subscriptions to the 1947-1948 program. It is hoped that these will be continued and expanded so that graduate education will annually be available to every practitioner in the State of Pennsylvania. It is of interest, also, to note that the Medical Service Association of Pennsylvania has shown financial security due to the excellent management which it has had.

Your committee feels that the Board of Trustees and Councilors has well demonstrated its far-sightedness in the creation of the Study Committee on Emergency Disaster Medical Service and the Emergency Disaster Committee of the Society, with regional areas and committees. Your reference committee recommends that their functions be continued, so that in the event of atomic war, the medical profession in Pennsylvania will be prepared to act.

It is evident that MSAP has outgrown its infancy and become an adult when it is considered that it paid back to The Medical Society of the State of Pennsylvania \$80,880 in bonds and cash previously loaned or otherwise advanced by the Medical Society.

In view of the splendid work of the Woman's Auxiliary in public relations, the increased budget of the Advisory Committee to the Woman's Auxiliary strikes a welcome note.

Future needs for space in the State Society headquarters were solved by the Board of Trustees' purchase of the property adjoining the present headquarters building in Harrisburg. Ample room should be available for the necessary expansion in the future. The Board

also is to be commended for employing sufficient office help to assure prompt and proper functioning at the headquarters' offices.

The committee recommends expression of the thanks of the entire Medical Society for the splendid work performed by the Board of Trustees in the past year, and especially commends its retiring chairman, Park Deckard, who is completing his ten years of service on the Board.

DR. MCCREARY: Mr. Speaker, I move the adoption of this portion of the report.*

[The motion was seconded by Dr. John M. Keichline, Jr., Huntingdon, put to a vote, and carried.] *

Report of Secretary-Treasurer: It is interesting to note that the membership in The Medical Society of the State of Pennsylvania continues to grow. The figures show a net increase in membership of 151 members, notwithstanding the fact that 167 were lost by death, 143 by removal from Pennsylvania, 41 by resignation, and 4 on account of having their license to practice in Pennsylvania suspended.

It is noted that 12 applications for assistance from the State Society's medical defense fund were received. Your attention is called to the By-laws, which state that "The Society will not undertake the defense of any member unless his application is made within seven days after service of summons." This is brought to your attention because your committee is informed that frequently the physician fails to notify the secretary of the Society promptly.

Your committee regrets that thirteen component medical societies did not see fit to send representatives to the Secretaries and Editors Conference. It is hoped that in the future more than one representative from each county society will profit by attending the well-planned programs. Ideas introduced and developed there may readily help each society to become locally more effective.

The Veterans Loan Fund, which was established on a voluntary contribution basis, has apparently fulfilled its purpose, as most veteran physicians have again assumed their place in civilian practice. Your committee agrees with the recommendation of the Board that the Veterans Loan Fund MSSP be closed as of December 31, 1948, and that the "total balance of the 90 per cent and the names of all outstanding debtors with the amount involved be returned to the county societies to be disposed of as each county society may designate."

The financial condition of The Medical Society of the State of Pennsylvania continues to be sound. Each designated fund appears to have a satisfactory surplus.

The purchase of the property at 226 State Street in Harrisburg, adjacent to the present headquarters of the State Society, was a sound investment, and was paid for at a price of \$37,604.87. This assures further expansion of the present facilities.

With the finances in such an admirable condition, the Society is well buffered against future economic regression which might threaten an adjustment of dues. The financial wizardry of our treasurer and Board of Trustees may be noted by a close inspection of each item in the financial statement appearing in the August and September issues of THE PENNSYLVANIA MEDICAL JOURNAL.

* SECRETARY'S NOTE: This routine was repeated each time that Chairman McCreary completed the reading of the reference committee's reactions to the various reports referred to it. Where there was question or amendment or re-referral proposed, same appears in these minutes.

DR. MCCREARY: Mr. Chairman, I move the adoption of this portion of the report.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield.]

SPEAKER BUCKMAN: The question is on the adoption of this portion of the report. I call the attention of the House to the fact that there is one feature which, if this report is acceptable, will result in the liquidation of the Veterans Loan Fund.

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: This portion of the report is adopted.

Report of the Editor: The editor notes that very few of the disease control committees have used the editorial pages of the JOURNAL as a means of activating the interest of practicing physicians all over the State in the presentation and control of disease. Your committee urges such delinquent committees to check themselves and make use, whenever possible, of all means of carrying your message to the physicians of the State.

Report of the Executive Secretary: It is important to note that 887 package-by-mail library requests were filed in the past year, which breaks all previous records, but when it is considered that over 10,000 physicians are eligible for library loans, your committee feels that more physicians should avail themselves of this opportunity which is featured in each issue of the JOURNAL.

Your reference committee feels that the addition of more secretarial help and the institution of staff conferences has improved the efficiency of the executive office.

Reports of the Twelve District Councilors: Your reference committee believes that it behooves each member of the State Society to read carefully the councilors' reports, especially since the councilor from the Twelfth District questions their value. Your committee feels that there is much to be gained by reading these reports, and urges the House of Delegates to heed their messages. They come from the fathers of their respective districts, whose experience in state and county society activities is available at first hand.

Among the most important suggestions from the aggregate reports your committee recommends:

1. That each component county society consider having public meetings to further the interest of the lay public in health problems and medical advances.

2. That each county society properly indoctrinate new members, and possibly assign an older member to advise and counsel them in the proper ethical practice of medicine.

3. That there is much to be said about each county society having some system of answering all emergency calls. The occasional time when medical assistance is not available is widely publicized. The many times when the physician answers the call without hope of recompense passes as a duty.

It is noted that several county societies are now experimenting with plans to assure 100 per cent coverage of the sick. Your committee recommends that the experience gained in these experiments be passed on to the state society's Committee on Public Relations, so that in the future a satisfactory plan on a statewide basis may be evolved.

There has been universal satisfaction expressed by all councilors in the Society's courses in graduate instruction throughout the State, which are to be expanded this year. Hope is expressed that these will

continue to improve and to reach more and more doctors of medicine. All should avail themselves of this golden opportunity to improve their knowledge of that which is new in medicine.

There has been a steady increase of active members in more than half of the county societies, but your committee feels that a more active campaign for membership could and should be conducted in every county society, so that every eligible doctor of medicine in Pennsylvania may soon become a member of The Medical Society of the State of Pennsylvania.

Your reference committee believes that the question of combining councilor district meetings with dinner meetings held at the conclusion of a postgraduate course at a nearby center is a local problem and should be decided and arranged by each district councilor.

The councilor for the Tenth District calls attention to the need for eradicating the custom of rebating fees. He recommends that full fees be openly charged for medical service with no covering up by accepting merchandise or profits therefrom. This is a problem that each component county medical society should solve. Your reference committee heartily endorses this opinion.

Advisory Committee to Woman's Auxiliary: The reference committee calls your attention to the report on the rapid growth in membership of the Woman's Auxiliary. Fifty-nine counties are now represented, with a membership approximating 4000, a gain of 400 in the past year.

The work of the Auxiliary in furthering public relations has been limitless. In Venango County alone, 8000 people were reached by instructive films. Health programs were sponsored by the auxiliaries in 35 instances.

In addition to this work, \$8,251 was donated by the auxiliaries to the medical benevolence fund, which provided about 73 per cent of the total disbursements from the fund.

The Medical Society owes the Auxiliary many thanks for its splendid work and your reference committee so recommends.

Centennial Celebration Committee: The program will not need to be reviewed in this report. It has been amply advertised. The committee has not missed any phase in the scientific or entertainment field to make this the best of all conventions. Your reference committee commends the Centennial Committee for its excellent selection of programs and for the many hours spent in preparation for this great event. We further recommend the discharge of this committee as soon as is feasible.

[Vice-Speaker Flannery assumed the chair.]

Committee on Defense of Medical Research: Your reference committee believes that every member of the State Society would profit by reading the report of this committee in the August PENNSYLVANIA MEDICAL JOURNAL. It urges all medical, dental, veterinary, and pharmaceutical units to unite to stop the action of the antivivisectionists. Much newspaper publicity has been given to this problem.

The time has come for believers in medical progress, in the alleviation of suffering, and in the saving of human lives, to stand up and be counted. Lay groups must be properly informed.

Your reference committee recommends that this committee be continued and given the wholehearted and demonstrable support of the State Medical Society.

Delegates to the American Medical Association: Your reference committee calls attention to the many

important committee posts held by delegates from The Medical Society of the State of Pennsylvania in the A.M.A. House of Delegates. Drs. Donaldson, Hess, Shafer, Bates, and Borzell held important committee appointments.

The new constitution and by-laws of the A.M.A. were finally accepted under the chairmanship of Dr. Borzell.

One of the changes of interest to Pennsylvania is that each delegate to the House represents 1000 members or fraction thereof, so that Pennsylvania will now have eleven delegates, an increase of one in the 1949 session.

Dr. Borzell was elected Speaker of the House without opposition.

Your committee draws these facts to your attention to show the standing of Pennsylvania medicine in the House of the American Medical Association.

Your reference committee wishes to call to your attention an appended request from the 1948 House of Delegates of the American Medical Association. I quote: "The A.M.A. Council on National Emergency Medical Service requests that each state medical society and its component county medical societies, as well as the Medical Society of the District of Columbia, appoint and organize a committee directly responsible for national emergency medical service within its organization. Each such state committee is requested to present to the American Medical Association, Council on National Emergency Medical Service, a list of its members, as well as of the members of its component county society committees, and the terms of organization under which the committee is authorized to function. It is further requested that each state association cooperate fully with the Committee on National Medical Service in its program to meet the great growing problems of medical health and sanitary service confronting the medical profession as related to national defense."

The following resolution was unanimously adopted by the Pennsylvania delegation:

"Whereas, Dr. Edward L. Bortz, of Philadelphia, has brought great credit to the medical profession of Pennsylvania while serving the nation as president of the American Medical Association; therefore, we, the delegates from his native state, in recognition of his spirit and service, personalized during the past year in the finest ideals and the highest standards of our profession, commend this administrative record to the 1948 House of Delegates of The Medical Society of the State of Pennsylvania."

Committee on Graduate Education: Your reference committee commends the Committee on Graduate Education for the excellent courses given in the six designated centers. It is of interest to know that approximately 90 per cent of the cost was borne by the registrants. The fact that ten centers have been designated for this year is indicative of the widespread interest in the program. It is hoped that continual expansion will be possible so that every practitioner in Pennsylvania within easy travel distance will be able to attend these meetings.

Committee on Mental Hygiene: Your reference committee has considered the eight points submitted by the Committee on Mental Hygiene and notes that this committee has a complete understanding of its various problems. We urge that this committee continue its efforts to bring about the necessary changes in the care of the

mentally ill. We recommend that this committee be continued.

Committee on Necrology: The reference committee regrets that God has seen fit to remove 167 of our members, to call them to their final reward. We wish to direct specific attention to the death of Dr. Walter Orthner, an active trustee and councilor, who died during the year; also Drs. Joseph Scattergood and John J. Brennan, past councilors. It is hoped that by their example and devotion to service those of us who remain will be made better in the practice of our profession.

DR. MCCREARY: Mr. Speaker, I would like a bit of clarification on the report of the Committee on Public Health Legislation. There are four proposed bills which we are recommending. I would like to know whether they have to be voted on separately.

VICE-SPEAKER FLANNERY: I think they probably should be voted on separately.

Committee on Public Health Legislation: This committee continues to do yeoman work for organized medicine in the State of Pennsylvania. The bulletins on Federal legislation have been one of their invaluable contributions. Proposed bills considered by this committee are:

1. A bill creating a laboratory in the Department of Health to be utilized by coroners in cases of sudden death, where there are no toxicologic facilities in existence. The Pennsylvania Association of Clinical Pathologists, at its recent meeting, passed a resolution calling for such legislation.
2. A bill providing qualifications for trained professional personnel in the Department of Health.
3. A bill providing for the licensing by the State Department of Health of laboratories for animal experimentation under proper humane and sanitary conditions.
4. A proposed bill prohibiting rebates on ophthalmologic and surgical supplies is being considered.

SECRETARY'S NOTE: The reference committee "recommended such legislation" as the four bills listed and the House of Delegates by separate motions approved.

DR. JAMES J. MONAHAN [Schuylkill]: Mr. Chairman, I would like to read the action of the Executive Committee of the Pennsylvania Academy of Ophthalmology and Otolaryngology in regard to this:

The Executive Committee of the Pennsylvania Academy of Ophthalmology and Otolaryngology at a meeting held in Harrisburg April 25, 1948, unanimously approved the following statement as an expression of opinion:

The president of the Academy, Dr. James J. Monahan, was given authority to use this statement at his discretion:

RESOLUTION

The Pennsylvania Academy of Ophthalmology and Otolaryngology is the most representative group of ophthalmologists within the Commonwealth of Pennsylvania.

The Academy is aware of certain procedures in the prescription of glasses whereby the ophthalmologist has a pecuniary interest in their sale.

The Academy condemns strongly and considers unethical any form of rebating, but it fully approves of procedures as practiced by most of its members. These

procedures consist of furnishing glasses to the patient at the ophthalmologist's office, or of having an optical organization act as agent for the ophthalmologist, provided there is no secrecy whatsoever about any of these transactions.

The Academy is not averse to any publicity about this situation, although it deprecates publicity designed to interfere with the good faith of patients and to harm the trust of patients in their physicians.

VICE-SPEAKER FLANNERY: You have heard this presentation. Do you wish to have this added to the report as the committee has given it? You can probably amend the motion made.

DR. FRANCIS F. BORZELL [Philadelphia]: Mr. Speaker, I rise to a point of order. With all due respect for the substance of the presentation, I feel that it is distinctly out of order at this time. We are listening to a report of a reference committee. If the delegate wishes to present a motion to amend the report by the inclusion of this statement, that would probably be in order, but I can't help but feel that we are a bit out of order if we consider it at the moment.

VICE-SPEAKER FLANNERY: Do you wish to make a motion that this be added to the report of the reference committee?

SECRETARY DONALDSON: Mr. Chairman, may I speak? I have the feeling that this resolution should be referred to this reference committee, and after they have completed their report now in progress, they could meet again, consider it, and bring back a report on the resolution.

VICE-SPEAKER FLANNERY: Without further debate, if it is acceptable, we will refer this resolution to the reference committee for further consideration and report back to this House.

DR. THOMAS R. GAGION: May I rise for a point of information? We are asked to approve a word in there—consider the legislation. May I ask the committee chairman, please, do you mean that you approve the introduction of such legislation or the further study of such legislation to consider such legislation?

DR. MCCREARY: Consider further study of it.

DR. GAGION: That would be the interpretation of the House and instruction to the Board—further study. The House understands that question?

VICE-SPEAKER FLANNERY: Consider this legislation.

The motion was made and seconded previously that this portion of the report be accepted.

[The motion was put to a vote and carried.]

DR. MCCREARY: I will continue our report on the Committee on Public Health Legislation:

Important opinions by the Supreme Court have been reported and should be read by every member.

Through the efforts of your Public Health Legislation Committee, in conjunction with the Department of Health, the Federal grant-in-aid fund exceeded \$2,000,000 to help in disease control. Your reference committee believes that unlimited credit is due the Committee on Public Health Legislation.

Committee on Public Relations: Your Committee on Public Relations has completely reorganized since the last meeting and has started on a long-range plan for better public relations. They believe that many years will be needed to complete their plan.

Every method of communication to individual physicians and to the public at large has been used to convey the message of organized medicine to all parts of the State. These include:

1. Public relations forum page in the State JOURNAL.
2. Public relations news letter.
3. Liaison with voluntary health agencies.
4. "Better Health" pamphlets distributed to the public.
5. "Your Health" columns in newspapers throughout the State.
6. Health poster contests.
7. Expansion of the free film library for lay meetings.
8. Cooperation with the press in news releases.
9. Radio programs, using local physicians or transcribed programs supplied through the State Society.
10. Television, which will be used for the first time at this convention.

Your reference committee feels that the Committee on Public Relations has attempted to do its duty by carrying the message of Pennsylvania medicine to every home. However, in the opinion of the reference committee, this work will be for naught unless the sick patient can receive medical aid when needed, and we recommend for consideration the development of a plan for twenty-four-hour emergency call service throughout the State.

The Benjamin Rush Award is a forward step toward making the people more conscious of health problems and assures greater cooperation and better relations between the public and the physician.

Your reference committee feels that the request of the Public Relations Committee for the addition of a woman to their staff, trained in publicity technique, who can guide them in their relations with women's organizations, and who can spend a considerable portion of her time in aiding the Woman's Auxiliary, is an excellent request and should be carried on to a conclusion.

Some of the best public relations has come from the centenarian project. Each 1948 centenarian in Pennsylvania has been honored and each centenarian stands as a monument to the practice of medicine in the State of Pennsylvania.

State Healing Arts Advisory Committee: Your reference committee regrets to note that irregular invoices in the Department of Public Assistance occasionally raise their ugly heads, but wishes to congratulate the censors of the Society in those counties where such irregularities have occurred for performing their honest duty.

It is interesting to note that of the money expended for medical service in the past year by the Department of Public Assistance, only about 50 per cent found its way to the 2000 or more participating physicians. Pharmacists, dentists, nurses, and clinics received the remaining 50 per cent.

Committee on Telephone Directory Classifications: Adoption of this report is recommended.

Committee on Medical Benevolence: Your reference committee notes that assistance was given to 22 beneficiaries, the total expenditure being \$11,080. By simple arithmetic, this is reduced to \$500 per beneficiary. Your committee is not aware of the method of arriving at the amount to be paid and wonders if sufficient as-

sistance is given to those in need, in view of the present cost of living and the amount available in the Benevolence Fund. The committee recommends that the Committee on Medical Benevolence consider these factors when arriving at the figures in the next year.

Committee on Archives: It is noted that many county societies have not yet filed their histories. Your reference committee recommends that each society check with its secretary and if a history has not been filed, urge that it do so in the near future.

Committee on Psychiatric Services to Criminal Courts: Your reference committee notes that this committee has been inactive in the past year, but urges that it be continued, since more activity is planned in the next year.

Mr. Speaker, I move the adoption of this section of the report as a whole at this time.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield, put to a vote, and carried.]

Dr. McCREARY: Mr. Speaker, shall I continue with the supplemental report of this committee?

[Speaker Buckman resumed the chair.]

SPEAKER BUCKMAN: If you mean the report of your committee on the supplemental reports, proceed.

Address of President Hess: The reference committee suggests that each member of the State Society carefully read Dr. Hess's address. (See page 223.)

We heartily endorse his withdrawal of support from the pending legislation on mental health when it was so amended as not to require a physician at the head of the department. We agree that this problem belongs in the Department of Health and recommend action by the House of Delegates to place mental health in this department.

We agree that proper appropriations to the medical schools by the Appropriations Committee of the State House and Senate should be sought for preventive medicine and public health, and we so recommend.

Your committee feels that a resolution from this House of Delegates concerning the humane use of animals for medical research would bear much weight.

Dr. Hess has properly stressed medical organization at the county level and has properly placed the responsibility for practice and ethics in the lap of the component county society.

Your committee feels that Dr. Hess has stressed an important point on the physician's responsibility as a citizen to exercise his right of franchise and thereby be in a better position to discuss legislation concerning medical practice with the elected representatives.

The committee most heartily commends Dr. Hess for his forceful leadership and hopes that he will be given an opportunity to continue to render us his assistance even after he no longer holds the highest office in organized medicine in Pennsylvania.

Mr. Chairman, I move the adoption of this portion of the report.

[The motion was seconded by Dr. William Bates, Philadelphia.]

SPEAKER BUCKMAN: Dr. McCreary, President Hess in his address specifically recommended that the House offer resolutions regarding vivisection. Has your committee drawn those resolutions?

Dr. McCREARY: No; the House is in no position to draw them. I should think the House would order this portion of the report returned to the committee.

Dr. FRANCIS F. BORZELL [Philadelphia]: I move that this portion of the report be returned to the committee, with the request that appropriate resolutions be drawn and presented to the House.

[The motion was seconded by Dr. Augustus S. Kech, Blair.]

Dr. PALMER: To what resolutions are you referring?

SPEAKER BUCKMAN: Dr. Hess in his address to the House Monday recommended that the House go on record by forming resolutions urging the humane use of animals for medical research.

Dr. PALMER: That resolution appears in the supplemental report of the Committee on Public Health Legislation.

Dr. McCREARY: We will come to that later.

SPEAKER BUCKMAN: Dr. Borzell, will you withdraw your motion?

Dr. BORZELL: I will, under the circumstances, withdraw my motion, hoping there will be definite action taken some way or other.

SPEAKER BUCKMAN: The question, then, is on the adoption of this portion of the reference committee's report. Are you ready for the question?

[The motion was put to a vote and carried.]

Dr. McCREARY: Now we come to supplemental reports of committees.

Your reference committee endorses the resolution urging consideration of the dignity and importance of the office of first vice-president and urges that those selected for this office be as carefully chosen as are those for president-elect.

Your committee feels further that some duties should be delegated to the vice-president and that consideration be given to having him sit without vote in the meetings of the Board of Trustees and of committees and commissions.

Supplemental Report of Committee on Public Relations: Your reference committee notes that the Committee on Public Relations did not stop its work with the publication of its annual report. The members are continuing their work at this moment, as evidenced by the excellent press releases and the motion pictures and radio broadcasts going on during the convention. Many merchants in this city and elsewhere deserve the thanks of The Medical Society of the State of Pennsylvania for their assistance in bringing Pennsylvania health to public attention through their unselfish cooperation.

Supplemental Report Concerning a Fee Schedule for all Governmental Agencies: Your reference committee notes that although the chairmen of the Committees on Medical Economics, Public Health Legislation, and Public Relations have compiled a list of items from the fee schedules approved by the proper authorities of The Medical Society of the State of Pennsylvania, an acceptable fee schedule has not yet been arrived at. We commend these committees for their tireless work and recommend that their work be continued until a satisfactory schedule is arranged.

Supplemental Report of the Medical Service Association of Pennsylvania: The committee notes the progress and growth of the Medical Service Association of Pennsylvania during the past three years as exemplified in an increase of about 248,000 subscribers and an increase of assets of \$610,250 during this period. These

accomplishments are further reflected in this Association having liquidated completely its financial liability to The Medical Society of the State of Pennsylvania, and furthermore in having paid fully the physicians of Pennsylvania for their services rendered. It is further noted that formal working agreements have been reached and are now operating between the MSAP and the Inter-County Plan, the Blue Cross Plan of Philadelphia, the Blue Cross Plan of Pittsburgh, and the Blue Cross Plan of Wilkes-Barre. The committee recommends that acknowledgment of these accomplishments and recognition of progress and growth be given by the House of Delegates with commendation for their work.

Supplemental Report of Committee on Public Health Legislation:

1. *Mental Health*

The committee notes with gratification that steps have been taken to transfer the Bureau of Mental Health from the Department of Welfare to the Department of Health. Your committee urges the adoption of the following resolution:

WHEREAS, Mental health is largely a medical problem, and WHEREAS, The Secretary of Health is assured of a position in the Governor's cabinet, which position must be held by a physician who is a graduate of a reputable school of medicine; therefore, be it

Resolved, That the House of Delegates of The Medical Society of the State of Pennsylvania favors the transfer of the Bureau of Mental Health to a strengthened State Department of Health.

8. *Psychologists*

Continued efforts should be made to see that proper legislation is written for the licensing of qualified individuals. Your committee feels that the advice of psychiatrists should be sought in drafting this legislation.

19. *Licensing Practical Nurses*

It is noted that the Committee on Public Health Legislation notified the Pennsylvania Nurses Association favoring the licensing of practical nurses along the lines as advocated by the A.M.A. House of Delegates. Your committee feels that a resolution to this effect would be proper for this House of Delegates to consider.

20. *Legislation for Registered Nurses*

The American Nurses Association has suggested uniform legislation covering the practice of nursing. Your committee feels that a resolution by this House of Delegates favoring such legislation would be in order.

24. *Licensing Masseurs*

It is noted that representatives of physiotherapy, chiropractors, and masseurs in meeting with the chairman of the Committee on Public Health Legislation decided that masseurs should be certified by local departments of health. Knowing the wide variation in personnel of local health departments, your reference committee feels that uniform state licensing would give a more rigid and proper control.

25. *Woman's Auxiliary*

Your committee notes with great interest that closer cooperation is sought between state and county public health legislation committees of the State Society and the Woman's Auxiliary. It is our opinion that the House of Delegates should grant the request of the chairman of the Legislative Committee of the Woman's Auxiliary for the county chairmen of the Woman's

Auxiliary to approach the proper officers of the local county societies.

4. *Osteopaths*

Your committee recommends that further efforts be made to arrive at a satisfactory conclusion as to osteopathic representation on the State Board of Medical Examiners.

SPEAKER BUCKMAN: Dr. McCreary moves adoption of this portion of the reference committee's report. I will put the questions separately, inasmuch as there were several recommendations incorporated in this last reading. The first had to do with the resolution regarding mental health. The committee recommends that we adopt the following resolution:

[Speaker Buckman read the resolution; see first column.]

SPEAKER BUCKMAN: The question is on the adoption of this resolution. Are you ready for the question?

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: The resolution has been adopted.

The rest of the report has to do with licensing of psychologists, continued effort for the licensing of practical nurses, then the committee says that it feels a resolution to this effect would be proper for this House of Delegates to consider. The committee, unfortunately, did not present these resolutions. A motion will now be in order to return this portion of the report to the reference committee for that purpose.

DR. WILBUR E. FLANNERY [Lawrence]: I so move.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield, put to a vote, and carried.]

SPEAKER BUCKMAN: This portion of the report is returned to the committee for the drawing of resolutions.

Next was the matter of licensing masseurs, followed by the question of uniform legislation covering the practice of nursing. Again, the House urges that a resolution be adopted. A motion would be in order to return this portion of the report to the committee for drawing resolutions.

DR. FRANCIS F. BORZELL [Philadelphia]: Mr. Speaker, perhaps I may now be in order to move that this portion of the report be returned to the committee with a request for the return of proper resolutions.

[The motion was seconded by Dr. Norman K. Beals, Venango, put to a vote, and carried.]

SPEAKER BUCKMAN: This portion is returned for that purpose.

Then, there was the subject heading "Licensing Masseurs" without specific recommendation. There was a recommendation that the Woman's Auxiliary be granted the request of the chairman of the Legislative Committee of the Woman's Auxiliary for the county chairmen of the Woman's Auxiliary to approach the proper officers of the local county societies.

There was a recommendation that further efforts be made to obtain representation for the osteopaths on the State Board of Medical Examiners.

Are you ready, then, for adoption of these portions of the report?

DR. PALMER: Mr. Speaker, I don't want to prolong discussion of this report, but if this House adopts the recommendation that masseurs be licensed, that is exactly what they want. We have studied this question quite seriously and it is very difficult to determine any

standards of education or training for such persons. Also, it is difficult to evolve any type of legislation that would not interfere with the recognized licensed physiotherapists. We feel that our committee should be permitted to go ahead and try to get the local departments of health to certify as to the sanitary condition of the various establishments, and that would satisfy them.

I think it would be rather unsatisfactory to those allied with us if this House should adopt a recommendation that we try to develop licensure for masseurs.

SPEAKER BUCKMAN: The Chair apologizes for giving the wrong impression. I read now from the reference committee's report: "It is noted that representatives of physiotherapy, chiropractors, and masseurs in meeting with the chairman of the Committee on Public Health Legislation decided that masseurs should be certified by local departments of health. Knowing the wide variation in personnel of local health departments, your reference committee feels that uniform state licensing would give a more rigid and proper control."

Well, then, we are not far apart. Although I did present the reference committee as recommending that there be uniform state licensing, your chairman of the Committee on Public Health Legislation recommends differently.

The question, then, is on the adoption of the reference committee's report which recommends uniform state licensing as opposed to the Committee on Public Health Legislation which recommends local certification. Am I correct, Dr. Palmer?

DR. PALMER: That is right. The committee prefers local certification.

SPEAKER BUCKMAN: Your committee prefers local certification; the reference committee recommends uniform state licensing.

DR. MCCREARY: I think the reference committee misunderstood Dr. Palmer's report.

SPEAKER BUCKMAN: Do you wish to redraw that?

DR. MCCREARY: We wish to withdraw that portion of the report.

SPEAKER BUCKMAN: That leaves us, then, to adopt these portions of the supplemental report, namely, the heading Psychologists, the heading Woman's Auxiliary, and the heading Osteopaths, none of which seem to contain controversial matter.

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: This portion of the report is adopted.

A motion is now in order to adopt as a whole, except those portions which have been returned to the committee, this report of the reference committee on supplemental reports made by certain committees.

Are you ready for the question?

DR. MCCREARY: Mr. Speaker, I so move.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield, put to a vote, and carried.]

SPEAKER BUCKMAN: This portion of the report is accepted, except for that which has been returned to the committee. Dr. McCreary will doubtless want to announce an immediate meeting of his committee, inasmuch as the resolutions from the Pennsylvania Academy of Ophthalmology and Otolaryngology have also been referred to it.

DR. MCCREARY: If the committee and those interested will meet in Room 135 now, we will endeavor to straighten out these new assignments. (See page 281.)

SPEAKER BUCKMAN: Ladies and gentlemen of the House, there has been a visitor from Chicago in our midst for two days. It just didn't seem convenient at any previous moment to introduce him for remarks to the House, which was busily engaged in its own deliberations all the time. If I hear no objection, the business will be set aside for a few minutes in order that we may hear Mr. Tom Hendricks, executive secretary of the Council on Medical Service of the American Medical Association. Do I hear any objection?

The Chair recognizes Dr. Borzell.

DR. BORZELL: Mr. Speaker and Members of the House: You heard General Hawley present a certain phase of the problem of prepayment medical insurance on Monday. The Council on Medical Service of the American Medical Association has the responsibility of reviewing all such proposals. It is with pleasure that I present to you the executive secretary of the Council on Medical Service, who, I think, will give you as briefly as possible the present position of the Council on the question of national insurance. In presenting Tom Hendricks I wish to say that he is the wheel-horse of the Council on Medical Service, of which our own Dr. Elmer Hess is also a member.

MR. TOM HENDRICKS: Mr. Speaker, Dr. Borzell, Dr. Donaldson: I only wish Walter's many friends throughout the A.M.A. could have attended that wonderful meeting last night to enjoy with him the presentation of that beautiful tribute from your Society.

I have been here for the last three days and I must comment upon your spirit and background, and upon this magnificent meeting that you are holding. Having spent four years at Princeton, I always enjoy coming to Philadelphia.

Coming this time in the capacity of a representative from the Council on Medical Service and the Board of Trustees of the American Medical Association, I do want to say that this is certainly the very best state medical society meeting that I have ever had the pleasure of attending in my twenty years' experience. The widely representative attendance at your state dinner Monday evening and that beautiful public ceremony last night for the induction of your president were public relations off the printed page and in action. As to your Benjamin Rush Awards, I have already heard three state medical society presidents who attended say, "We are certainly going to do that in our state."

Your House of Delegates, representing nearly 11,000 physicians, is doing something that is very difficult to do. It is an art to have an efficient, up and going medical organization working as you have without losing the initiative and the right of the individual physician to give voice at all times to exactly what he feels in regard to questions under discussion.

As I say, it is a pleasure to be here and meet old friends with whom I have worked for a number of years in medical organization work—Drs. Palmer, Borzell, and Hess.

To turn to the one point that Dr. Borzell asked me to talk upon, the report of the Council on Medical Service and the Board of Trustees in regard to Dr. Hawley's proposal, I must say that coming from Indiana, as does also Dr. Hawley, where we all revere him as a soldier and as a physician, I hope you can sense that I must hold a basic feeling for a fundamental difference

in policy which alone could bring me here to differ with my good friend and fellow-Hoosier, Dr. Hawley.

I will read from a unanimous statement by the Council on Medical Service of the American Medical Association and the A.M.A. Board of Trustees on October 2, last Saturday. The first paragraph says:

"The Council on Medical Service of the American Medical Association is deeply concerned over the proposed formation by Blue Cross and Blue Shield of an insurance company, rather than a reciprocal enrolling agency to handle national accounts. Because of the far-reaching potentialities of this proposal, the Council recommends to the Board of Trustees and the House of Delegates that at this time we do not approve the formation of a national health insurance company under the auspices or the direction of the Blue Cross-Blue Shield."

Here is another statement from which I will read a few words so that you may at this time get the background of this affair:

"A prepayment conference of state medical society presidents or their representatives was called by the Council in Chicago, June 19, to advise the Council on the proposal of Blue Cross and Blue Shield (your Blue Shield is A.M.C.P.—Associated Medical Care Plans) to form an insurance company. It was the consensus of this conference, attended by representatives of forty-two state medical associations and the Territory of Hawaii:

"1. That no insurance company be formed at this time.

"2. That some agency for enrolling national accounts is desirable."

The actions of this June 19 conference were approved by the House of Delegates at the Chicago session of the A.M.A. immediately following the conference, and the House recommended that studies on the subject be continued and an early report be made to the House of Delegates.

At the time of the June 19 meeting, the A.M.C.P. spokesman stated that the program originally proposed at the Los Angeles Blue Shield-Blue Cross meeting, held early in the spring, was undergoing fundamental changes. It was not until the Blue Cross and Blue Shield Commissions met August 20 that the newly prepared proposal was approved by the Blue Cross and Blue Shield Commissions, and it was not until September 10 that official copies of the proposals were sent to the Council and distributed to the plans.

The proposal was presented formally to the Council at its meeting (September 10 was when it was finished by the Commission and sent to the Council September 30; that was last Thursday) by the representatives of the A.M.C.P., the Blue Shield Commission. At that time the representatives appeared before the Council and, in addition to the A.M.C.P. representatives, the commission which referred it at that time, the council representatives from various state medical societies appeared at their own request at this meeting of the Council and expressed disapproval of the proposals.

A representative from one state, who was a member of the Commission, handed into the Council a minority report from the Commission itself in regard to this proposal.

Also, many unsolicited letters and telegrams disapproving the formation of an A.M.C.P. insurance company were received at that time. The Council has prepared this preliminary report and formal statement and given the reasons for it at this time.

The Blue Cross-Blue Shield annual conference is to be held at French Lick, Indiana, on October 23-28, and due to the fact that numerous requests have been received from state medical societies asking that a statement in regard to the proposal be forthcoming immediately following the September 30 meeting of the Council, this is the preliminary statement from which I have quoted as prepared by the Council and approved by the Board of Trustees. The committee report will be ready for the interim session of the House of Delegates at St. Louis.

Here is the crux of the report I believe: Frankly, the Council on Medical Service feels that a vote upon this insurance company proposal of the A.M.C.P. group at French Lick is putting the cart before the horse; that the A.M.C.P. should not take action creating an insurance company before the proposal is cleared by the only body which can speak for American medicine on a matter of such national import—the House of Delegates of the A.M.A. I hope that I haven't taken up too much of your time in giving you this message.

SPEAKER BUCKMAN: The next order of business is to receive the report of the Reference Committee on Scientific Business. The Chair recognizes Dr. Kech.

Report of Reference Committee on Scientific Business

DR. AUGUSTUS S. KECH: The Reference Committee on Scientific Business reports at this time on the printed reports of committees and commissions assigned to this committee.

Before presenting the reports on each committee or commission, the committee wishes to commend the many committees for having their organization meetings at the time of the annual session. These initial meetings serve a most useful purpose in getting the year's program started.

The Reference Committee on Scientific Business recommends that all committees and commissions be instructed to have their organization meetings at this time and outline their policies for the year. Any member accepting an appointment on a committee should be interested enough to respond to the call. The criticism of members of a committee never being informed of its activities by the chairman need not then occur. Conversely, a member should be relieved of his responsibility if he does not attend the organization meeting.

These committees are organized by this House for action, and not honor.

Reporting on the different commissions, the first is:

Commission on Acute Appendicitis Mortality: The commission reported in the October JOURNAL, 1947, the first of a series of yearly (1946) surveys conducted by the counties themselves. Fifty-one counties cooperated; ten counties have no general hospitals, and six did not report. In this survey 26,982 cases of acute appendicitis were reported with 187 deaths, a mortality rate of 0.69 per cent.

The commission is correct in the assumption that by making yearly checks on these cases in their own local hospitals, the physicians and surgeons of each county will become appendicitis-conscious to the point of forcibly impressing on the people of their communities the fact that appendicitis is potentially a dangerous disease.

The yearly county surveys should receive the support of all physicians, as the information obtained is a check on local medical progress.

The commission reports that the third Fifth Year

Survey (1947) should be ready for publication in the fall.

The report is approved and continuation of the commission is recommended.

Commission on Cancer: At the October 14, 1947, meeting of the Commission on Cancer there occurred a harmonious and cooperative union of the various agencies involved in the fight against cancer. The three agencies involved were:

1. The Department of Health (Cancer Division).
2. The American Cancer Society.
3. The Commission on Cancer.

Throughout the year the same spirit of dedication to a common cause was manifest at the meetings of the commission.

The officers of the Wainwright Tumor Clinic Association were invited to become ex-officio members of the commission. It is planned that the yearly meeting of this association be held in various cities throughout the State.

The commission continues its efforts to stress the education of physicians in oncology at the undergraduate and graduate levels.

Much of the success of the Commission on Cancer during the past year has been due to the activities of the coordinating committee for the various groups in the Commission on Cancer.

The suggestion has been made that due to the frequency with which cancer is encountered in dental practice that one or two dentists from the Pennsylvania State Dental Society be invited to meet ex officio with the Commission on Cancer.

The report is approved and continuation of the commission is recommended.

Committee on Child Health: The Reference Committee on Scientific Business recommends the continuation of the Committee on Child Health. The appointment of Dr. William W. Briant, Jr., of Pittsburgh, to succeed Dr. Henry T. Price, who has retired from medical practice, is recommended.

Because of the importance of the Committee on Child Health, your reference committee respectfully suggests more frequent meetings and more active participation by the various members of the Committee on Child Health.

Commission on Diabetes: The Reference Committee on Scientific Business notes the increased activity and splendid work of the Commission on Diabetes. Your reference committee believes that this is a fertile field in which to labor, because of the actual and potential good that will accrue to the ever-increasing number of patients with this disability.

Your reference committee recommends that the Commission on Diabetes work in full harmony with the American Diabetes Association, which is about ready to launch a nation-wide program designed to help the unrecognized and, therefore, untreated cases of diabetes.

The Reference Committee on Scientific Business approves the acceptance of this report and the continuation of the Commission on Diabetes.

Committee on Laboratories: A survey of the accuracy with which bacteriologic diagnoses are made was conducted during the year by the committee. A number (7) of unannounced bacteriologic cultures were sent to the laboratories of representative hospitals throughout the State. The results of this survey will

be published soon in THE PENNSYLVANIA MEDICAL JOURNAL.

If the results of the bacteriologic survey are as enlightening as the chemical survey which was conducted the year before last, the committee should be encouraged to continue such investigations.

The report of the committee is approved and its continuation is recommended.

Committee on Nutrition: The reference committee notices with pride the continued effort of this committee to spread the basic knowledge of nutrition not only to the profession through county society bulletins and editorials but in the hospitals and to the public. They noted that only 23 county societies had committees on nutrition, and at their annual meeting in September made their present objective the stimulation of increased interest at the county level. They recommend a new exhibit on "Early Recognition and Treatment of Deficiency Diseases" and continued contact with the Pennsylvania Nutritional Council and lay organizations.

The report is approved and continuation of the committee is recommended.

Committee on Physical Medicine: The reference committee notes the activity of the Committee on Physical Medicine, and especially recommends the committee's idea of closer integration between the Committee on Physical Medicine and the Advisory Committee to the Bureau of Rehabilitation in order to better correlate the work of the committees and thus diminish or prevent overlapping of efforts.

The Reference Committee on Scientific Business moves that this report be accepted and that the Committee on Physical Medicine be continued.

At this time, Mr. Speaker, I move the adoption of the portions of our report presented up to this time.

[The motion was seconded by Dr. Joseph A. Parrish, Centre, put to a vote, and carried.]

Commission on Public Health and Preventive Medicine: This commission deserves the special commendations of the House of Delegates and medical profession of the State of Pennsylvania for its accomplishments since its creation by this House in 1946.

Its first objective—the creation of a graduate school of public health in the State of Pennsylvania—will be fulfilled by the recent public announcement of the gift to the University of Pittsburgh of \$13,500,000 for the establishment of a school of public health and the appointment of Dr. Thomas Parran as its director.

The meetings of the commission, in bringing interested persons to the realization of our responsibility in the public health problems of our citizens, will rebound to the credit of our profession for this forceful leadership.

Its second objective—the rewriting of the health laws of the State of Pennsylvania to meet present health needs, thereby reorganizing the Health Department to accomplish this purpose—should be the policy of this House of Delegates. In its report the commission emphasizes: (1) the establishment of district health units based on population rather than on political units (the county) with adequately staffed personnel; (2) the decentralization of the Department of Health; (3) the elimination of the small borough boards of health, to be taken into the district units; (4) the guarantee of reasonable tenure of office of the trained personnel with adequate compensation to make it inviting to applicants for positions.

Your reference committee sustains the recommenda-

tion of the commission that the salaries of the professional personnel equal those of other states for similar work and that otherwise a high standard of health cannot be expected.

The commission recommends a more uniform method of immunization in infectious disease and other pertinent objectives in the over-all health problems.

This reference committee believes that the objectives of this commission should be the policy of The Medical Society of the State of Pennsylvania and that public expression should be given this report.

Mr. Speaker, I move the adoption of this portion of our report and continuation of the commission.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield, put to a vote, and carried.]

Committee to Study Control of Rheumatic Fever: The Reference Committee on Scientific Business feels that a definite start has been made to bring about greater awareness of the magnitude of the problems of rheumatic fever and rheumatic heart disease by the Committee to Study Control of Rheumatic Fever.

The reference committee realizes that the work is rather new and progress must be made slowly, but wishes to point out the unlimited benefit to society if and when the aims of the Committee to Study Control of Rheumatic Fever are realized.

The reference committee moves that this report be accepted and that the Committee to Study Control of Rheumatic Fever be continued.

Commission on Control of Syphilis and Venereal Disease: Your reference committee notes that only one meeting was held during the year to develop plans for control and treatment of syphilis by penicillin, to be published in THE PENNSYLVANIA MEDICAL JOURNAL.

There is a question in the minds of the reference committee whether this commission should be continued on the basis of its own report. However, continuation of the commission is advised with a program of action.

Committee on Tuberculosis: Your reference committee notes that there are twenty members on this committee. The only activity reported is informal conferences with the Director of Tuberculosis Control of the State Department of Health on problems of policy. Several members are acting on a special advisory board to the Director.

This committee is top-heavy. A small committee of three to five could be equally effective. The problem of tuberculosis deserves more activity.

Your reference committee recommends continuance of the committee with increased activity by a smaller committee.

Commission on Maternal Welfare: The commission reports the lowest maternal death rate ever achieved in Pennsylvania (1-1000 births). This achievement is the result of the persistent activity of the commission over the many years of its organization. In its present report the commission points out that the maternal death rate from hemorrhage is not reduced even with adequate preventive and recovery methods at the physician's disposal. It is also pointed out that the remedy lies in early recognition of the signs by the physician. The commission again emphasizes the importance of a painstaking and searching review of all maternal deaths in each county hospital by the staff as well as by county society maternal welfare committees and other interested physicians.

The deaths from toxemia and infections have been reduced in the past year.

I move the adoption of this report, except that part dealing with the use of penicillin in the newborn, which was referred to the Reference Committee on New Business, also for continuation of the Commission on Maternal Welfare.

I recommend the adoption of these previous reports.

SPEAKER BUCKMAN: Dr. Kech recommends the adoption of the reports he read since that of the Committee on Physical Medicine and prior to the report on the Commission on Maternal Welfare. The Chair would remind the House that this committee was about to recommend that one or two commissions not be continued, and then felt that they should be continued. Your By-laws as adopted yesterday give you the power to discontinue any commission or committee which, in your judgment, hasn't done its work. However, the question is on adopting this portion of the report. Are you ready for the question?

DR. KECH: We wish to remind these committees that they ought to be more active, but we would like them to be continued. Our reference committee wanted to scold them for inactivity, with the hope that they will do better next year.

SPEAKER BUCKMAN: Dr. Kech, your committee is speaking for the House. What you meant to say was they must have action.

DR. KECH: I will put it that way.

SPEAKER BUCKMAN: Are you ready for the question?

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: That portion of the report is adopted.

Now, a review of the reference committee's report on the report of the Commission on Maternal Welfare.

DR. KECH: The earlier motion concerning the report of the Commission on Maternal Welfare was duly seconded.

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: That portion of the report is adopted.

DR. KECH: There was referred to this reference committee on Monday a favorable report on the creation of a Section on Anesthesiology, also changing the title of the Section on Dermatology to include the words "and Syphilology." Since the adoption of the new Constitution and By-laws, eliminating all scientific sections except medicine and surgery, we did not take any action.

I move the adoption of our report as a whole.

[The motion was seconded by Dr. John M. Keichline, Jr., Huntingdon, put to a vote, and carried.]

SPEAKER BUCKMAN: I am informed that the Board of Trustees would like one of its representatives to address the House for five minutes. If the House has no objection, at this moment I will call on Dr. Thomas R. Gagon of the Board of Trustees.

The Chair recognizes Dr. Gagon!

DR. THOMAS R. GAGON: Mr. Speaker and Members of the House of Delegates: The question that Mr. Thomas Hendricks brought before you this morning is one of the most important problems for the future of medicine that you will face. The Board of Trustees has asked me to tell this House that we had the pleasure, and the very profitable privilege, of having Dr.

Hawley and Mr. Hendricks with our Board on Monday. We delved into this question as meticulously as we could on so short a notice.

Your Board of Trustees is by no means of unanimous opinion concerning this proposal and will not come to any definite conclusion before longer and more careful study and quite free discussion. The delegates from this Society to the interim session of the A.M.A. (Nov. 30-Dec. 3) will be informed of the opinion of your Board of Trustees and Councilors on the proposed formation by Blue Cross and Blue Shield of a national insurance company. This matter requires a lot of study, not only by your Board but by you and your respective county societies. Please keep informed. Thank you very much!

[**SECRETARY'S NOTE:** The afternoon session of the November 18 meeting of the Middle Atlantic States Regional Conference, in Philadelphia, was devoted to further study of this subject. It was attended by seven members of the Board of Trustees and Councilors of The Medical Society of the State of Pennsylvania and by Pennsylvania delegates to the A.M.A., all of whom later joined the Board of Directors of the Medical Service Association of Pennsylvania for the same purpose at a special meeting of the Board of Trustees and Councilors of the State Medical Society at 6:30 p.m. (5 A.M.A. delegates present).]

SPEAKER BUCKMAN: This brings us to a consideration of the report of the Reference Committee on New Business. The Chair recognizes Dr. Fredette.

Report of Reference Committee on New Business

DR. JOHN W. FREDETTE: Mr. Speaker and Members of the House: Your Reference Committee on New Business will present its report in two parts, the first on the original reports of standing committees, and the second on the supplemental reports and resolutions that have been handed in during this session.

Advisory Council on Medical Service: This council has continued its study of the basic science laws, and has also considered the matter of disciplinary measures for members who may be guilty of unethical practice. It concludes that "a basic science law operates effectively only where there is already a single licensing board," and recommends no approval of a basic science law for Pennsylvania at this time. The council favors serious consideration of a one-board bill and changes in the present law referable to qualifications of the personnel constituting the board. Also, it believes that the Board of Medical Education and Licensure should have greater and more extended powers for inspecting schools that teach any form of medical practice and should have more power to enforce the present act more effectively.

It recommends that the State Medical Society continue its studies of the entire question of medical licensure and continue consultations with the proper agencies of the state government. No action was taken on the question of discipline, because the Judicial Council of the American Medical Association is still studying and revising the code of ethics of the American Medical Association and "also, because of the anticipation of some effective changes in our own constitution and by-laws that may be recommended to the House of Delegates by the committee appointed to perform that task."

Mr. Speaker, I move the adoption of this report which has required a great deal of study.

SPEAKER BUCKMAN: The question is on the adoption of this portion of the report. Are you ready for the question?

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: This portion of the reference committee's report is adopted.

(**SECRETARY'S NOTE:** This routine was repeated each time that Chairman Fredette completed the reading of the reference committee's reactions to the various reports referred to it. Where there was question or amendment or referral was proposed, the same appears in these minutes.)

Committee on Conservation of Vision: The committee has continued its activity of stimulating interest and effective action in the glaucoma program. It regrets that the Board of Trustees failed to approve the granting of more funds to make possible the mailing of more than one glaucoma spot card to 10,500 Pennsylvania physicians. It has met with various state organizations and actively participated in discussions relative to the betterment of conditions of the blind and unfortunates with defective vision. Some difficulty has been experienced by the Rehabilitation Bureau in obtaining competent physicians to examine the eyes of its beneficiaries, and the committee recommends that a more adequate fee be paid to examining ophthalmologists. The committee feels that it should have more information concerning the relation of a Board of Opticians to the Board of Optometry and their combined relation to the dispensing of glasses.

The committee approves of the re-examination of school children, if necessary, but believes that they should be referred to the present clinics and not to optometrists.

The committee is interested in studying the comparative values of the use of penicillin as contrasted with silver nitrate in the prevention of ophthalmia neonatorum, but believes that "a four- or five-year test should be given under direct supervision before the relative superiority of one over the other will be definitely established."

The committee's report is approved and continuation is recommended.

Mr. Speaker, I move the adoption of this portion of the reference committee's report.

Commission on Industrial Health and Hygiene: The activities of this commission continue, as will be noted in their extensive report. Dr. Daniel C. Braun, of Pittsburgh, was appointed co-chairman for the Western District and has been doing excellent work. In August, 1947 the commission released to the Committees on Industrial Health of the component county medical societies a report dealing with the endeavors of unions, particularly miners' unions, in the field of medical care and hoped that the principles laid down, with the consent of the governing body of our Society, will be of help to the physicians and miners alike. Your reference committee urges a careful study of this report which follows the commission's regular report in the August JOURNAL.

The work of the commission in the larger industrial centers has been progressing satisfactorily. In Philadelphia there has been a reorganization of the Health Committee of the Chamber of Commerce in an effort to improve the health conditions in small industries. In Williamsport, the first county medical society post-graduate course in industrial nursing was given and

fifty nurses were awarded certificates. This achievement is highly commended by your reference committee. The Williamsport group initiated a local bulletin on industrial health, and further proposes a postgraduate course in industrial medicine for physicians in that area. The commission notes with disappointment that "there has been no change throughout the State in the status of the teaching of industrial health, either undergraduate or postgraduate."

The commission looks forward to increasing its activities through 1948-49.

The commission concludes its report by advising the House of Delegates of the honor accorded one of its members, Dr. T. Lyle Hazlett, of Pittsburgh, when he was awarded the Knudsen Medal for high achievement in the industrial field by the American Association of Industrial Physicians and Surgeons. It respectfully suggests that a suitable resolution be passed by the House of Delegates, to which your committee heartily concurs.

Resolution

WHEREAS, Our fellow member, T. Lyle Hazlett, M.D., of Pittsburgh, has practiced the art and taught the practice of industrial medicine for many years, standing as a national pioneer in this field, and

WHEREAS, His colleagues in industry, grouped as the American Association of Industrial Physicians and Surgeons, have this year singled him out for their highest honor, the Knudsen Award; now, therefore, be it

Resolved, That this House of Delegates send him its heartiest congratulations and thus express its pride in the well-deserved recognition of his outstanding talents.

Committee on Deafness Prevention and Amelioration: This committee is in active cooperation with the State Department of Public Instruction and plans to have testing and diagnostic centers established so that suitable cases can be handled in their own communities rather than in special schools. Dr. Landis, of Reading, is conducting his clinic for deaf children, and similar ones are established in Pittsburgh (Dr. Day), and in Philadelphia (Dr. Macfarlan). No program, national or state, has yet been settled upon for the care of either urban or rural cases.

The report is approved and continuation of this committee advised.

Commission on Maternal Welfare: This commission is concerned about the use of penicillin as a prophylactic measure in the eyes of the newborn, and strongly urges that a long-range study, for a period of two or more years, be conducted in selected teaching hospitals before any such use of penicillin be accepted, approved, or rejected.

Committee on Medical Economics: This committee, through its diligent work, has succeeded in ironing out some of the differences relative to the fee schedule proposed to the Veterans Administration. However, there are still some controversial items that require adjustment. Careful reading of the committee's report as printed in the August PENNSYLVANIA MEDICAL JOURNAL is advised.

The committee further notes that "careful study of Catalogue No. 4 revealed that over 140 fee amounts had been altered by the Veterans Administration without knowledge or approval by the committee." The committee informed Dr. Jacques, chief of the VA Out-patient Section for Pennsylvania, that this proposal was unacceptable, and this action of the committee was approved at a meeting of the Board of Trustees of our Society.

Your reference committee feels that we should take

a definite stand in this matter and agrees with the proposals cited for further negotiations.

The pension portion of the United Mine Workers Health and Accident Fund is being closely watched by the committee. An over-all fee schedule for all government agencies has been considered, but it was thought best to settle first the VA schedule, which could then be used as a base.

The Board of Trustees assigned to the Committee on Medical Economics the study of the relationship of general practitioners to hospitals. This study has begun, but no specific report is yet available.

The question of a state-wide fee schedule for the medical treatment of polio victims, whose families are indigent and whose bills for medical service are subsidized or paid in full by the National Foundation for Infantile Paralysis, is also receiving careful consideration.

Your reference committee highly commends the work of this committee and recommends its continuance.

Mr. Speaker, I move the adoption of this portion of the reference committee's report.

SPEAKER BUCKMAN: The Chair recognizes Dr. Jones.

DR. LOUIS W. JONES [Luzerne]: Mr. Speaker, Members of the House: It is my pleasure to inform this House that official word has been received within the last few hours that the Veterans Administration Office of Supply in Washington has accepted the amended agreement form No. 11; also, that the fee schedule as presented by the Committee on Medical Economics and later revised by that committee has been accepted by the Office of Supply of the Veterans Administration in Washington.

Conference of Professional Licensures: This conference met on several occasions and agreed that at least two thirds of the registration fees be recommended for use in enforcement by the Law Enforcement Division in the Department of Public Instruction, rather than a large part being turned into the general treasury from which none of the boards receive benefit.

Committee on Public Health Legislation:

Paragraph 7—membership in organizations.

Paragraph 11—further examination and treatment of ophthalmologic and hearing defects discovered in school medical examinations.

Paragraph 12—the survey made by the Governor's Commission.

Paragraph 13—approval of new hospital construction by the Welfare Department.

Paragraph 14—the Milk Control Commission.

Since there is nothing controversial and no specific recommendations, we advise the adoption of this portion of the report and recommend that the committee be continued.

Advisory Committee to the State Board of Vocational Education, Bureau of Rehabilitation: The activity of this committee was concerned with a fee schedule and some changes made which met with their approval. A \$5.00 consultation fee for physicians specially trained in physical medicine was also suggested by the committee.

Funds for expanded services of the Bureau have been frozen because all the appropriated and available funds have been utilized. If the Governor approves of additional appropriations, the Bureau will proceed to expand its services.

We recommend the adoption of this portion of the reference committee's report and continuation of the committee.

Committee on Rural Medical Service: This committee met on several occasions, at which meetings the real need for physicians in rural areas was determined, and locations were appended to its report. The committee did not feel that the need for more physicians locating in rural communities was as real as had been thought.

The committee did not favor subsidizing courses for individuals desiring to study medicine through state funds or from a fund raised by the State Medical Society. It did, however, agree to obtain the names of individuals from rural areas who desired to study medicine and use their influence to get them to take a medical course, realizing that to practice in a rural area an individual must enjoy rural life.

The committee felt that many problems would arise in connection with rural medical service.

Your reference committee recommends the adoption of this report and continuance of the committee.

State Healing Arts Advisory Committee: This committee met on several occasions and indicated a desire for hospitalization of public assistance cases. On December 10 the committee settled the question of surgical procedures necessary for the correction of defects found in school children by the medical examiners. The committee admits that the fees are not satisfactory, but advises continuance of the work and the rendering of as much service as possible so that statistics might be available to present at the 1949 session of the Legislature.

The committee is not in favor of increasing the number of school medical examinations made in an hour. The law now provides for four, or fifteen minutes for each examination.

We recommend the adoption of this report and continuation of the committee.

Committee on Workmen's Compensation Laws: The committee recommends continuation of the Committee on Workmen's Compensation Laws to function during the regular session of the Legislature, which will convene in January, 1949.

Your reference committee agrees and recommends the adoption of this report.

I move the adoption of this section of the report of the reference committee as a whole.

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: Dr. Fredette will continue with the report of his reference committee on those supplemental reports which have been referred to him.

Resolution from Board of Trustees Regarding Voluntary Enlistment of Physicians: Your reference committee concurs with the resolution to meet the requirements for providing a sufficient number of available physicians as per the urgent request from the A.M.A. Council on National Emergency Medical Service.

If a sufficient number of younger physicians, many of whom did not serve in World War II, and many recent graduates whose tuition has been paid by the National Government, do not volunteer, drafting may be reinstated.

It is urged that the county medical societies contact these available physicians and that copies of this resolution be mailed to the secretaries of the component county societies for action.

Mr. Speaker, I move the adoption of this resolution. [The motion was put to a vote and carried.]

Supplemental Report of Committee on Public Health Legislation, Paragraphs 7, 15, and 23:

Paragraph 7. Membership in Organizations. The committee requests permission to subscribe to the *Washington Report on Medical Sciences*.

Paragraph 15. Medical Research. The resolution states that prohibition of animal experimentation in medical research will be extremely detrimental to the progress of medical science and resolves: "That the House of Delegates is unconditionally opposed to any such legislation and favors legislation providing for medical research under proper humane and sanitary conditions."

Mr. Speaker, I move the adoption of this portion of the supplemental report.

[Speaker Buckman put the question on the adoption of the resolution stating that the House of Delegates favors legislation providing for animal experimentation under proper humane and sanitary conditions, also the request that the Committee on Public Health Legislation be allowed to subscribe to the *Washington Report on Medical Sciences*.]

[Both questions were put to a vote and carried.]

SPEAKER BUCKMAN: The question now is on the reference committee's report relative to Red Cross blood banks. The reference committee recommends the report of Dr. Palmer's committee deploring the issuing of free blood and recommending that the control of the blood banks be on a county level if the county medical societies can show adequate means of caring for them. Are you ready for the question?

[The question was put to a vote and carried.]

DR. FREDETTE: Mr. Speaker, I move the adoption of this portion of our report.

[The question was put to a vote and carried.]

Supplemental Report of Committee on Medical Economics, Sept. 22, 1948: Your reference committee commends the committee on the agreement as to the fee schedule with the Veterans Administration and recommends a continuation of its efforts with the Office of Supply in Washington.

We approve of the recommendation of payment of physicians at the local prevailing rate in polio cases.

Mr. Speaker, we recommend the adoption of this supplemental report.

Supplemental Report of State Healing Arts Advisory Committee: This committee met Aug. 31, 1948, and made recommendations to the State Board of Public Assistance dealing with the pricing of drugs, physicians' fees, and mileage.

Mr. Speaker, I move adoption of this portion of the supplemental report.

Supplemental Report of Committee on Conservation of Vision: This report was made in the form of a resolution stating that, inasmuch as the proper examination and correction of eye defects is the most important part of the examination of school children, the House of Delegates recommend a change in Act 174 to read "recognized ophthalmologists" instead of "recognized ophthalmologists or optometrists," with the approval of the school medical examiner.

Mr. Speaker, your reference committee agrees and I move the adoption of the resolution.

DR. C. L. PALMER: Under the law the selection of the individual who will examine the eyes of these children is under the supervision of the medical examiner, who must be a Doctor of Medicine or a physician licensed to practice medicine in the Commonwealth. There are many areas in this state without an ophthalmologist within reasonable distance. Then the medical examiner must use an optometrist. As chairman of the committee, I believe it would be well to leave this law as it is and not open it up for amendment.

I would suggest that the committee refer this to the Committee on Public Health Legislation for further study and consideration.

[Speaker Buckman put the question on the acceptance of the reference committee's report on the supplemental report of the Committee on Medical Economics and its report on the supplemental report of the State Healing Arts Advisory Committee, neither of which was controversial.]

[The questions were put to a vote and carried.]

SPEAKER BUCKMAN: This brings us to the report of the reference committee on the supplemental report of the Committee on Conservation of Vision, in which the latter wishes us to adopt the resolution recommending a change in Act 174. Favorable action will recommend to Dr. Palmer's committee that it approach the 1949 Legislature to effect an amendment to the law. Contrary action will refuse action to the Committee on Conservation of Vision, after which it can be referred, if you please, to Dr. Palmer's committee for further study.

Any further discussion on this matter? The question is on the adoption.

DR. WILLIAM BATES [Philadelphia]: Under the law the question of the choice of an ophthalmologist or an optometrist is in permissive language. It is logical to assume that if there is an ophthalmologist in the neighborhood, the examining doctor is going to call an ophthalmologist. So I speak in support of Dr. Palmer's contention about this.

DR. J. HART TOLAND [Philadelphia]: I know that Dr. Owen's wishes are to leave the law alone. We find it satisfactory in Philadelphia and would like to go along with it.

DR. CHARLES L. FACKLER [York]: Mr. Chairman, as an ophthalmologist, I think the law ought to stand as it is. I don't think it is within our domain to recommend that all cases be placed in the hands of an ophthalmologist. There are many people in this state, parents, who may want to refer the child patient to an optometrist.

[The question was put to a vote and lost.]

SPEAKER BUCKMAN: The report of the reference committee is not adopted. That refuses the request of the Committee on Conservation of Vision.

DR. PALMER: If it is in order, I move that this question be referred to the Committee on Public Health Legislation for further study and consideration.

SPEAKER BUCKMAN: The question is on referring this matter to the Committee on Public Health Legislation. Are you ready for the question?

[The question was put to a vote and carried.]

SPEAKER BUCKMAN: The question is returned to the Committee on Public Health Legislation.

Report of Medical Service Association of Pennsylvania: This excellent report shows the remarkable progress that MSAP has made in the past few years, but deplores the fact that only 65 per cent of the physicians in Pennsylvania are participating physicians in the plan. The association feels that not only must there be more participating physicians but that these physicians must be informed, enthusiastic, and cooperative. They suggest that the Board of Trustees activate and prosecute an effective campaign to recruit at least 2500 additional participating physicians. They further suggest that the secretaries of the county societies be sent a list of the participating and non-participating members so that they can urge the non-participating members to join MSAP.

Your reference committee heartily concurs and reminds you that, after all, MSAP is *your* organization. It strongly commends this report and moves its adoption.

Mr. Speaker, I move the adoption of this report.

[The question was put to a vote and carried.]

Resolution of Philadelphia County Regarding Prophylactic Treatment of Ophthalmia Neonatorum: This resolution presented to the House of Delegates yesterday is concerned with the prophylactic treatment of ophthalmia neonatorum, stating that "1 per cent silver nitrate has very little or no prophylactic value" and that "penicillin acts as a specific in the treatment of gonococcal infections in the eyes of the newborn." These statements are substantiated by several reports.

In view of the report and recommendations by your own Committee on Conservation of Vision and the Commission on Maternal Welfare that this subject be given more study, your reference committee feels that no definite action should be taken at this time.

Mr. Speaker, I move the adoption of the reference committee's report.

SPEAKER BUCKMAN: The question is on this portion of the reference committee's report, the effect of which is to refuse the resolution of the Philadelphia County Medical Society relative to the use of penicillin in ophthalmia neonatorum. Are you ready for the question?

[The question was put to a vote and carried.]

Resolution of Philadelphia County Regarding Revocation of License: Your committee commends the State Board of Medical Education and Licensure in maintaining a high standard of medical practice and recommends that it continue the investigation and prosecution of all questionable characters who practice the healing art.

Mr. Speaker, I recommend the adoption of the committee's report on this resolution.

[The question was put to a vote and carried.]

DR. FREDETTE: I move adoption of the reference committee's report on supplemental reports as a whole.

SPEAKER BUCKMAN: The Chair recognizes Dr. Donaldson.

SECRETARY DONALDSON: Mr. Speaker and Members of the House: Early in this report, action was taken on the recommendation of the committee (and I noticed they made a similar recommendation in connection with a number of committees) on the report of the Advisory Council on Medical Service to the effect that the council be continued.

On Monday, Dr. Borzell, for many years chairman of that council, accompanied by Dr. Bates, who had been an active worker as its secretary, appeared before the

Board of Trustees and stated that he was resigning. After considerable discussion, the Board agreed that the advisory council should in the future become an Advisory Committee on Medical Service, reporting to the Board of Trustees and Councilors, largely because the Board meets five or six times a year and problems occasionally coming before this advisory council are of great importance. Furthermore, I should state that the council is not included in the Constitution and By-laws as they have been adopted this week. I believe that harmony in the continuation of the functions of this group may be best served if it is permitted now to become a committee of the Board of Trustees. In my judgment, Mr. Speaker, that would require only reconsideration of this final recommendation that the council be continued.

SPEAKER BUCKMAN: You have heard the remarks of Secretary Donaldson. The procedure would be for somebody to move reconsideration of our action in accepting the report of the reference committee on the report of the Advisory Council on Medical Service, wherein the reference committee recommended the continuation of the council.

DR. WILBUR E. FLANNERY [Lawrence]: I move reconsideration of that action.

[The motion was seconded by Dr. Joseph A. Parrish, Centre.]

SPEAKER BUCKMAN: The question, then, is on reconsideration of our action in recommending the continuation of the Council on Medical Service.

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: We reconsider our action.

The question now is whether or not we reject this recommendation of the reference committee. The question is now open as a main question.

DR. WILLIAM BATES [Philadelphia]: May I offer an amendment to that resolution to read that the House of Delegates recommends to the Board of Trustees the continuation of that function vested in a committee—the Advisory Committee on Medical Service—appointed by the Board?

SPEAKER BUCKMAN: Dr. Bates moves that the report of the reference committee on the report of the Advisory Council on Medical Service be not accepted, but recommends to the Board of Trustees the formation of a committee by the Board—an Advisory Committee on Medical Service.

[The motion was seconded by Dr. Irwin J. Ober, Westmoreland, put to a vote, and carried.]

SPEAKER BUCKMAN: We have rejected the report, but we have recommended to the Board that a committee be constituted by them—an Advisory Committee on Medical Service.

The Chair recognizes Dr. Flannery.

DR. WILBUR E. FLANNERY [Lawrence]: With reference to the question of the Red Cross blood bank, we emphasized that we deplored the issuing of free blood. As I understood it, the A.M.A.'s position was that they deplored the use of the term "free blood," not the issuing of it. It might later prove a little difficult if we take the stand that we deplore the issuing of free blood.

SPEAKER BUCKMAN: Did your committee use that in its report?

DR. FREDETTE: I don't think so.

SPEAKER BUCKMAN: The error was on the part of the Chair when stating the question. Inasmuch as any action that is taken is on the basis of how the Chair states it, no matter how it may be written or presented by anyone else, it is required that we reconsider our action in accepting that report because of the error of the Chair.

DR. FLANNERY moved that we reconsider our action in accepting that portion of the reference committee's report.

Are you ready for the question? As many as favor, signify by saying, "aye"; contrary-minded, "no." The "ayes" have it and we reconsider that portion of the report.

Now, the question is on the adoption of that portion of the reference committee's report which recommends the adoption of the report of the Committee on Public Health and Legislation contained in paragraph 23. Are you ready for the question?

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: We will accept that portion of the report in proper form.

Now, the question is on the adoption of the report as a whole. Are you ready for the question? As many as favor signify by saying "aye."

DR. LOUIS W. JONES [Luzerne]: I rise to a point of order. I think we voted against one or two of these recommendations; therefore we can't adopt the report as a whole unless we exclude those.

SPEAKER BUCKMAN: There have been no amendments Dr. Jones except for the rejection of that one on the Council on Medical Service. But the Chair accepts your correction.

The question is on the adoption of the report of the reference committee as a whole and as amended.

[The question was put to a vote and carried.]

SPEAKER BUCKMAN: The report of the reference committee as a whole and as amended is accepted.

The Chair recognizes Dr. McCreary.

Report of Reference Committee on Reports of Officers and Standing Committees (continued)

DR. MCCREARY: Referring back to the recommendation of your committee on a proposed bill prohibiting rebates on ophthalmologic and surgical supplies your committee recommended that such a bill be considered. In the meantime the statement through the authority of Dr. James Monahan president of the Academy of Ophthalmology was presented which I shall read (see page 269).

Mr. Speaker I move the adoption of the original suggestion of your reference committee and that the statements as read from Dr. Monahan be referred to the Board of Trustees sitting as a Judicial Council.

SPEAKER BUCKMAN: The question is on the adoption of the reference committee's report and referral of these resolutions to the Board of Trustees. Are you ready for the question?

[The question was put to a vote and carried.]

SPEAKER BUCKMAN: The reference committee's report is adopted and these resolutions are referred to the Board of Trustees.

DR. MCCREARY: Your committee offers this resolution:

Resolution

WHEREAS, The nursing and medical professions are closely allied in their professional care of the public; and
WHEREAS, The State Nursing Association is trying to improve the nursing education and standards; and

WHEREAS, The elevation of standards of nursing would be improved by the licensing of qualified practical nurses; and
 WHEREAS, The demand for nursing service in the homes and hospitals is increasing to such an extent that it becomes necessary to develop some means of providing some facilities; therefore, be it
Resolved, That this House of Delegates approves the licensing of practical nurses along the lines adopted by the A.M.A.

Mr. Chairman I move the adoption of this resolution.

SPEAKER BUCKMAN: The question is on the adoption of this resolution. Are you ready for the question?
 [The question was put to a vote and carried.]

SPEAKER BUCKMAN: The resolution is adopted.

DR. MCCREARY: Concerning the legislation for registered nurses we have withdrawn our own proposal for a resolution and have amended the statement to read:

"The American Nurses Association has suggested uniform legislation covering the practice of nursing. Your committee feels that it should be referred to the Committee on Public Health Legislation for further consideration."

Mr. Speaker I move the adoption of this portion of the report.

[The question was put to a vote and carried.]

DR. MCCREARY: Concerning masseurs we have also withdrawn our proposal for a resolution. We reworded our report as follows:

"It is noted that representatives of physiotherapy, chiropractors, and masseurs in meeting with the chairman of the Committee on Public Health Legislation decided that masseurs should be certified by local departments of health. Your reference committee approves the action taken by the Committee on Public Health Legislation."

Mr. Speaker I move the adoption of this portion of the report.

[The question was put to a vote and carried.]

SPEAKER BUCKMAN: This portion of the report is adopted.

DR. MCCREARY: Mr. Speaker, I move the adoption of your reference committee's report as a whole as amended.

SPEAKER BUCKMAN: The question is on the adoption of the reference committee's report as a whole, as amended.

[The question was put to a vote and carried.]

SPEAKER BUCKMAN: The report is adopted.

The Chair recognizes Dr. John F. McCullough, chairman of the Committee on Place of Meeting.

SECRETARY DONALDSON: Speaking for Dr. McCullough—the House has previously accepted the Allegheny County Medical Society's invitation to meet in Pittsburgh next year and should accept a current invitation of the Philadelphia County Medical Society to meet in Philadelphia in 1950.

SPEAKER BUCKMAN: The Chair recognizes Dr. Park A. Deckard, chairman of the Board of Trustees.

DR. PARK A. DECKARD: Mr. Speaker, Members of the House: This is the action taken by the Board of Trustees regarding the resolution presented by the Columbia County Medical Society:

The Board of Trustees has under advisement and study the resolution introduced by the Columbia County Medical Society regarding "the practice of medicine by

closed staff institutions which employ physicians on a salary basis exploiting their services and which thereby do practice medicine as institutions."

When the Board of Trustees' investigations into this problem are complete they will report back to the House of Delegates.

By unanimous action the Board of Trustees recommends to the 1948 House of Delegates that the 1949 dues of The Medical Society of the State of Pennsylvania remain the same as last year—\$15.00—one dollar to be allotted to the Medical Benevolence Fund and two dollars to the Educational Fund.

SPEAKER BUCKMAN: The question is on the adoption of the recommendation of the Board of Trustees that the dues for 1949 be set at \$15.00 of which \$1.00 shall be allotted to the Medical Benevolence Fund and \$2.00 to the Educational Fund. Are you ready for the question?

[The question was put to a vote and carried.]

SPEAKER BUCKMAN: The House of Delegates has set the dues at \$15.00, with allotments as noted.

The Chair recognizes Dr. Keichline. [No response]

Ladies and gentlemen, as far as the Chair is aware, that brings us to the close of business.

DR. THOMAS R. GAGION: Mr. Speaker, may I have the privilege of the floor for one minute?

The announcement by Dr. Jones that he had just received word from the Office of Supply that our schedule of fees with the Veterans Administration had been accepted was the culmination of a most difficult piece of work and hours and hours of work on the part of Dr. Jones and his committee. We who sat with his committee in the Board appreciate how carefully he guarded the interests of The Medical Society of the State of Pennsylvania. I as a member of the Society and as a member of the Board of Trustees would like here and now to express my gratitude to Dr. Jones and his committee for the great accomplishment that has been theirs. If I were a member of this House, sir, I should like to have the privilege of moving it from the floor. I am not a member of your House. Thank you, Dr. Buckman!

DR. FREDERICK O. ZILLESSEN [Northampton]: Mr. Speaker, I so move.

[The motion was seconded by several delegates.]

SPEAKER BUCKMAN: The question is on a vote of thanks to the chairman of the Committee on Medical Economics for its splendid cooperation with the Veterans Administration. The Chair would add to the remarks that have been made the thoughts that came to his own mind, having once been chairman of medical economics in the days when the duties were much lighter and much easier. The Chair has some knowledge of what Dr. Jones has accomplished and what he has gone through to accomplish it.

The question is on the adoption of the resolution.

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: The resolution is adopted.

The Chair has just observed that Dr. Edward L. Bortz has entered the room. Dr. Bortz is not only an ex-president of the American Medical Association but did yeoman work this year in preparing for this marvelous one hundredth anniversary meeting in Philadelphia. The Chair will be very glad if Dr. Bortz will address the House for a few minutes.

DR. EDWARD L. BORTZ: Mr. Speaker, Dr. Donaldson, Members of the House: I would like to express to you my very deep and grateful appreciation for the superb support you have given the Centennial Committee in making this meeting one of the significant meetings in the history of American medicine. After all, the centennial celebration of organized medicine in the Commonwealth of Pennsylvania is a landmark in the history of our country. Here in this Commonwealth medicine was born and there can be no doubt about it—I have had abundant proof of the fact during the past year as I visited many states—I have found that they look to Pennsylvania medicine for leadership. I would like to call to your attention the importance of a meeting such as we had on Sunday afternoon in the realm of, should we say, public relations; let's get down to more basic fundamentals and call it perhaps human relations.

Isn't it important that the medical profession in each community at the county and the state level align itself with those great and important interests of human nature that give life and living its meaning, its color, its richness, and its luster? And, whether you like it or not, there are too many doctors who claim an indifference to religious ideals and thoughts; but whether you like it or not, innate in the heart of everyone of us there is a yearning desire to become more closely affiliated with the eternal things of the spirit. You don't have to be a church-goer to experience that; you don't necessarily have to belong to any denomination. I feel an indifference to creeds, and particularly denominations, but we must understand, ladies and gentlemen, that in the profession of medicine, which is the profession of living science, there is so much more than the somatic, because we have disorders of the intellect and disorders of the emotional pattern and disorders of the personality and the spiritual pattern, too—yes, disorders of the entire individual, and then we have social aberrations with which we must deal. If we profess an indifference to those great religious truths, then we are neglecting one of the great fields that medicine must deal with.

So I would like very much to see medicine in Pennsylvania open every year with a religious ceremony on Sunday afternoon. I would like to see next year in Pittsburgh a great meeting; possibly we might have one of those great Catholic cathedral choruses in Pittsburgh furnish the music, and then have a series of distinguished speakers there followed by a buffet.

I hope you all liked the meeting last evening. That was, I believe, the proper move again in the field of public relations. I would like to see next year the Pittsburgh Symphony Orchestra and the University of Pittsburgh Glee Club possibly.

We are spending how much in the field of public relations every year? But here we are, gentlemen, at the yearly session and why shouldn't we capitalize when we come together and bring our best interests to a focus and show the public that we are tremendously and vitally interested in them? One of the best ways, I believe, is to have a meeting such as we had last night and ask the public to come in.

Mr. Larry Rember is here from the A.M.A. I hope he carries that back. The Board of Trustees of the A.M.A. has heard some rather straight and plain talking from its president during the past year. I hope he will carry it back, because I think they, too, should continue what they let down. We had a great meeting in Atlantic City, but we let down a little bit in Chicago.

I pass that on to you gentlemen. If it is good for the state, possibly, too, it is good for each county, and

once each year possibly we might have in mid-winter in every county a program to which we would ask the other great professions—the ministerial profession and the legal profession and the architects and the school teachers—to come in and join us. Why shouldn't they? Let's have a luncheon perhaps; let the ladies have a luncheon for the community and then a scientific session in the afternoon with distinguished leaders from other groups, other professions coming to address the assembly, and then in the evening have a fine open house where all professions come together. Why shouldn't they look to medicine for leadership?

Some one has said, "If ever the human race is going to elevate itself and become better and finer physically, intellectually, emotionally, and spiritually, the profession of medicine must furnish that leadership."

I hope that you have enjoyed this meeting as much as I have, and I am proud to be a Pennsylvanian. I thank you for the opportunity to be here.

DR. WILLIAM BATES: [Philadelphia]: Mr. Speaker, may I offer a resolution?

Resolution

Inasmuch as the Centennial Celebration Committee has so successfully arranged an outstanding celebration which may well set a model for such occasions in other states and in our own counties and future state meetings of this Society, be it

Resolved, That the House of Delegates of this Society extend to Dr. Bortz and his efficient committee members the sincere thanks of this House of Delegates.

SPEAKER BUCKMAN: The question is on the adoption of this resolution presented by Dr. Bates directed to Dr. Bortz and his committee.

As many as favor, signify by saying, "aye"; contrary-minded, "no." The "ayes" have it. The resolution is adopted.

DR. LYON: I was only going to request that we amend that so that all local committees would be included and emphatically thanked.

SPEAKER BUCKMAN: Dr. Lyon, I think you are yet in order. I was about to ask for an action from the floor relative to these several committees from the Philadelphia County Medical Society, the boys at home who did the work. I think it would be quite appropriate if you would offer such a resolution at this time.

DR. LYON: Mr. Speaker, may this House resolve that it extend its hearty and grateful thanks to all of the committees, state and local, who contributed so signally to the success of this meeting.

SPEAKER BUCKMAN: As many as favor, signify by saying, "aye"; contrary-minded, "no." This resolution is adopted.

Is there any other new business? If not, we will entertain a motion to adjourn sine die.

DR. BATES: I so move.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield, put to a vote, and carried.]

[The House of Delegates adjourned sine die at twelve-fifty o'clock.]

LEWIS T. BUCKMAN, *Speaker*,
WILBUR E. FLANNERY, *Vice-Speaker*,
WALTER F. DONALDSON, *Secretary-Treasurer*,
JOHN DAVIS PAUL, *Assistant Secretary-Treasurer*.

APPENDIX A

Supplemental Report of the Committee on
Public Health Legislation*To the President and House of Delegates:*

The following numbered paragraphs refer to additional action on items reported in the Committee on Public Health Legislation's annual report to the president and House of Delegates:

1. *Mental Health.*—The question of mental health in the State of Pennsylvania was thoroughly discussed by an unofficial committee composed of representatives from the Pennsylvania Psychiatric Society (PPS), Public Charities Association (PCA), and The Medical Society of the State of Pennsylvania (MSSP).

Among the items mentioned which are included in *Enclosure No. 1* was the approval of the transfer of the Bureau of Mental Health from the Department of Welfare to a strengthened Department of Health. A committee consisting of Miss Louisa J. Eskridge (PCA), Dr. E. Arthur Whitney (PPS), and C. L. Palmer (MSSP), was appointed to draft appropriate legislation authorizing such a transfer.

With the approval of the House of Delegates, the Board of Trustees, and the Committee on Mental Hygiene of The Medical Society of the State of Pennsylvania, this committee will proceed to draft legislation and when such is completed will present the drafted bill to the Board of Trustees and the Committee on Public Health Legislation for their consideration.

The following resolution should be considered by the House of Delegates and adopted if deemed proper:

Resolution

WHEREAS, Mental health is largely a medical problem, and
WHEREAS, The Secretary of Health is assured of a position in the Governor's cabinet, which position must be held by a physician who is a graduate of a reputable school of medicine; therefore, be it

Resolved, That the House of Delegates of The Medical Society of the State of Pennsylvania favors the transfer of the Bureau of Mental Health to a strengthened State Department of Health.

Also at this meeting a request was made that the proper officers and committees of The Medical Society of the State of Pennsylvania be asked their formal attitude on the matter of the national Mental Health Act funds being used to subsidize mental health clinics. The Committee on Public Health Legislation passed the following motion:

The Committee on Public Health Legislation suggests to the Board of Trustees favorable consideration of this question, and acceptance of the funds if principles are enunciated conforming to the action of the AMA House of Delegates, which briefly explained is as follows: Funds may be accepted when the necessity for these funds is proven and there is no interference in local administration on the part of the Federal bureau granting them.

Your chairman met with Miss Louisa J. Eskridge and Mr. Ross W. Sanderson at the office of the Public Charities Association, Pittsburgh, and discussed the question of the transfer of the Bureau of Mental Health to a strengthened Department of Health. It was decided that each of the organizations would study what type of legislation will be necessary to make this transfer and meet later.

This later meeting was held at 12:00 noon, September 21, in the office of Dr. Roscoe Kandle. Those

present were Miss Eskridge, Mr. Sanderson, Dr. Kandle, and your chairman. We had luncheon at the Penn-Harris Hotel and Dr. Petry joined us there. The discussion at this meeting concerned what was needed to strengthen the Department of Health before moving the Bureau of Mental Health from the Department of Welfare to the Department of Health. It was agreed that at a meeting in the latter part of October this question should be discussed and definite suggestions made.

The Committee on Mental Health Laws, authorized by the last session of the Pennsylvania Legislature, to study the mental health laws in Pennsylvania have so far made and distributed copies of the statement entitled "The Legal Disposition of the Sexual Psychopath" (Enclosure No. 2), which is reproduced from the University of Pennsylvania Law Review of June, 1948, pages 872-887.

4. *Osteopaths.*—On September 20 a committee consisting of Drs. Park A. Deckard, T. Grier Miller, and C. L. Palmer representing The Medical Society of the State of Pennsylvania met with a committee consisting of Drs. R. G. Dorrance, Jr., John McA. Ulrich, and Pearson representing the Pennsylvania Osteopathic Association.

The discussion at this meeting was very constructive. The osteopathic representatives asked whether or not the State Medical Society had at any time gone on record as favoring a composite board. They were informed that the State Medical Society at one time sponsored a composite board and that the House of Delegates and the Board of Trustees had been informed through reports of the Committee on Public Health Legislation during the past several years that such a board should be established through some legislative measure acceptable to both organizations.

The next question discussed was the number of osteopaths who should be appointed to the board. They felt that five doctors of medicine on the proposed board and only one osteopath made it an unbalanced board. They were informed that the Medical Practice Act provides that there shall be one representative each from The Medical Society of the State of Pennsylvania, the State Homeopathic Society, and the Eclectic Society, and that the other two making up the five shall not be of the same school. When consideration was given to the fact that their membership was only about 1000, whereas the State Medical Society had 10,700 members, they wanted to present the matter to their House of Delegates at its meeting the week of September 20.

The osteopaths were concerned that their institutions and hospitals would not be accredited by a composite board with only one osteopath on it. We all agreed that this question should be discussed later and details worked out with the Board of Medical Education and Licensure. They agreed to report the attitude of their organization regarding this question to your chairman, who will refer their report to Dr. Park A. Deckard, chairman of the Board of Trustees; and Dr. Deckard will bring it before this House of Delegates.

7. *Membership in Organizations.*—Your committee respectfully requests that it be permitted to subscribe to the *Washington Report on Medical Sciences*. This report is very thorough and contains many items of interest from a legislative standpoint. The AMA subscribes to it and recommends in an editorial in the *Journal AMA* that the membership read this report.

A weekly subscription for fifty-two weeks at \$45.00 will be satisfactory.

8. *Psychologists*.—The material mentioned in the annual report of the committee regarding regulations for licensing and registering psychologists has also been referred to Mr. Carroll A. Whitmer, director of the Division of Psychological Services, University of Pittsburgh. The National Association of Psychologists met in Boston in September. According to Mr. Whitmer, this meeting revealed that the attitude of their national organization was to have a more or less uniform bill drafted for each state in cooperation with psychiatrists and doctors of medicine to provide for some method of licensing qualified individuals. A bill has already been passed in Kentucky and one is being drafted in New Jersey in cooperation with psychiatrists.

Your chairman will meet with representatives of the State Psychological Society some time in October, at which time this question will be further discussed. No doubt the advice of psychiatrists will be necessary in conforming to the ideas of the psychologists. If and when legislation is proposed and drafted, it will be presented to the Board of Trustees and the Committee on Mental Hygiene of the State Medical Society for consideration and approval before introduction.

15. *Medical Research*.—The following resolution is presented for your consideration:

Resolution

WHEREAS, Groups of individuals are endeavoring to prohibit animal experimentation in medical research, and

WHEREAS, If such prohibition is established by law, it will be extremely detrimental to the progress of medical science, and to the health and welfare of all our citizens; therefore, be it

Resolved, That the House of Delegates is unconditionally opposed to any such legislation and favors legislation providing for medical research under proper humane and sanitary conditions.

16. *Rebates*.—This question was referred to the Committee on Public Health Legislation pursuant to resolutions adopted by the Allegheny and Dauphin County Medical Societies requesting legislation. Information was assembled from states which have laws concerning rebates on their statute books. *Enclosure No. 3* is a summary and opinion that James H. Thompson, Esq., has made on this question.

After careful consideration and a very comprehensive discussion of the question, it was finally decided at the meeting on September 16 that a separate meeting should be called to discuss only this subject. Representatives from the State Board of Medical Education and Licensure and the Pennsylvania Academy of Ophthalmology and Otolaryngology should be invited to present their views. The committee will distribute copies of material regarding the question of rebates to the representatives selected by these organizations.

17. *Maternal Mortality Records*.—A resolution on the part of the Allegheny County Medical Society requesting the proper authorities of the State Medical Society to do what is necessary to obtain maternal death certificates from the Vital Statistics Bureau in the State Department of Health was referred by the Board of Trustees to your chairman and Dr. James S. Taylor, chairman of the Commission on Maternal Welfare.

Mr. George E. Greenwood, director of the Vital Statistics Bureau, advises that, beginning August 1, photostatic copies of maternal death certificates of Allegheny County will be received by the Allegheny County Medical Society Maternal Mortality Committee around September 15 and the same date of each succeeding month for the preceding month. This request was

granted as a result of advice from the Attorney General's office.

18. *Chartering Medical Schools*.—Your committee is in possession of a model bill providing proper qualifications for medical schools. This matter has been taken up with the proper officers of the Association of Urban Universities.

19. *Licensing Practical Nurses*.—Material has been received from the Pennsylvania Nurses Association requesting the licensing of practical nurses. A copy of this material and a questionnaire were sent to each member of the Committee on Public Health Legislation. Those answering the questionnaire favored the licensing of practical nurses.

At the September 16 meeting of the Committee on Public Health Legislation, proper licensing of practical nurses along the lines advocated by the AMA House of Delegates was approved, and the Pennsylvania Nurses Association was so notified.

20. *Legislation for Registered Nurses*.—The American Nurses Association suggests uniform legislation covering the practice of nursing.

21. The committee desires to thank the officers of the Northampton County Medical Society for their prompt response to our request to clear up a case concerning an unlicensed chiropractor. The Northampton County district attorney was holding up the case. The Department of Justice and the Law Enforcement Division requested your chairman to ask a committee from the Northampton County Medical Society to call on the district attorney and endeavor to get some action. This was done, and so far as we know, the individual is not practicing at present.

22. *Dental Program*.—Dr. Linwood G. Grace, chief of the Dental Division in the Department of Health, informs us that legal entanglements will have to be unraveled before he can put his program of decay prevention into effect. He intended to have dental hygienists apply fluorides on decay spots in teeth, but has been informed by the Attorney General's office that dental hygienists are not legally qualified to do this work; therefore, the program will be held in abeyance until this matter is settled.

23. *Red Cross Blood Banks*.—Miss C. R. Kennedy, state relations officer of the Red Cross, requested your chairman to look into the question of some cooperative arrangement between the Red Cross and the state and county medical societies regarding their blood banks. The AMA House of Delegates at its last meeting adopted the report of the Reference Committee on Miscellaneous Business regarding these blood banks, from which the following excerpts are taken:

"It is the opinion of your reference committee that the 'Approval in Principle' be construed as follows:

"First, local control must be by the county medical society.

"Second, the local medical society should be the initial contact in the contemplation of inauguration of a new blood bank.

"Third, no publicity nor news releases shall be released except by mutual consent of the local county medical society and the local chapter of the American Red Cross.

"Fourth, difference of opinion in establishment or operation of a blood bank in either administrative or technical detail shall be arbitrated at state levels by

joint committees from the state medical society and the American Red Cross.

"Your reference committee feels that any provision of free medical service or supply to everyone without regard to ability to pay is in opposition to the principle that it is the responsibility of an individual to assume the obligations of medical expense just as he does for other living expense. Your reference committee deplores the use of the term 'free blood' in the publicity of the American Red Cross."

Since that time Miss Kennedy has resigned, and her work is to be taken over by Mr. C. Clayton Streevy. Your chairman will contact Mr. Streevy when he begins work in Harrisburg.

24. *Licensing Masseurs*.—A meeting was held the afternoon of September 15 in the offices of The Medical Society of the State of Pennsylvania, 230 State Street, Harrisburg. Those present were Mr. Robinson and Mr. Lundgran, representing the physiotherapists; Dr. Seltzer, representing the chiropractors; Mr. Thomas and Mr. Linderman, representing the masseurs; and your chairman. The discussion centered about the question of licensing masseurs and masseuses under the regulations of the Board of Medical Education and Licensure.

After considerable discussion, it was finally decided that it would be better to have these individuals certified by the local departments of health and issued certificates.

25. *Woman's Auxiliary*.—At the May 20 meeting of the Committee on Public Health Legislation, a motion was passed that the chairman of the Legislative Committee of the Woman's Auxiliary to the State Medical Society be invited to attend the meetings of the Committee on Public Health Legislation of the State Medical Society.

Through the Woman's Auxiliary president-elect, Mrs. Craig, and Mrs. Doyle, chairman of their Legislative Committee, The Medical Society of the State of Pennsylvania has received a request that the chairman of the county Woman's Auxiliary legislative committee be permitted to approach the proper officers of the county medical societies in order to cooperate with them. The Committee on Public Health Legislation believes this request should be granted.

All items requiring approval were approved by the committee at their meeting September 16. All other items were informative and did not require approval.

Respectfully submitted,

C. L. PALMER, *Chairman*.

Enclosure No. 1

Memo regarding meeting of representatives of the Public Charities Association (PCA), Pennsylvania Psychiatric Society (PPS), State Medical Society (MSSP), and Philadelphia County Medical Society, held Aug. 26, 1948, in the Medical Tower and at the Three Trees Restaurant.

Presiding: Dr. LeRoy M. A. Maeder.

Present: Drs. Howard K. Petry, C. L. Palmer, Hamblen C. Eaton (MSSP); Drs. Philip Q. Roche, Thomas A. Rutherford, E. Arthur Whitney (PPS); Messrs. Everett S. Elwood, Charles H. Frazier, Hugh R. Jackson, and Judge Nochem Winnet (PCA), and Dr. Samuel B. Hadden of Philadelphia County Medical Society. (Dr. Whitney had to leave fairly early during the course of the meeting, and Mr. Elwood was unable

to stay for the dinner session.) The meeting lasted approximately from 5 to 9 p.m.

This meeting was held for the purpose of arriving at as much common agreement as possible on several matters regarding the state mental health program which will arise in connection with the 1949 meeting of the State Legislature.

I. A. Appropriations—State Hospital

The first item discussed was the matter of appropriations, with the discussion being held on both the matter of operating budgets for the state hospitals and capital construction costs for the hospitals. Dr. Petry was asked to discuss the probable budgetary requests of the state hospitals. He stated that the hospitals are not consulted as to the amount of the budget which will be provided. This is determined by the Department of Welfare and, after appropriations are made, the department allocates among the hospitals the available money without consulting the hospitals. He said that he felt that the salary scale was now on a pretty good level and placed the state hospitals in a limited competitive position with private industry. Dr. Petry emphasized that with the recent increase of salary levels the budget for the hospital system will likely run into a deficit.

Mr. Jackson said that the PCA had considered the probable needed appropriation and in the light of current costs, the evident deficiencies in personnel, and the comparative per capita costs in other states, the PCA felt that a per capita appropriation of somewhere between \$2.50 and \$3.00 a day would be found to be the necessary amount. He suggested that further study would have to be made to substantiate the exact amount needed.

Dr. Petry said that \$1.76 was being spent at present and that he felt \$2.50 would be a reasonable basis from which to start; certainly not less than that was needed. He said that Pennsylvania has been the second lowest state in the New England and Middle Atlantic states in per capita expenditures for at least a decade. (He brought out the interesting sidelight that in Pennsylvania each institution is charged for its own deportations rather than having them assessed to the central budget and that it therefore penalizes an institution to determine out-of-state residence of patients and return them to their homes. This results, he said, in a much larger number of patients being sent back into Pennsylvania from other states than Pennsylvania sends out.)

As a result of the general discussion of appropriation for operating state hospitals, a committee consisting of Dr. Eaton, Dr. Whitney, and Mr. Howard Wolf was appointed to obtain further figures and bring back a specific report with recommendations to the group.

B. Capital Construction Budget

The capital construction budget for state mental institutions was then discussed. Mr. Sanderson reported that a newspaper article had stated that the cost of remaining needed projects, after the expenditure of the present available \$80 million, would still be \$150 million because of the increased building costs. Dr. Petry said that in 1944 the estimated cost of the necessary construction was \$120 million and that in terms of today's building costs those needs would be about \$300 million. Therefore, the figure of \$150 million for the balance needed was certainly a conservative figure. After some discussion, it was decided to have a committee consisting of Dr. Eaton, Dr. Kenneth E. Appel, and Mr. Wolf

study this matter and report back to this group with a recommendation as to the total capital needs, together with the appropriate amount which might be sought for the coming biennium.

In the case of the two committees, it was understood that Mr. Sanderson would be willing to act as secretary and Dr. Eaton and Mr. Sanderson would be responsible for convening the groups and preparing reports.

II. *Eastern State Psychiatric Institute and Clinic (ESPI)*

There was considerable discussion of the proposed ESPI. It was explained that there was a possibility that the University of Pennsylvania may be invited to operate the institute as part of its medical system with the capital investment and operating costs provided by the State. Dr. Petry explained the great advantage of this arrangement in that the university could set up the personnel in the institute on a professional basis in regard to salaries and thus attract more competent persons. While it was recognized that administration by other than a state agency would have certain advantages, it was also pointed out that there is a danger that it would not serve as an integrated part of the state mental hospital system in the way that it should.

Dr. Hadden felt that we should not press for the ESPI at this time because he felt that there were more urgent needs, that the present weakness of the Western State Psychiatric Institute tended to put us in a vulnerable position, and because it would simply spread a little thinner the present psychiatric personnel available in the Philadelphia area. It was pointed out, however, that all three of the state organizations represented were on record as being in favor of the institute, and it was certainly a propitious time to forward it if the Governor was personally interested in developing it at this time.

A motion was made and approved that the resolution of the Mental Hygiene Committee of the MSSP, abbreviated to leave out the reference of the WSPI, should be approved by this group.

III. *Civil Service and National Mental Health Act Funds*

There was considerable discussion in regard to the merit system and the desirability of accepting Federal funds under the national Mental Health Act. The group felt that they were all on record as being in favor of the merit system. They also agreed to a motion favoring a more comprehensive system of mental health clinics with adequate financial support either from state funds or such other funds as may be available for achieving this end.

The group also specifically asked that the State Medical Society and the Pennsylvania Psychiatric Society consider their formal attitude on the matter of the national Mental Health Act funds.

IV. *A Revision of the Mental Health Act of 1923*

The Mental Health Act of 1923 is to be qualified and revised by a subcommittee of the Joint State Government Committee with recommendations to the Legislature. The PCA has a committee which is considering the possible recommendations to the committee of the Joint State Government Committee for desirable changes, and it was suggested that Dr. Eaton for the MSSP and Dr. Keys for the PPS be invited to represent the interests of those groups.

V. *PCA Luncheon*

The arrangements for a luncheon discussion with Dr. William C. Menninger on Thursday, October 7, were explained and Dr. Maeder pointed out the desire of the PCA to have selective representatives of the MSSP and the PPS present at this luncheon, which will be primarily a mixed meeting of lay and professional people.

VI. *Mental Health Organization*

After considerable discussion as to the most desirable form of organization for the administration of mental health functions of this state, a motion was proposed by Judge Winnet as follows: "We favor a reorganized and strengthened Department of Health and the transfer of the mental health functions to this Department of Health. We propose that a joint committee should be appointed by our representative organizations to consider this matter if they agree upon the desirability of transferring mental health functions to strengthen the Department of Health." This motion was adopted after the PCA had clearly stated its feeling that a separate Department of Mental Health would still be the most desirable change at the present time.

A committee is to consider this further and bring back recommendations. This committee is to be composed of one or two representatives of the three state organizations, and it was suggested that Miss Louisa Eskridge might serve as secretary for this committee. It was also suggested that the joint committee include Dr. C. L. Palmer (MSSP), Dr. E. Arthur Whitney (PPS), and others to be designated later.

It was agreed that the group should meet again in the latter part of October at the call of the Pennsylvania Psychiatric Society to hear reports on the various items which have been discussed this evening and referred to respective organizations or to committees.

Enclosure No. 2

THE LEGAL DISPOSITION OF THE SEXUAL PSYCHOPATH

("Prepared for Committee on Mental Health Laws by the staff of Joint State Government Commission, Room 450, Capitol Building, Harrisburg. Memorandum—MH-2, September, 1948 . . . Reproduced from the "University of Pennsylvania Law Review" of June, 1948, pages 872-887, upon the suggestion of several members.")

It is the general consensus of opinion that the rate of recidivism is very high among sex offenders since, in the majority of psychopathic personalities, the desire to commit an illegal act far outweighs the penalty involved. The inadequacy of the punitive approach has been recognized in the statutes of Illinois, California, Massachusetts, Michigan, Minnesota, Ohio, and Wisconsin as well as in the recent formulation of a model statute based on the experience of these states. The provisions of the model law are briefly set forth below.

According to the model act, a sexual psychopath is "any person suffering from such conditions of emotional instability or impulsiveness of behavior, or lack of customary standards of good judgment, or failure to appreciate the consequences of his acts, or a combination of any such conditions, as to render such person irresponsible with respect to sexual matters and thereby dangerous to himself or to other persons." Emphasis is placed upon the care, treatment, and rehabilitation of sexual psychopaths.

When a person has been charged with a sex offense, it is made mandatory upon the district attorney to petition the court for an inquiry into the mental condition of such person. Furthermore, the district attorney has

discretionary power to prepare a petition in any case where there is good cause to institute judicial inquiry. In this latter instance the petition must be executed and verified by a person having knowledge of the facts on which it is based. All petitions are presented to the county court of legal settlement or in which such alleged sexual psychopath is present. Petitions relating to juvenile offenders are filed with the juvenile court.

Trial of the case is postponed pending examination by a board of qualified psychiatrists appointed by the court. If the board finds that the person examined is a sexual psychopath, a court hearing is held for which there is no jury and to which admission of the general public is discretionary upon the court. The person complained of is entitled to be present at the hearing with appropriate representation, and the board of psychiatrists is represented by the district attorney. Both parties have the legal right to subpoena witnesses. At the conclusion of the hearing the court issues an order specifying whether or not the person examined has been finally determined to be a sexual psychopath, from which decision the person so adjudged has the right of appeal. Under the model law, the court may order detention of the alleged sexual psychopath, pending inquiry if such detention is necessary.

No person who is found to be a sexual psychopath may be tried upon the charge or indictment arising out of the sex offense for which the petition was filed. If it is found that the person charged with a sex offense is not a sexual psychopath, criminal proceedings must be resumed on the original charge. Where judicial inquiry has been instituted at the discretion of the district attorney and it is found that the person alleged to be a sexual psychopath is not a sexual psychopath, the model law provides that such person shall be freed and discharged.

The model act further provides that persons determined to be sexual psychopaths must either be committed to the State Department of Mental Health or released on probation to such persons and under such conditions as the court deems advisable. Discharge from a mental hospital or from probation is contingent upon the recommendation of the supervising authority to the Department of Mental Health which, in turn, must recommend release to the committing court. After court hearing, the person may be discharged or returned to custody with such modifications as the court deems desirable.

Enclosure No. 3

Dr. C. L. Palmer, Chairman,
Committee on Public Health Legislation,
The Medical Society of the State of Pennsylvania,
Pittsburgh, Pa.

DEAR DR. PALMER:

You have submitted to me a great deal of material concerning the question of rebates, fee splitting, etc., for my study and have asked me to give you my reaction thereto as to whether or not your committee should sponsor legislation prohibiting the same.

At the beginning, we believe that we should point out that the material before us indicates that consideration should be given first to legislation prohibiting the giving by purveyors and the accepting by physicians of commissions, discounts, or gratuities for the giving or accepting of service or services which includes all the items more fully set forth in the ordinance of the City of San Diego, Calif., which is included in this report. Second, consideration should be given to the

splitting of fees by one physician or surgeon with another physician or surgeon by reason of being called in consultation or the sending of patients to either physician or surgeon.

This last item is designated "fee splitting," while the first item is usually designated by "rebates," "kick-backs," or some such term. As we proceed with this discussion, the distinction between fee splitting and rebates must be kept in mind.

The recent action of McIntire, Magee & Brown Company, and to a certain extent that of the York Optical Company, both of this city, in requiring patients to deal direct with their doctor in securing glasses and optical supplies, if state-wide, makes the discussion of criminal proceedings for rebates merely academic. That would leave for consideration only the question of whether or not the merchandising in glasses and optical supplies by the doctor himself is unprofessional and should be the subject for legislation authorizing the State Board to suspend or revoke the license of such doctor for such unprofessional conduct.

Four of the states reviewed in the 1932 Analysis of the Bureau of Legal Medicine and Legislation of the AMA made no provision for criminal prosecution for fee splitting, but did make provision for revocation or suspension of license, and all the states that did have provision for criminal prosecution had also discretionary or mandatory power to revoke or suspend licenses.

Iowa, for example, under its 1939 Code of Laws, provides that license to practice a profession shall be revoked or suspended when the licensee is guilty of immoral, unprofessional, or dishonorable conduct and defines unprofessional conduct, among other things, to include division of fees or agreement to do so. I am attaching hereto copy of letter from the Iowa State Medical Society indicating this.

The letter sent you by the Kansas Medical Society under date of June 8, 1948, contains no information about criminal proceedings, although the 1932 Analysis does list that state as having such procedure. I like very much the provisions of the rules of that society that the applicant must further agree that he will be governed in his practice in that state by the principles of medical ethics promulgated by the AMA which were adopted by that board as a standard to be maintained in that state, which also provides that any willful violation of the principles of medical ethics, the applicant must agree, will constitute grounds for disciplinary action by the board.

The ordinance of the City of San Diego, Calif., contains a fairly complete list of goods and supplies, including glasses, lenses or optical supplies or equipment, which are liable to be the subject of rebate by purveyors and the acceptance of rebates by physicians. This ordinance gives us a very good sample of legislation that might be put in the form of a state law if we are particularly interested in the question of payment of rebates by purveyors. I am making a copy of this ordinance so that it may be part of this report.

Judge Kenworthy's proposed ordinance for the city of Philadelphia is concerned with the same subject, that is, the payment by a purveyor of a commission for recommending his services and the acceptance of the same by a physician.

As I have just said, the action of opticians in no longer supplying glasses has removed the question of paying rebates for such services, but might raise the question as to whether or not a physician by merchandising is acting unprofessionally.

I am glad that the action of the opticians has made the question of criminal prosecution for the payment of rebates obsolete. I say this for the reason that the initiation of criminal proceedings places on the person who undertakes the same considerable responsibility and annoyance.

He is required to file a complaint before a committing magistrate and make out a case for court. He then should follow the same through the district attorney's office so that the district attorney has a full understanding of the facts and can investigate the law concerning the same. He is required to gather sufficient evidence so that the grand jury will return a true bill. He is required to get enough evidence for the district attorney to place the case before a petit jury to secure a conviction.

Ordinarily, the complainant could expect the assistance of the usual agencies concerned with the suppression of crime, but such a case as this would not be considered the usual and ordinary case that comes before the criminal courts and the complainant, of necessity, would be thrown back pretty much on his own resources.

May I conclude by stating that the questions before us are:

1. Whether or not we wish to control the merchandising in glasses by physicians as unprofessional practice by having their licenses suspended or revoked by the State Board.

2. Whether or not we wish to prohibit physicians from receiving rebates for recommending or procuring services set forth in detail in the San Diego ordinance by declaring such practice unprofessional and having their licenses suspended or revoked by the State Board. If so, this can be done by amending the Medical Practice Act giving the State Board such authority.

3. Whether or not we are interested in punishing purveyors for paying rebates, etc., to any person, directly or indirectly for recommending such services by sponsoring criminal legislation to that effect. Such proceedings would involve the procedure already outlined herein of filing complaint with a committing magistrate and the making of provision that the same be followed through the courts.

4. Whether or not the State Society is interested in legislation prohibiting a physician or surgeon from dividing his fees with another physician or surgeon who calls him into consultation or refers a patient to him, such practice being commonly known as "fee splitting"; if so, such practice to be controlled either by suspending or revoking the physician's license or by criminal legislation similar to that in effect in the state of Michigan.

Respectfully submitted,

JAMES H. THOMPSON.

Sept. 7, 1948

Appended is the letter from the Iowa State Medical Society and the ordinance for the city of San Diego, Calif., referred to in the above statement:

C. L. Palmer, M.D.,
Pittsburgh, Pa.

The Code of Iowa, 1939, has a chapter (115) on Practice Acts—General Provisions. This covers many different professions, among them medicine.

Paragraph 2492 deals with revocation of licenses.

"Grounds. A license to practice a profession shall be revoked or suspended when the licensee is guilty of any of the following acts or offenses:

1. 2.
3. Immoral, unprofessional, or dishonorable conduct."

Paragraph 2493 defines unprofessional conduct.

"Unprofessional conduct. For the purposes of section 2492 'unprofessional conduct' shall consist of any of the following acts:

1. 2. 3.

4. Division of fees or agreeing to split or divide the fees received for professional services with any person for bringing or referring a patient or assisting in the care or treatment of a patient without the consent of said patient or his legal representatives."

A. B. PHILLIPS, M.D.,
Secretary.

July 10, 1948

(An ordinance prohibiting the payment of rebates by the purveyors of certain goods, supplies or services, or the receipt of rebates from any purveyor of said goods, supplies or services.)

Be it ordained by the Council of the City of San Diego, as follows:

SECTION 1. *Purveyors of Certain Services Regulated.*

A. Whenever used in this section, the following terms shall mean and include:

1. "Purveyors." A person who directly or indirectly engages in the business of supplying a service or services to another person or persons for use or utilization by such other person or persons.

2. "Services or Service." The sale, renting, supplying or furnishing of:

- (a) clinical laboratory services or supplies;
- (b) x-ray laboratory services or supplies;
- (c) inhalation therapy service or equipment;
- (d) ambulance service;
- (e) sick room supplies;
- (f) physical therapy service or equipment;
- (g) orthopedic or surgical appliances or supplies;
- (h) drug, medication or medical supplies;
- (i) glasses, lenses or optical supplies or equipment;
- (j) hearing aids or devices;
- (k) any other goods, services, supplies or procedure prescribed or suggested for medical diagnosis, care or treatment.

B. For the better protection and preservation of the public health, safety and welfare of the City and its inhabitants, it shall be unlawful for any purveyor, directly or indirectly, to pay or give, permit or cause to be paid or given or offer to pay or give, to any person, or for any person, directly or indirectly, to request, receive or accept from any purveyor any sum of money, credit or other valuable consideration as a commission, discount or gratuity for recommending or procuring a service of such purveyor for any other person, or directing patronage or clientele to such purveyor, or influencing any person to refrain from using or utilizing a service of any other purveyor.

SECTION 2. Any person violating any of the provisions of this ordinance shall be deemed guilty of a misdemeanor, and upon conviction thereof shall be

punished by a fine not exceeding \$500 or by imprisonment in the City Jail for a period of not more than six months, or by both fine and imprisonment.

SECTION 3. This ordinance shall take effect and be in force on the thirty-first day from and after its passage.

APPENDIX B

Supplemental Report of the Committee on Public Relations

To the President and House of Delegates:

Following the order in which we submitted the annual report of the Committee on Public Relations, we herewith present the following supplemental report bringing you up to date on the committee's activities from June 30, 1948 to October 4, 1948.

Exhibits.—An exhibit depicting several of the projects promoted by the Committee on Public Relations may be viewed at Convention Hall. These exhibits include: "100 Years of Medical Progress," "Medical Research," "Benjamin Rush Award," and our "Centenarian Project."

A health education exhibit on "100 Years of Medical Progress" may be viewed in the foyer to the auditorium in Gimbel's Department Store at 9th & Chestnut Streets.

Centennial Celebration.—Every effort has been made to insure adequate news coverage of our centennial convention. Philadelphia newspapers have been contacted personally and assigned reporters to cover our convention. The UP, AP, INS, and Acme News Services have likewise pledged their cooperation in transmitting news releases of our convention.

All daily newspapers in Pennsylvania have been invited to send representatives to cover our convention or to print the wire service releases.

Many special stories have been released as well as the promotion of such coverage as appeared in the Sunday *Philadelphia Inquirer* rotogravure section and the feature stories in the Sunday *Philadelphia Bulletin*.

A press luncheon was held on Saturday, October 2, at which time our scientific program, scientific exhibits, and social functions were highlighted. Convention activities in general were outlined in an effort to make the news reporters' jobs easier and more productive.

Our special radio transcription on "100 Years of Health" has been broadcast throughout the State. Twelve radio programs in Philadelphia have been arranged and will be broadcast over eight Philadelphia radio and television stations this week.

"Hippocrates would feel at home in Philadelphia" is the heading of an institutional advertisement sponsored by the Girard Trust Company, Philadelphia, which will appear in both Philadelphia papers this week.

One thousand Philadelphia ministers were requested to invite their parishioners to attend our Sunday "Religious Hour." This invitation was extended in an announcement from the pulpit in many cases, while others incorporated it into their church bulletins.

The green office announcement card found in the August PENNSYLVANIA MEDICAL JOURNAL was another medium used to encourage attendance at our convention.

A large invitation poster welcoming all medical students, nurses, interns, and residents to our Centennial Convention was placed in all medical schools, hospitals, and nurses' homes in the Philadelphia area.

Poster Contest.—The judging of the school Health Poster Contest was conducted on Sunday, September 26, and the winning posters are on display at Gimbel's Department Store and at the public relations booth at Convention Hall.

Motion Pictures.—During the week in the auditorium of Gimbel's Department Store, health education motion pictures are being shown continuously to the lay public. Gimbel's ads are carrying information on this project inviting their patrons to be the guests of The Medical Society of the State of Pennsylvania and view these outstanding health education movies.

Benjamin Rush Award.—The Board of Trustees selected Mr. Alan Magee Scaife of Pittsburgh as the winner of the Benjamin Rush lay individual award and the Rotary Club of Lancaster as the winner of the lay organization award. The award will be on exhibit at our public relations booth in Convention Hall for your inspection.

Woman's Auxiliary.—During the past two months, the public relations department has assisted the Woman's Auxiliary in the publication of its annual report, its news letter, and various correspondence. This added responsibility entailed the mimeographing of over 9600 sheets of copy.

Conclusion.—The continuing help and enthusiastic support of many members of the profession and the laity have made possible many things which could otherwise not have been consummated. To this vast unnamed group of "they who also served," we acknowledge our indebtedness and proffer an expression of our appreciation.

The program of public relations consists always of two distinct phases—a long-distance established program which creates a groundwork of good-will and an immediate and changing program meeting day-by-day problems and taking advantage of popular interests.

The long-distance program involves primarily the business of convincing the public of not only the essential quality but the superiority of our goods. It involves careful self-discipline and the maintenance of high standards of performance by every individual physician, while remembering always that he is not an individual but the representative of a profession. It requires zealous and self-sacrificing collective conduct as an organization. To create this good-will, we must first earn it and then ethically publicize our good works.

The immediate short-distance problem of public relations involves a day-by-day alertness to trends and attitudes. We must note smoldering resentments and criticisms and eliminate their causes. We must be quickly cognizant of misrepresentation of our conduct and motives in order to correct and properly inform public opinion.

Basically, our program must be positive and preventive, rather than negative and critical. We must lead rather than advise.

Respectfully submitted,
HOWARD K. PETRY, *Chairman.*

APPENDIX C

Supplemental Report of State Healing Arts Advisory Committee

To the President and House of Delegates:

At a meeting of the State Healing Arts Advisory Committee on Aug. 31, 1948, the following were recommended to the State Board of Public Assistance:

1. That the present system of prior approval for special remedies not included in the approved list in the Medical Care Program in the Department of Public Assistance be eliminated; therefore, doctors may write prescriptions for anything they desire without prior approval being required, except in those costing over \$10.

2. Instead of the rather complicated system for pricing of drugs at the present time, it was recommended that 90 per cent of this list price or cost plus 50 per cent be the formula for the basis of paying the drug bills. There will be a minimum of \$.75 per prescription.

3. On recommendation of the chairmen of the various county medical society subadvisory committees to the local Boards of Public Assistance who met in the offices of The Medical Society of the State of Pennsylvania on June 13, 1945, a \$30 instead of a \$25 fee for obstetrical cases and an increase in the mileage for rural areas were recommended. These have already been approved by the State Board of Public Assistance and have been in force for some time.

The following fees were also recommended:

	<i>Present</i>	<i>Proposed</i>
1. <i>Office visits</i> —per recipient	\$1.00	\$1.50
2. <i>House visits</i>		
One patient, per visit	2.00	2.50
Additional patients during same call—each additional patient ..	1.00	1.50
Total maximum for whole family	3.00	4.00
From 11 p.m. to 7 a.m., additional fee per visit	1.00	2.50
<i>Visits to recipients residing in congregate shelters (rooming, boarding, nursing homes, etc.)</i>		
1. First recipient treated	2.00	2.50
2. Each additional recipient treated during same visit	1.00	1.50
3. Maximum fee for any one call	5.00	7.00
4. From 11 p.m. to 7 a.m., additional fee per visit	1.00	2.50

Dental fees are raised in proportion and nurses' fees will be considered after a survey by the nurses the early part of the year.

All these items were approved at the Sept. 13, 1948, meeting of the State Board of Public Assistance and will go into effect December 1.

Copies of the official resolutions of the State Board of Public Assistance are available on request.

Respectfully submitted,

C. L. PALMER, *Chairman.*

Resolutions of State Board of Public Assistance

Decentralization

WHEREAS, The revised Medical Assistance Program, which became effective Aug. 1, 1945, provided that all prosthetics and appliances furnished by the Department of Public Assistance be authorized by the supervisor of the Medical Program in the State Office; and

WHEREAS, Considerable help and interpretation have been given by the supervisor of the Medical Program to county offices in determining the types of requests which meet the criteria established; and

WHEREAS, The county offices have gained considerable experience in handling such requests so that they are becoming able to make proper decisions as to which requests meet the criteria established for providing such items; be it

Resolved, That as criteria are developed and as local staff demonstrate capacity to apply the criteria, authority be given to the county offices to pre-authorize prosthetics and appliances; and be it further

Resolved, That prosthetics and appliances costing less than \$10 require no pre-authorization.

Dispensing by Physicians

WHEREAS, It is customary for many physicians in both rural and urban areas to dispense medications during the course of home and office calls, and such dispensing is considered by the medical profession to be consistent with sound medical practice; and

WHEREAS, The Department of Public Assistance cannot and should not attempt to control the medical profession in how it shall practice medicine, but rather should recognize that it is the custom of many physicians to dispense medications and to charge extra fees for expensive medications so dispensed; and

WHEREAS, Usual fees include the dispensing of ordinary and inexpensive drugs; and

WHEREAS, Assistance recipients cannot be expected to pay physicians for more expensive medications thus dispensed; be it

Resolved, That when a physician dispenses medications costing him \$2.00 or more, he be permitted to present for payment an invoice showing the kind and amount of medication dispensed, and the actual cost of the ingredients so that he may be reimbursed for the actual cost of such medications; and be it further

Resolved, That this regulation be put into effect as soon as possible.

Drug Payments

WHEREAS, The present system of using two pricing methods, one for official drugs and another for non-official drugs with the additional requirement of prior authorizations for non-official drugs, has resulted in auditing difficulties and many misunderstandings on the part of physicians and pharmacists which have required a disproportionate expenditure of administrative time to rectify; and

WHEREAS, A uniform system of pricing for all types of drugs would considerably simplify the auditing process without increasing costs; and

WHEREAS, The cost of operating retail drugstores has increased, and pharmacists are complaining in increasing numbers that fees paid by the Department do not cover the actual cost of filling prescriptions; be it

Resolved, That a uniform pricing system be adopted for all drugs except "over-the-counter" items which are separately listed in the present DPA Manual under that heading; and be it further

Resolved, That the uniform pricing method adopted by the Department be at the rate of cost plus 50 per cent (or 90 per cent of list); and be it further

Resolved, That the minimum price per prescription be \$.75; and be it further

Resolved, That prior authorization be required only for prescriptions amounting to more than \$10 each; and be it further

Resolved, That invoices covering prescriptions filled before the effective date of the new regulations be approved for payment without regard to whether or not the ingredients are official if the charge is not more than \$.75, and that the requirement of pre-authorization of prescriptions for non-official drugs be waived in all instances.

Dental Fees

WHEREAS, It was recognized at the time the present fee schedule for dental service was established that certain of the dental fees were so low as to constitute only "token" payments to dentists; and

WHEREAS, The costs of material and laboratory service have increased since that time; and

WHEREAS, The Department has adjusted other professional fees as required; be it

Resolved, That the proposed fees for repairs to dental prosthetics as recommended by the dental representative on the State Healing Arts Advisory Committee be approved (listed in supplemental report of the chairman of the State Healing Arts Advisory Committee); and be it further

Resolved, That these increased fees be made effective as soon as practical.

Physicians' Fees

WHEREAS, The Department of Public Assistance in 1946 negotiated with representatives of The Medical Society of the State of Pennsylvania for increased fees, and agreed that fees for home and office calls should be increased; and

WHEREAS, Since it was later found that limited funds precluded increasing assistance grants, and it was therefore considered inadvisable to put into effect all of the proposed increases in professional fees; and

WHEREAS, The fees for home and office calls were not increased at that time, nor since the beginning of the program; and

WHEREAS, Funds for increasing assistance grants have become available in the meantime; be it

Resolved, That the intent of the State Board of Public Assistance as expressed at its meeting on Dec. 10, 1946, be reaffirmed at this time and increased fees be put into effect (listed in supplemental report of the chairman of the State Healing Arts Advisory Committee); and be it further

Resolved, That the new schedule of fees be made effective as soon as practical; and be it further

Resolved, That, as heretofore, fees for home and office calls shall cover the dispensing of ordinary medications usually dispensed by physicians, and that it be understood that assistance recipients are not expected to pay additional amounts for such medications.

APPENDIX D

Address of Congressman Ivor D. Fenton, M.D.

Mr. Chairman, Members:

It is indeed a privilege to be with you today, and I want to assure you that I appreciate the opportunity of mingling with the members of my chosen profession.

Although being a member of the Congress of the United States for almost ten years has taken me out of medical circulation to a certain degree, I have at all times been interested in the work and progress of my profession.

Indeed, I have been proud of the fact that I am a physician, and I feel sure that any service that I may have rendered my country, any valuable service, is due to the fact that I enjoy the reputation of being a doctor. So, I want to repeat that I am happy today to be with you, my fellow physicians.

We, who are members of the Pennsylvania State Medical Society, are concerned today, as are thinking men everywhere, with the grave situation which exists throughout the world. We hope, as do all men, to see the foundation of lasting peace firmly grounded. Medicine has a leading role to play in laying such foundations.

There are two principal international organizations through which this Society and each of its members have an opportunity to influence the world situation. One of these is the World Health Organization (WHO), which is the official international health agency of the fifty-four member governments. The other is the World Medical Association (WMA), which is the non-governmental association of the physicians of some thirty countries represented through their national medical associations. The Medical Society of the State of Pennsylvania, a component unit of the American Medical Association, is an integral part of WMA; as citizens of the United States we all have a stake in WHO.

Having had the privilege of serving as Congressional adviser to the U. S. delegation to the first World Health Assembly, the annual general conference of WHO, I am in a position to tell you something of the importance of WHO, its work and the hope that is placed in it.

It is important that all physicians appreciate fully the part that medicine can play in stabilizing the world situation. It is particularly important that the physicians of this state, who have contributed so greatly to medical science and its application to human welfare, understand medicine's present responsibility to the world.

Medicine can do two things of vital importance. By lifting the burden of preventable disease, which depresses at least half the world's population, it can convert consumers to producers, thereby strengthening the economic base upon which peace must rest. Second, it can provide a non-political meeting ground for nations that is unique in its spirit of fellowship and community of interest.

The importance of economic stability and world productivity as a basis for peace was highlighted this past spring by the Congress when it appropriated five billion dollars to buttress and rebuild the economic structures of certain foreign countries. As physicians, we are particularly conscious of the human factor affecting the general economy. The chronically ill, physically or mentally, are a drag on the economy of any social structure. Those who could in health produce more

than they consume become through illness net consumers and economic dependents.

A broad look at the human resources of the world today gives a depressing picture. In a total population of approximately two billion there are an estimated 300,000,000 annual cases of malaria, 50,000,000 cases of tuberculosis. In certain large areas, with populations running in the tens of millions, 80 per cent of the population sampled has been found to be syphilitic. Schistosomiasis, leishmaniasis, hookworm, filariasis, trachoma, together affect other hundreds of millions of persons. The true quantitative picture of chronic disease cannot be sharply drawn because of the inadequacy of accurate information obtainable in vast areas of the world, where there are no doctors and millions die undiagnosed and untreated.

In the face of this appalling situation modern medicine has a great contribution to make.

Malaria through the use of DDT is today entirely preventable. Greece with the help of two international organizations, UNRRA and the Interim Commission of WHO, has reduced its malaria rate by an estimated 90 per cent. Where formerly, in a population of 7,500,000, there were 1 to 3 million cases of malaria annually depending on the rainfall and other variables, there is now no significant malaria problem. A by-product of DDT house spraying has been the control of flies and other disease-bearing and annoying insects. It is important to recall that many diseases in various parts of the world are conveyed, in part at least, by household insect vectors. Among these are yellow fever, dengue, relapsing fever, verruga peruana, plague, typhus fever, visceral leishmaniasis, typhoid fever, the dysenteries, filariasis, and trachoma. This gives us a hint of the opportunities that exist in DDT alone. Today in Crete, Sardinia, and Cyprus campaigns are in progress aimed at the complete eradication of anopheles mosquitoes. The success of these campaigns appear assured. This experience can guide eradication of Anopheles and other insects in larger land masses and offers a hopeful view of the future.

In areas where the modern treatment of tuberculosis and isolation of infectious cases cannot be accomplished within the foreseeable future for social and economic reasons, BCG vaccine offers the one great hope for mass control of this disease. Under the joint auspices of WHO, the International Children's Emergency Fund, the Scandinavian Red Cross, and individual European governments, a huge campaign of BCG vaccination is now underway in Europe. It is estimated that over 50,000,000 children will be tuberculin-tested and some 15,000,000 negative reactors inoculated with BCG vaccine. On a smaller scale, WHO has introduced BCG into India. This is a vast experiment in disease control which we can hope will strengthen the manpower resources of the next generation.

Through relatively simple techniques available today modern medicine can lift the immense burden of preventable disease that so distressingly depresses world economy. This is the long objective view. What touches us more closely as physicians is the great human service we can render at the same time to untold millions of our suffering fellowmen.

I was deeply impressed by the World Health Assembly. The delegations of the fifty-four member states were composed almost exclusively of physicians, the leaders of medicine and public health in their own countries. The U. S. delegation under the chairmanship of Dr. Thomas Parran, former Surgeon General of

the U. S. Public Health Service, included as delegates Dr. James R. Miller, a trustee of the American Medical Association, and Dr. Martha Eliot, president of the American Public Health Association. In addition, there were some twenty alternates and advisers comprising a distinguished group, truly representative of the best in American medicine and public health.

The spirit that pervaded the Health Assembly was the same spirit of professional fellowship and mutual respect that characterizes meetings of this society. Differences of language, color, race, religion, and political ideology posed no serious barriers to the interchange of ideas. All sought a common objective, the improvement of world health. Agreement on the means to its attainment was readily reached. Such meetings do not hit the headlines. They have a deeper meaning. The Health Assembly meant to me that there is real hope that nations can work together amicably and fruitfully. Medicine has here a special challenge and responsibility. In no other field is there the same opportunity for easy, friendly, and useful cooperation among all nations.

Administratively, WHO consists of three major elements: first, the annual World Health Assembly, which is the top policy body attended by delegations from each member state; second, the Executive Board composed of persons technically qualified in health designated by eighteen member states, elected by the Assembly; and third, the Secretariat headed by the director general and staffed by experts and their assistants.

WHO is based on its own treaty, the Constitution of WHO which was developed and signed by sixty-one nations at the International Health Conference called by the United Nations in New York in 1946. It is related to the United Nations through an agreement adopted by the recent Health Assembly. Through this agreement it becomes one of the family of specialized agencies of the U.N. which includes the Food and Agriculture Organization (FAO), the International Civil Aviation Organization, the International Monetary Fund, the International Bank for Reconstruction and Development, the United Nations Educational, Scientific and Cultural Organization (UNESCO), and the Universal Postal Union.

The Health Assembly elected Dr. Brock Chisholm as director-general of WHO for a five-year term. Dr. Chisholm is a distinguished psychiatrist who carried on a general practice in Canada for some years before specializing. During World War I he served as a combat officer and during the recent war as Surgeon General of the Canadian Army. At the time of his election in 1946 as executive secretary of the Interim Commission of WHO he was Deputy Minister of Health of Canada. During the two-year life of the Interim Commission he developed and directed the Secretariat which has become the nucleus of the WHO staff. Dr. Chisholm has a distinguished record as a physician, soldier, and statesman.

The program adopted by the Health Assembly for the remainder of 1948 and the full year 1949 falls into two parts: advisory services to governments and basic international health services.

The advisory services to governments are aimed at the development and strengthening of national and local health services toward the end that the world may eventually be blanketed by services competent to attack and control disease at its source. WHO will provide to governments experts from its own permanent staff and experts employed on a temporary basis. It will also provide demonstration teams expert in various

control techniques. Of great importance it will, during its first year, grant some 250 fellowships for study abroad. Many of these Fellows, all of them advanced students, who will return to work in their national health service, will come to the United States to study. This provides us a rare opportunity to influence the development of medicine and public health throughout the world; to spread on a world-wide basis the spirit of American medicine.

In providing advisory services to governments, WHO during its early life will concentrate its efforts on six major fields, namely, malaria, tuberculosis, venereal disease, maternal and child health, environmental sanitation, and nutrition. While extending specific technical knowledge in these fields it will at the same time assist in building the national services necessary for the attainment of permanent health improvement. Thus it will concern itself with the development of medical education, nursing, sanitary engineering, public health education, and other elements of a sound public health structure.

By becoming a channel for medical and public health knowledge between countries, such as ours, which have taken great forward steps in health and those that are lagging behind, WHO will find its greatest field of service.

WHO is also conducting certain services of basic international character that are of the highest importance. These are not new. They are inherited from pre-existing international health agencies which WHO has absorbed. I shall discuss two aspects of this work of WHO in order to indicate something of the character and scope of technical work that has meaning only when done on an international basis. I refer to its work on international standards and international epidemiology.

International Standards

The composition of certain therapeutic substances is so complex that the therapeutic activity cannot be determined by the usual laboratory analytical methods. In this category are found the various biologic products, hormones and other glandular extracts, certain of the vitamins, and some vegetable drugs. However, most of these substances do lend themselves to assay by comparative tests in animals or through their action on micro-organisms. This permits the determination of both the safety and the therapeutic potency of this group of products before their use in the treatment of diseases in man. For example, the potency of penicillin is determined by its action on a culture of staphylococcus. Others are assayed in the mouse, rat, guinea pig, cat, and to a limited extent, man where he may be the only suitable test animal.

The use of test animals in the potency or safety tests introduces a variable which cannot be fully controlled. This necessitates the use of a reference standard against which each product may be compared. Realizing the importance of adequate reference standards and the need for uniformity in these standards in all countries, the Interim Commission of the World Health Organization early established an Expert Committee on Biological Standardization. This provides a continuation of the pioneer work previously inaugurated by a similar committee under the League of Nations Health Organization. The function of this committee is twofold: (1) to prepare and distribute international reference standards, and (2) to determine what reference standards are needed to better protect the public.

In addition to providing protection to the public, international standards serve other useful purposes. They give research scientists and physicians the world over a uniform method of expressing potencies and therapeutic dosage. This becomes of major importance to the scientific literature in this field. International reference standards also provide a common mode of expression which facilitates the purchase and sale of these products in the international channels of trade.

The Expert Committee on Biological Standardization meets as frequently as the circumstances demand. It functions through its own members, by reference to other interested scientists, or by the appointment of small groups who are experts in a particular field.

International Epidemiology

Modern national quarantine procedures are based upon an intricate system of international notification of the occurrence and spread of pestilential disease. This epidemiologic notification system, which was developed first in 1907 by the International Office of Public Health in Paris, was further developed and improved by the League of Nations Health Organization and by UNRRA, which operated it temporarily during the later war years. Two years ago the Interim Commission of WHO, as heir to these three international health agencies, consolidated and streamlined the service. WHO operates today a service which provides a continuing and rapid flow of information concerning the occurrence and spread everywhere in the world of smallpox, cholera, plague, typhus and yellow fever. On the basis of information received it notifies countries that are threatened at any time, using cable, radio, or telegram, as appropriate, when the threat to any country is imminent. This service proved its worth in dramatic fashion in last year's cholera outbreaks in Egypt, providing reliable daily information which counteracted a rapidly developing international hysteria.

This service depends for its inflow of information on agreements reached by governments in the various sanitary conventions, the latest of which was signed in 1944. Information flows to WHO headquarters through the Pan-American Sanitary Bureau in the Western Hemisphere, the Alexandria (Egypt) Sanitary Bureau in the Eastern Mediterranean area, the WHO European Epidemiologic Station in the Southeast Asian and Western Pacific areas, and directly from other parts of the world. The Singapore Station provides daily and weekly bulletins concerning infected ports to ships at sea and in the air through a radio network that blankets the Western Pacific and Indian Oceans and adjacent areas.

In addition to the immediate notification service, the complete world picture of pestilential disease derived through this service is presented statistically in weekly, monthly, and annual publications.

Further basic international work is being carried on and developed in regard to the identification and study of influenza virus strains, the development of an international pharmacopoeia, world-wide surveys of insulin and penicillin requirements and resources, the collection of Salmonella strains, and in the other similar fields.

In its work WHO will call upon the medical profession and the related professions concerned with health in this country on many occasions. The Interim Commission of WHO established fourteen expert committees and subcommittees. American experts served on all of these with the single exception of the quarantine subcommittee concerned with the Mecca pilgrimage. So

long as the United States holds its position of leadership in medicine and public health, WHO must draw upon us heavily in order to accomplish its objective. Therein rests responsibility and an opportunity and we must give of our best.

Both the World Health Organization and the World Medical Association are in a true sense our organizations as American physicians. It is our duty to understand them and to support them at every opportunity. Through them we can make our personal and group contribution to a better world—a world at peace.

As I have had occasion to tell the public press, if we make the World Health Organization succeed, the United Nations will succeed. In that lies our hope for the future. As American physicians at a point in history when the United States holds unchallenged leadership in medicine and public health, it is peculiarly our responsibility to guarantee the success of this great adventure in international good-will and accomplishment.

APPENDIX E

Report of the Medical Service Association of Pennsylvania

To the President and House of Delegates:

Three years ago, when the then executive director of the Medical Service Association of Pennsylvania spoke to you, he pleaded for the medical profession's support of a struggling organization. At that time MSAP was fighting valiantly, with the help of a few friends, to carry out the mandate of the 1938 House of Delegates. This was to provide for the people of Pennsylvania a practical plan of voluntary prepaid medical care under the control of the medical profession. It was beset with powerful opponents and viewed with skeptical apathy.

Today, as president of the Association, I take great pride in advising you that the puny infant you were familiar with in 1945 has developed into a lusty youngster in which the medical profession can and should take pride. The Medical Service Association of Pennsylvania is in reality providing in Pennsylvania the only concrete alternative to the government control of medicine. Its nickname—Blue Shield—is fast becoming a byword throughout our Keystone State to men and women to whom it extends protection in times of serious illness and injury.

I can report to you that MSAP has passed the hazards of infancy. Judged by two important factors, your Association is today a successful and substantial organization. First, it is financially strong and completely sound. Second, it is being accepted by the people of our state for whom it was designed with ever-increasing rapidity. But, I hasten to caution you that the full growth of its maturity is yet to be reached.

I realize that statistics and figures when presented orally tend to be dry and boresome, but I would like to take just a few moments to compare for you the MSAP organization of 1945 and the MSAP of 1948.

In October, 1945, there were 24,000 subscribers enrolled. As of August 31, 1948, there were 272,000 subscribers—an increase of nearly 250,000 subscribers or 1033 per cent.

The Association balance sheet of August, 1945, showed assets of \$62,729. Of this amount \$39,450, or more than half, represented money advanced to the Plan by the State Medical Society. The balance sheet of August, 1948, showed assets of \$672,979—over ten times more—and none of which represented money ad-

vanced by the State Medical Society. During this three-year period the Association increased its assets by \$610,250.

In 1945 it was reported that in the first nine months of operation that year earned subscription fees amounted to \$82,309. In 1948, during the first eight months of this year, which are the latest complete figures available, the Plan earned subscription fees amounting to \$1,209,000. Even though the period for 1948 is one month shorter, the increase amounts to over \$1,126,691 or 1369 per cent more.

In 1945, for the nine months' period, physicians of Pennsylvania were paid \$48,640. In 1948, during the first eight months, physicians were paid \$837,000, or an increase of \$788,360, which is more than three-quarters of a million dollar increase.

In 1945 the Association had a formal agreement with the Inter-County Hospitalization Plan to act as its agent for the sale and servicing of its medical service agreements, and was attempting to work out a similar arrangement with the five Blue Cross plans located in Pennsylvania. Today I am able to tell you that, in addition to the agreement with the Inter-County Plan, since last October the Association also has a formal working agreement with the Blue Cross plans located in Philadelphia, Pittsburgh, and Wilkes-Barre wherein they too act as the agents for the sale and servicing of Blue Shield to subscribers. While it has taken me only a few seconds to advise you that these agreements are in effect, I can assure you that they were arrived at only after literally hundreds of hours of effort on the part of the Association's Board of Directors, so that the interests of the medical profession might be fully protected and the control of the Association retained completely in the hands of doctors of medicine.

A few minutes ago I referred to money advanced to the Association by the State Medical Society. Subsequent to the meeting of the 1945 House of Delegates, additional money was advanced to the Association by the State Medical Society until at its peak the Society had advanced in cash and securities more than \$72,000. In addition, it had assumed financial responsibility for the salaries and expenses of a number of persons employed in enrollment activities and the procurement of participating physicians.

During the years 1946 and 1947 the Association repaid to the State Society \$15,000 of the cash which they had advanced. Several months ago the Society was repaid an additional \$57,033.15, which consisted of \$32,333.15 in cash and \$24,700 in securities. This completely repaid all the cash and securities which had been advanced and completely liquidated the liability. But at the same time the Association found itself in a position to reimburse the Society for the travel expense and salaries of the personnel which they had paid, which amounted to \$23,846, and a check in this amount was also given to your Board of Trustees.

It is important to recognize that all of the assets which the Association owns today have been contributed by subscribers to the plan—the people of Pennsylvania—and that these people also made possible the return to the Society of the money which they advanced to get the plan under way. Consequently, today there exists in Pennsylvania a medical service plan under the control of the medical profession but financially supported solely by its subscribers.

In the final analysis the success of any program depends upon its acceptance by the public. This is especially important in the case of a voluntary medical care

plan when it is offered as an alternative to government control. This summer a cross-section survey made of Blue Shield subscribers who have received benefits showed that 95 per cent were completely satisfied with the manner in which Blue Shield handled their physicians' bills.

Leaders in business and industry everywhere have welcomed Blue Shield when they have understood its provisions and objectives. In large cities and in small towns employers are cooperating and making Blue Shield available to their personnel. In many cases all or a portion of the monthly subscription fees are being paid by the employer so that his people might have this form of protection.

It has been the Association's sincere desire to make Blue Shield just as acceptable to the medical profession as it is to subscribers. From time to time you have been told that as Blue Shield grew additional phases of medical practice would be included which were not possible to include in the original plan. The original Blue Shield coverage was such that surgeons operating in hospitals constituted the only group in the medical profession whose services were covered. But, the number of subscribers has increased and benefits have been broadened and services expanded as the plan has grown.

Today, Blue Shield covers, in addition to in-hospital surgery, the treatment of medical cases in the hospital, obstetric deliveries in either the home or the hospital, and under its Medical-Surgical Agreement, surgical services both in and out of the hospital—and again I assure you there is additional coverage to come. Thus, more and more physicians have a greater opportunity to participate personally—an extremely important factor in MSAP selling the public on the value of voluntary, prepaid medical care as compared to any bureaucratic plan.

The feasibility and practicability of Blue Shield as a workable plan to help the public meet the impact of catastrophic illness is no longer a question. The acceptability of Blue Shield by those who have received its benefits is a proven fact. But what of Blue Shield's standing with the medical profession by whom "the doctors' plan" was conceived and organized for the high purpose of providing better medical care for more people?

Statistically, only 65 per cent of the members of our State Society—which sponsors the plan and which ventured nearly \$100,000 of its funds to underwrite its early operations—are participating physicians. And this, despite repeated appeals by letters, and through the pages of the JOURNAL, for physicians to become participating physicians. A few more than 6500 physicians have taken the time to become participating physicians.

Blue Shield was formed "to maintain the high standards of the medical profession and to preserve the existing physician-patient relationship, thereby assuring complete freedom of enterprise." How can Blue Shield or any other "doctors' plan" accomplish that purpose when only 65 per cent of the members of our State Society are participating physicians? How can the Association do a completely convincing job among employers when more than one-third of our own members apparently are not interested in "assuring complete freedom of enterprise?"

Then, too, many among the 6500 participating physicians are not familiar with the "doctors' plan," according to reports reaching our offices from surprised subscribers. Some participating physicians tell their patients bluntly that they know nothing about Blue

Shield—and this despite the fact that every participating physician has been sent the MSAP fee schedule, explanatory material, and frequent issues of "Physician's Bulletin," which deals exclusively with Blue Shield information and explanations of procedures. The same deplorable situation exists among office assistants.

Your Association needs participating physicians and it needs participating physicians who are informed about the objectives, purposes, and importance of the "doctors' plan." They must be familiar with the simple procedures involved in extending the plan's benefits to Blue Shield patients. Responsible executives in high places are criticizing the "doctors' plan" because of the manner in which too many participating physicians are handling—or rather are mishandling—their employee-subscribers. Employees themselves are losing confidence in the "doctors' plan" when they find to their amazement that physicians disregard their agreements with MSAP.

It is not my desire or purpose to complain. But as a physician who depends upon the practice of medicine for a living, and as president of the Association—which to say the least is time-consuming and without compensation other than the feeling that a contribution is being made to preserve the private practice of medicine—I feel it a dutiful responsibility to call to your attention these inexcusable conditions which are militating seriously against the success of Blue Shield as a vital public relations instrumentality of the medical profession.

Every time a new Blue Shield group is formed, another stout plank is added to the bulwark against which the tide of socialized medicine beats. But every time an uninformed physician or lay assistant pleads ignorance of the Blue Shield Plan, the bulwark is weakened.

The pressure for government control of medicine has not decreased. It will never cease to be a serious threat until voluntary plans of prepaid medical care extend their protection to limited income groups of employed men and women in every corner of America. That process, in my opinion, demands much greater cooperation by individual members of the medical profession than exists today.

This is a task that the profession must do itself. It is your responsibility to get the cooperation of the physicians for the "doctors' plan." Representatives of MSAP—both members of the Board of Directors and the administrative staff—are fighting your battles every day.

I mean exactly what I say. Tomorrow night when the rest of us are enjoying the ceremonies connected with the installation of our president, a physician member of our Board of Directors, who I am sure would have liked to be present at the installation meeting, will at that time be addressing the medical staff of a hospital here in Philadelphia on the Medical Service Association. Next Tuesday night another physician on our board will leave his office in Lancaster and travel to Reading to address the Berks County Medical Society at 10 p.m. on the same subject. On the same night I will leave my own office to travel to the Lebanon County Medical Society, and two nights later I will do the same thing at a meeting of the Huntingdon County Medical Society. And so it goes.

We will continue to do our part, but the profession itself—The Medical Society of the State of Pennsylvania—cannot escape its responsibility with impunity. The Blue Shield is still the "doctors' plan." MSAP is still the child of the medical profession.

To insure complete success and greater acceleration,

MSAP must have: first, a large number of participating physicians; and, second, informed, enthusiastic, and cooperative participating physicians.

It would be an improper use of subscribers' money to spend large sums of it for the purpose of "selling" physicians on the idea of participating in their own plan. The only money which the Association has today, and rightfully so, is the money contributed by its subscribers; therefore, it is quite obvious that enrollment of participating physicians is primarily the responsibility of the medical profession. The same thing applies to a great extent to securing greater cooperation and support of participating physicians.

MSAP'S accomplishments in behalf of the physicians of Pennsylvania deserve positive action.

I specifically suggest that this House of Delegates take the necessary steps to have the Board of Trustees activate and prosecute vigorously an effective campaign to recruit at least 2500 additional participating physicians. I also recommend that the same action be taken to launch a campaign to insure that participating physicians are fully informed and cooperate in a manner that guarantees the success of the medical profession's greatest tangible form of public relations.

The officers and staff of MSAP will be happy to assist. They will be glad to meet with county societies. They will welcome the opportunity to counsel with committees, but the leadership must be taken by physicians—by this House of Delegates. The enthusiasm for genuine cooperation must stem from the medical profession itself. The Medical Society of the State of New York has a Bureau of Medical Care Insurance, with a full-time director, functioning under its Committee on Medical Economics. This bureau is concerned with extending the cooperation of physicians with the medical care plans in New York State.

To a great extent the future growth of the Medical Service Association, its Blue Shield Plan, and its effectiveness in combating socialized medicine depend upon whether the members of the sponsoring profession will truthfully participate and sincerely cooperate. Ten years ago another House of Delegates conceived MSAP among many doubts. In the meantime the Association has proven that its founders' ideas were sound, practical, and workable. An emphatic declaration of the Rich report two years ago was that MSAP "must be regarded as the major public relations aspect of the State Society's activities." The question today is: Will you—the profession itself—extend the cooperation necessary to make the "doctors' plan" completely effective and of maximum service to the people of Pennsylvania and the medical profession?

Nothing is impossible: there are ways which lead to everything, and if we have sufficient will, we should have sufficient means.

Respectfully submitted,

J. ARTHUR DAUGHERTY, M.D., *President.*

Record of Attendance of Members of the House of Delegates Representing Component County Societies at the 1948 Session in Philadelphia

(Figure indicates the number of elected delegates to which the county society is entitled plus its president

or its secretary. The House of Delegates met on Monday, October 4, at 10 a.m. and 2:10 p.m.; on Tuesday, October 5, at 2:10 p.m.; and on Wednesday, October 6, at 8:30 a.m. The figure 1 following a name indicates the presence of the delegate at the first meeting; 2, at the second meeting; 3, at the third meeting; and 4, at the fourth meeting.)

Adams (2), Arthur C. Richards, Jr., 1; Raymond M. Hale, Jr., 1 2 3 4.

Allegheny (18), Thomas M. Mabon, 1 2 3 4; William A. Bradshaw, 1 2 4; James C. Fleming, 1 2 3 4; John W. Fredette, 1 2 3 4; Harold B. Gardner, 1 2 3 4; James Hodgkiss, 1 2 3 4; Frederick M. Jacob, 1 4; Zoe Allison Johnston, 1 2 3 4; George F. Kowallis, 1 2 3 4; John J. Boucek, 1 2 3 4; George Leibold, 1 2 3 4; John F. McCullough, 1 2 3 4; Carl F. Nill, 1 2 3 4; Norman C. Ochsenhirt, 1 2 3 4; C. L. Palmer, 1 2 3 4; John W. Shirer, 3 4; John E. Weigel, 1 2 3 4; David B. Wolfe, 1 2 3 4.

Armstrong (2), Frank H. McNutt, 1; T. Craig McKee, 1 2 3 4.

Beaver (3), Wilson C. Merriman, 1; Thomas W. McCreary, 1 2 3 4; Fred B. Wilson, 1 2 3 4.

Bedford (2), John A. Topper, 1.

Berks (4), Leon C. Darrah, 1 2 3 4; Gilbert I. Winston, 3 4; Arthur A. Cope, 3; William J. Goetz, 1 2.

Blair (3), John O. Prosser, 1 3 4; Ralston O. Gettemy, 1 2 3 4; Augustus S. Kech, 1 2 3 4.

Bradford (2), Orlo G. McCoy, 1 2 3 4; Dominic S. Motsay, 1 2 3 4.

Bucks (2), Herman C. Grim, 1 2 3 4.

Butler (2), Robert S. Lucas, 1 2 3 4.

Cambria (3), C. Reginald Davis, 1 2 4; John W. Barr, 1 2 3 4; Daniel Ritter, 1 2 3 4.

Carbon (2), B. Frank Rosenberry, 1 2 3 4.

Centre (2), John G. Weixel, 1 2 3; Joseph A. Parrish, 1 2 3.

Chester (3), William A. Limberger, 1 2 3 4; Horace F. Darlington, 1 2 3 4; Robert Devereux, 1 2.

Clarion (2), J. Edwin Keppel, 1 2 3 4.

Clearfield (2), Ward O. Wilson, 1 2 3 4.

Clinton (2), David W. Thomas, 1 2 3; Edward E. Hoberman, 3 4.

Columbia (2), G. Paul Moser, 1 2 3 4; Joseph V. M. Ross, 1 2 3 4.

Crawford (2), James N. Strausbaugh, 1 2 4.

Cumberland (2), Richard R. Spahr, 3; Newton W. Hershner, 1 2 3 4.

Dauphin (4), John H. Harris, 1 2 3 4; Constantine P. Faller, 1 2 3 4; George L. Laverty, 1 2 3 4; Hewitt C. Myers, 1 2 3 4.

Delaware (4), Walter E. Wentz, Jr., 1 2 3 4; Dennis T. Sullivan, 1 2 3 4; E. Arthur Whitney, 1 2 3 4.

Elk (2), no representation.

Erie (3), Delmar R. Palmer, 1 2 3 4; Elmer G. Shelley, 1 2 3 4; Russell B. Roth, 1 2 3 4.

Fayette (3), John N. Snyder, 1 2 3 4; Ralph L. Cox, 1 2 3 4; L. Dale Johnson, 1 2 3 4.

Franklin (2), Louis C. Gordon, 1 2 3 4; Charles T. Buckingham, 1 2 3 4.

Greene (2), Donald R. Jacobs, 1 2 3 4.

Huntingdon (2), John M. Keichline, Jr., 1 2 3 4.

Indiana (2), Joseph W. Gatti, 1 2 3 4; Daniel H. Bee, 1 2 3 4.

Jefferson (2), S. Meigs Beyer, 1 2 3 4.

Juniata (2), Robert P. Banks, 1 2 3 4; Stephen I. Dodd, 3 4.

Lackawanna (4), Frederic B. Davies, 1 2 4; William J. Corcoran, 1 2 3 4; John P. Donahoe, 1 2 4.

Lancaster (4), William M. Workman, 1 3 4; James Z. Appel, 1 2 3 4; Roy Deck, 1 2 3 4; Henry Walter, Jr., 1 2 3 4.

Lawrence (2), John B. Barrett, 1 2 3; Wilbur E. Flannery, 1 2 3 4.

Lebanon (2), Louis G. Fetterman, 1 2 3 4; Walter H. Brubaker, 3 4.

Lehigh (4), John H. Hennemuth, 3; Willard C. Masonheimer, 1 2 3 4; Joseph D. Rutherford, 1 2 3 4; Robert L. Schaeffer, 1 2 3 4.

Luzerne (5), Francis J. Conlan, 2 4; Herman A. Fischer, Jr., 1 2 3 4; Louis W. Jones, 1 2 3 4; Frank M. Pugliese, 1 2 3; Charles L. Shafer, 1 2 3 4.

Lycoming (3), Reynolds M. Grieco, 3 4; Thomas J. Lewis, 1 2 3 4; Edward Lyon, Jr., 1 2 3 4.

McKean (2), Ralph E. Hockenberry, 1 3 4; Harrison J. McGhee, 1 2 3 4.

Mercer (2), James A. Biggins, 1 2 3; Victor M. Leffingwell, 1 3.

Mifflin (2), James R. McNabb, 1 2 3 4.

Monroe (2), Charles S. Flagler, 3 4.

Montgomery (5), Stephen J. Deichelman, 2; Edgar S. Buyers, 1 2 3 4; Teofil Babacz, 1 2 3 4; Louise C. Gloeckner, 1 2 3 4; Elwood T. Quinn, 1 2 3 4.

Montour (2), Roy E. Nicodemus, 1 2 4; Henry F. Hunt, 1 2 3 4.

Northampton (3), James E. Brackbill, 1 2 3 4; Frederick O. Zillessen, 1 2 3 4.

Northumberland (2), Mark K. Gass, 1 2 4; E. Roger Samuel, 1 2 3 4.

Perry (2), no representation.

Philadelphia (32), John Davis Paul, 1 2 3; William Bates, 1 2 3 4; William P. Belk, 1 2 3 4; Dorothy C. Blechschmidt, 1 2 3 4; Francis F. Borzell, 1 2 3 4; Frederick A. Bothe, 1; Charles L. Brown, 1 2 3 4; Carl J. Bucher, 1 2 3 4; W. Edward Chamberlain, 1 2 3; Walter S. Cornell, 1 2 3 4; John T. Farrell, Jr., 1 2 3; Theodore R. Fetter, 1 2 3 4; Leonard D. Frescoln, 1 2 3 4; Simon S. Leopold, 1 4; Pascal F. Lucchesi, 1 2 3 4; Theodore Melnick, 3; Roy W. Mohler, 1 2 3 4; Milton F. Percival, 1 2 3 4; William H. Perkins, 1; Joseph W. Post, 1 2 3 4; Rufus S. Reeves, 1 4; Stanley P. Reimann, 1 2; J. Parsons Schaeffer, 1 2 3 4; Frederick C. Smith, 1 2 3 4; J. Hart Toland, 1 2 3 4; Joseph J. Toland, Jr., 1 2 3 4; Ralph M. Tyson, 1; Bernard P. Widmann, 1; Joseph T. Cadden, 1 2 4; Henry B. Kobler, 2; Charles-Francis Long, 4.

Potter (2), Robert H. Kazmierski, 1.

Schuylkill (3), James J. Monahan, 1 2 3 4; Leslie J. Schwalm, 1 2 3.

Somerset (2), Charles I. Shaffer, 1 2 3 4.

Susquehanna (2), no representation.

Tioga (2), Eleanor Larson, 1 2 3; Archibald Laird, 1 2 3 4.

Union (2), Norman K. Beals, 1 2 3 4.

Warren (2), John C. Urbaitis, 4; Tom K. Larson, 1 2.

Washington (3), Guy H. McKinstry, 1 2 3 4; Milton F. Manning, 1 2 3 4.

Wayne-Pike (2), Nellie C. Heisley, 1.

Westmoreland (4), John F. Maurer, 3 4; Irwin J. Ober, 1 2 3 4; Willis H. Schimpf, 1; Thomas St. Clair, 1 2 3 4.

Wyoming (2), Charles J. H. Kraft, 1 2 3 4.

York (3), Charles L. Fackler, 1 2 3 4; Harry B. Thomas, 1 2 3 4; Wallace E. Hopkins, 1 2 3.

At Philadelphia Membership

Potter	3	10
Schuylkill	25	153
Somerset	8	31
Susquehanna	3	17
Tioga	6	24
Venango	5	50
Warren	12	51
Washington	17	143
Wayne-Pike	4	25
Westmoreland	20	205
Wyoming	3	11
York	39	171
	2803	10,568

REGISTRATION OF MEMBERS BY COUNTIES

At Philadelphia Membership

Adams	5	27
Allegheny	157	1680
Armstrong	5	46
Beaver	23	136
Bedford	2	14
Berks	55	254
Blair	22	127
Bradford	18	47
Bucks	20	88
Butler	4	64
Cambria	26	173
Carbon	7	33
Centre	11	32
Chester	36	117
Clarion	1	25
Clearfield	8	53
Clinton	6	27
Columbia	6	45
Crawford	4	59
Cumberland	9	44
Dauphin	83	252
Delaware	76	280
Elk	1	25
Eric	16	193
Fayette	13	117
Franklin	13	77
Greene	2	25
Huntingdon	5	28
Indiana	4	42
Jefferson	7	60
Juniata	2	8
Lackawanna	34	388
Lancaster	51	234
Lawrence	5	83
Lebanon	13	59
Lehigh	57	216
Luzerne	68	376
Lycoming	38	144
McKean	6	53
Mercer	10	89
Mifflin	8	33
Monroe	10	36
Montgomery	122	331
Montour	22	38
Northampton	51	197
Northumberland	15	77
Perry	0	11
Philadelphia	1501	3198

INSTALLATION MEETING

Tuesday Evening, Oct. 5, 1948

The Installation Meeting at the Centennial Celebration of The Medical Society of the State of Pennsylvania convened at eight-thirty o'clock in the Academy of Music, Philadelphia, Pa., President Elmer Hess, of Erie, presiding.

[The audience sang "The Star-Spangled Banner."]

PRESIDENT HESS: As president of The Medical Society of the State of Pennsylvania, I now call this Centennial Celebration installation meeting to order.

We will have the invocation by the Right Reverend William P. Remington, after which I shall ask you to remain standing while we have In Memoriam read by Dr. Milton F. Percival, chairman of the Committee on Necrology.

RT. REV. WILLIAM P. REMINGTON: O God, Who has entrusted to doctors and nurses the power to work with Thee in the relief of suffering and the cure of disease, bless the consultations of all physicians, surgeons, and especially of this medical society. Give unto its president, Gilson, Thy best blessings, and unto all in Thy service skillful hands, quick perceptions, and patient faith. Guide with Thy sure wisdom those who teach and those who learn and give them such purity of purpose and steadfastness in the pursuit of their unselfish profession that they may add to the welfare and health of the nations.

Make us all mindful of the needs of others and especially of those who are poor, sick, and distressed in body and mind. Fervently do we ask Thee for greater wisdom and means in the treatment of the mentally ill. O Lord, in these days when war has taken its toll and many are sick in body, mind, and soul and the whole world seems deranged and ill, help us to contribute to sane and peaceful solutions.

Our heavenly Father, pour out Thy blessing upon us as a nation; grant that we may look with the eyes of Thine own infinite pity upon our stricken world. Grant that out of the chaos of man's making, some vast good may come, that mankind may highly resolve that all of our sacrifices shall not have been in vain, that through them there may emerge some high impulse driving us on towards the City of God. Root out of each of us those qualities which in a nation make for war—selfishness, greed, lack of self-restraint, unbrotherliness, hate, and a petty and boastful nationalism. Hasten the time when nations shall dwell together in peace and unity;

when a brother's hand shall not be lifted against brother in stupid and senseless hate; when we shall have found saner and more permanent ways of settling our difficulties. Grant unto us all some part in bringing about the new freedoms and the new life in accordance with Thy purpose, through Jesus Christ, our Lord. Amen.

PRESIDENT HESS: Dr. Percival!

[Dr. Milton F. Percival read the report of the Committee on Necrology as printed on pages 1310-11 of the August, 1948 PENNSYLVANIA MEDICAL JOURNAL.]

[Selection, "Souls of the Righteous" by the Bach Festival Chorus.]

DR. EDGAR S. BUYERS: President Hess, Members of the State Medical Society, Members of its Woman's Auxiliary, Honored Guests and Friends: The Medical Society of the State of Pennsylvania is celebrating its one hundredth anniversary this week in the city where American medicine had its birth. It is fitting that we do this. It is also fitting at this time to welcome to our celebration the Woman's Auxiliary which with its 4000 members we like to think of as the good right arm of our medical society. The Auxiliary has joined with us in upholding the traditions of medicine and in improving the health of the citizens of this great Commonwealth. The Woman's Auxiliary is now twenty-four years old. Our only regret is that it was not born one hundred years ago to aid us in our fight against disease.

This evening I am highly honored as chairman of the Advisory Committee to the Woman's Auxiliary to present its very active, efficient, and, may I say, beautiful president—Mrs. Rufus M. Bierly.

MRS. RUFUS M. BIERLY: Dr. Hess, Members of The Medical Society of the State of Pennsylvania, their Guests and Friends—and I hope that last term is all-inclusive: This centennial anniversary of the founding of our State Medical Society is truly a wonderful occasion. We of the Auxiliary rejoice that you have attained your one hundredth birthday not only sound in mind and body and spirit but with a great reservoir of virility, courage, devotion, and idealism for another hundred years of war against disease and death in this great state of ours. You will go on serving humanity, yes, even that section of humanity that resists favorable health conditions, and we as doctors' wives like to feel that we play a rather unique and non-professional share in your great calling, having been adopted into the profession, as it were, and having caught from you some of your absorbing passion for it.

It was a Doctor of Medicine who labeled the doctor's wife the acolyte of medicine. Yes, we follow after you, we wait on you, and we wait for you. In those hours of waiting, we might well become restless with irritation and selfish discontent. But we of the Auxiliary are zealously interested in understanding the purpose, the ethics, the philosophy of medicine and in studying the growth of trends—social and economic—that affect the practice of medicine, so that as an organization of about 3600 women we may effectively serve our medical society in the interpretation of its aims and purposes and ideals to the general public. We serve with pride in the glorious accomplishments of your past and with devotion to your ideals for the future.

For centuries, staunch admirers have expressed their loving devotion with red roses, and so to you, our Medical Society, from your Auxiliary, one hundred red roses, one red rose for each of your years of sacrificial service. Congratulations!

PRESIDENT HESS: Thank you, Mrs. Bierly, and thank you, Dr. Buyers.

As an old soldier, it gives me a great deal of pleasure to welcome here tonight thirty-five veterans from Valley Forge Hospital as our guests. On behalf of The Medical Society of the State of Pennsylvania, I am positive that Mrs. Bierly will be happy to present fifty of these roses to the hospital through Private Joseph Kilbride. Will you stand and take a bow, Private Kilbride? And will you present these roses to your buddies at the hospital?

It is my privilege at the moment to present to you the president of the Philadelphia County Medical Society, a man whom I have known for a great many years. He is highly respected in his community and in the medical profession. I present Dr. Theodore R. Fetter, who will give the address of welcome.

DR. THEODORE R. FETTER: Mr. President, Mr. President-elect, Bishop Remington, Distinguished Guests, Members of The Medical Society of the State of Pennsylvania, Ladies and Gentlemen: It is a signal honor as president of the Philadelphia County Medical Society to welcome you to Philadelphia on this extraordinary and auspicious occasion—the Centennial Meeting of The Medical Society of the State of Pennsylvania—one hundred years of unparalleled accomplishments in medicine. It is eminently fitting and proper that Philadelphia should be the host because it is the birthplace of American medicine.

It is particularly pleasing that one of the outstanding leaders of the Philadelphia County Medical Society will be installed as the ninety-ninth president of our State Society.

It is sincerely hoped that the policy-makers of the Society will be forthright and unafraid to explore, study, and propound newer concepts in medical practice as they may affect and influence the public.

The members of the Philadelphia County Medical Society and their friends are proud indeed to be your hosts. It is our wish that everyone will exercise his rightful privilege by attending all of the features of the celebration which have been so ably arranged by a most energetic committee. We sincerely hope that your stay with us will be profitable and pleasant. It is our desire that you take full advantage of our hospitality and visit the various medical institutions and hospitals where displays on the progress of medicine will be in evidence.

We sincerely hope that your stay with us will be profitable and pleasant. Everything has been done to provide you with an intensive program of activities which are in keeping with the dignity of the occasion.

PRESIDENT HESS: Thank you, Dr. Fetter, for those very kind words of welcome.

DR. PARK A. DECKARD: Mr. President, Ladies and Gentlemen: As chairman of the Board of Trustees of The Medical Society of the State of Pennsylvania, I have a pleasant duty to perform. The gentleman to whom I will address myself has given very much of his time and energy to the faithful discharge of his duties as president of The Medical Society of the State of Pennsylvania. Dr. Hess, you have been constant and responsive, and at this time I present to you this duly inscribed silver mounted ebony gavel symbolizing your year as president of our society.

PRESIDENT HESS: Thank you very much, Park! I will always treasure this gavel as a memento of a busy

but happy year of close association with a fine medical body.

DR. THOMAS R. GAGION: Am I expected? I expected to be introduced, but the secretary just waved me on.

PRESIDENT HESS: You take me so by surprise. This is the champion story-teller of the Pennsylvania Medical Society. He is Dr. Tom Gagion, my classmate at the university.

DR. GAGION: Thank you. I didn't think I was expected.

Mr. President, Reverend Clergyman, Ladies and Gentlemen: In the interim between the annual meetings of the House of Delegates and this Society, the welfare of 11,000 doctors and the health really of the Commonwealth of Pennsylvania is pretty much under the care of the Board of Trustees of this Society. To be a good trustee, a man must have, I think, the sound judgment of a good businessman, the sagacity of a banker, the vision of a legislator, and the wisdom of a Solomon. For the past ten years, Dr. Park Deckard has brought all these qualities to our board in no small measure. He has served faithfully for ten years. I believe his record of attendance is unblemished. For the past two years he has served as chairman of the Board, and that, I may assure you since I am a member of the Board, takes the diplomacy of a Talleyrand. I think all these fine things of Park, the trustees all think these fine things of Park, but The Medical Society of the State of Pennsylvania say this to Dr. Park A. Deckard tonight through its president, secretary, and chairman of the Board of Trustees:

"In recognition of your ten years of faithful service 1938 to 1948 to The Medical Society of the State of Pennsylvania while a member of its Board of Trustees and its chairman for two years, and in appreciation of your private and official observance of the ethical principles of our profession, the Society through the undersigned officers proffers to you an expression of gratitude and of confidence that your valued cooperation will be continued.

DR. DECKARD: Thank you!

PRESIDENT HESS: Ladies and gentlemen, I have a very distinct and pleasurable duty to perform. I have known the gentleman whom I am about to present to you for a great number of years. He is one of your outstanding surgeons in this City of Philadelphia, where medicine was born in America. He has been a friend and confidant so long that I don't care to tell you how long. It is with a great sense of relief that I call him forward at this moment and pin upon him the badge of office.

Gilson Colby Engel, will you step forward, please?

May I present to you, Gilson Colby Engel, of Philadelphia, President from this moment on of The Medical Society of the State of Pennsylvania, and may God have mercy upon you.

[President Hess pinned the President's badge on President Engel.]

[President Engel read his inaugural address (see October JOURNAL).]

PRESIDENT ENGEL: I have a pleasant duty to perform in the presentation of the Benjamin Rush Awards.

Our Board of Trustees of The Medical Society of the State of Pennsylvania decided this year to establish

in the name of The Medical Society of the State of Pennsylvania an annual award to honor the lay person and the lay group in our state who each year have made outstanding contributions to the health of the citizens. After careful consideration it was decided, in giving this award a title, to honor Dr. Benjamin Rush and to call it the Benjamin Rush Award.

Benjamin Rush was a native of Pennsylvania, born in nearby Byberry Township, December 24, 1745. He graduated from Princeton University when he was 15 years of age.

He then went abroad to study medicine in Edinburgh, graduating there in 1768. As a physician and philanthropist, Dr. Rush occupied during his life the central place on the stage of American medicine. He was professor of the practice of medicine in the University of Pennsylvania and one of the founders of the Philadelphia College of Physicians, and was for thirty years a member of the medical staff of the Pennsylvania Hospital. He stands among the first of the giants of the revolutionary and formative period of our national government. Dr. Rush not only signed the Declaration of Independence but as a member of the Continental Congress served on the committee to consider, prepare, and report on the proposed Declaration of Independence by the Congress.

As a practitioner, educator, teacher, writer and patriot, he was one of the most original and energetic individuals the medical profession has ever claimed as its own. It is, therefore, fitting and proper that The Medical Society of the State of Pennsylvania should choose the name of Benjamin Rush for the award that it is here and now presenting to, in its judgment, the outstanding layman and the outstanding lay organization of 1947.

The lay individual winner of the award for 1947 served the U. S. Navy in World War I and as a lieutenant-colonel in the U. S. Army in World War II. He is a trustee of the Elizabeth Steele Magee Hospital, also of the Woman's Hospital, the Mellon Institute of Industrial Research, the Carnegie Hero Fund Commission, and of the University of Pittsburgh. As a trustee of the University of Pittsburgh, he was instrumental in creating a medical committee of the board of trustees for the University of Pittsburgh and has served as chairman of this committee since its creation. He has devoted a great deal of his time in furthering the development of the School of Medicine at the University of Pittsburgh and the hospitals comprising the University Medical Center. In fact, the success of this undertaking has been in large measure due to his activities and interest and support. He has a keen appreciation of the important role of the medical school's place in relation to the standards of service in a given community.

He is director of a number of large corporations, has been helpful in community activities, and is a member of the board of trustees of the Community Chest of Allegheny County.

It is with a great deal of pleasure tonight, on behalf of The Medical Society of the State of Pennsylvania, that I present the award for the outstanding lay individual of 1947 to Mr. Alan Magee Scaife, of Pittsburgh.

The lay organization recognized as worthy of this award is the Rotary Club of Lancaster. In the judgment of our committee the Rotary Club of Lancaster really makes a great contribution to the health of the

citizens of the State. When they realized the varied physiologic, psychologic, and social problems associated with harelip and cleft palate, they authorized a speech corrective clinic, employing the services of an internist, plastic surgeon, orthodontic and dental consultants, and a psychologist. Persons with harelip and cleft lip not only have a serious speech defect but have considerable facial disfigurement. Correction gives them courage and determination. What could be finer than the rendering of such skillful service to the handicapped.

Twenty to twenty-five patients constitute an average clinic day. A survey of 450 of their case histories shows that the patients have come from twelve states other than Pennsylvania to this Rotary-supported clinic in Lancaster. Graduate students from five medical and dental schools and from two foreign countries have attended the clinic for instruction. Follow-up of a number of their patients reveals some interesting figures. One patient is finishing his senior year in dental school; one is an honor student in a pre-law course; two are medical students; one is a supervising nurse in the obstetric department of a teaching hospital, and fifteen graduated from local high schools, three of these as honor students and class commencement day orators.

The Medical Society of the State of Pennsylvania considers this work as being unique in filling a gap which has existed in the complete rehabilitation of this type of patient. Therefore, the Board of Trustees of our medical society voted the Rotary Club of Lancaster as an outstanding lay organization in having done so much for the health of the people in the year 1947.

And now it is my great pleasure, on behalf of The Medical Society of the State of Pennsylvania, to present to Mr. Martin Keener, president of the Lancaster Rotary Club, the Benjamin Rush Award.

You have had surprises before this evening, but now we have another surprise; at least we think it is, if a wife can hold her tongue.

We have in our organization a member whose grandfather was a doctor, his father was a doctor, he is a doctor, and he has a son who is a doctor. He is a graduate of the Northwestern Medical School, the class of '08. He interned at the West Penn Hospital in Pittsburgh, and has served on the staffs of the West Penn, the South Side, and Presbyterian Hospitals. He has been a director of the Allegheny County Medical Society since 1919, and was its president in 1923. He was president of this State Society in 1917, as was his father in 1910. He has been editor of THE PENNSYLVANIA MEDICAL JOURNAL since 1940, received a citation for fifty years of practice of medicine this year. Since 1923 he has been a member of the House of Delegates of the A.M.A. and served on the Judicial Council of the American Medical Association since 1931. He is a Fellow of the American College of Physicians and a Fellow of the Pittsburgh Academy of Medicine. He is medical director of the Standard Life Insurance Company of America. And now he is finishing his thirtieth year as secretary of The Medical Society of the State of Pennsylvania.

The Board of Trustees has voted an award to honor this man who has served Pennsylvania medicine so faithfully for so many years.

Now, before he gets up, I want to say something else. The Board of Trustees, when they voted this award, were at a loss to know what to get Dr. Donaldson. So Drs. Whitehill and Palmer were delegated

to join Mrs. Donaldson at tea some afternoon to learn what her husband would like to have. So whether he likes it or not, Mrs. Donaldson will be in for it. Now, Dr. Donaldson, I am sure that you will like it, because your wife advised that you would like to have a television set. It will also have a radio with record player and recorder. I think it has everything but a deep freeze in it. It will be in your home in time for you to see the last part of the World Series, unless Mrs. Donaldson wants to look at a fashion show at that time.

It is a distinct honor and privilege for me tonight on behalf of the State Society to make the presentation of this award to Dr. Donaldson. The instrument will bear the following inscription on a metal plate:

Presented to

WALTER F. DONALDSON, M.D.

By the Members of

The Medical Society of the State of Pennsylvania

In recognition and appreciation of his thirty years of outstanding service as Secretary—1918-1948; Secretary-Treasurer, 1943-1948, and Editor, PENNSYLVANIA MEDICAL JOURNAL, 1941-1948.

October 5, 1948

SECRETARY DONALDSON: Thank you, Mr. President, and my good friends on the Board of Trustees and throughout the membership of the State Medical Society, for solving a mystery that has been disturbing me for quite some weeks—mysterious talks over the telephone, strange men's voices, and all that.

Now, I feel greatly relieved. I am sure that I will enjoy this gift. You have little idea of not only what this thoughtfulness on your part means to me but of the fitness of the wise selection that my good wife has made in my behalf. I am approaching the day when I expect to toast my shins and relax, and nothing could please me more than to have good music and an opportunity to listen to the crack of the bat and see the ball sail out over the fence for a home run.

I would like to say, too, that I value having had the opportunity to work in these thirty years' time with nearly a hundred members of this Board of Trustees and probably with 2000 members of the House of Delegates and having thousands of medical friends not only in Pennsylvania but throughout the United States who call me by my first name and expect me to call them by their first name. Friendship is something to be appreciated, as are memories that can't be taken away from one.

I don't want to speak of the past. I expect some of these days soon to sit back and enjoy the progress that lies before this organization under the administration and the guidance of wiser and younger men typified by Dr. Engel.

PRESIDENT ENGEL: I wonder if you all wouldn't like to see Mrs. Donaldson seated in Box 3.

[Selection, "The Lost Chord" by the Baltimore and Ohio Glee Club.]

[Following an intermission of five minutes, a musical program was presented by the Bach Festival Chorus and the Baltimore and Ohio Glee Club under the direction of James Allan Dash.]

SCIENTIFIC MEETINGS

PHYSIOLOGIC BASIS OF MEDICINE

Monday, Oct. 4, 1948

The first meeting of the Centennial Celebration Session, devoted to Cardiovascular Disease, was called to order in the ballroom of Convention Hall, Philadelphia, at ten o'clock, by the moderator, Joseph V. VanderVeer, Philadelphia.

The first paper, entitled "Physiologic Events in the Cardiac Cycle and Their Significance," was read by Morton J. Oppenheimer, Philadelphia. Julius R. Comroe, Jr., Philadelphia, read the second paper, "Cardiovascular Regulations." The third paper, presented by A. Reynolds Crane, Philadelphia, was entitled "Pathologic Physiology of Rheumatic and Coronary Heart Disease." Moderator VanderVeer read the fourth paper entitled "Physiologic and Pharmacologic Factors Concerned in the Diagnosis and Treatment of Cardiac Arrhythmias."

Following a very interesting question and answer period, the meeting adjourned at twelve-ten o'clock.

The second meeting, devoted to Psychosomatic Medicine, was called to order at one o'clock in the ballroom, Convention Hall, by Edward Weiss, Philadelphia, moderator.

Stewart G. Wolf, Jr., New York City, read the first paper entitled "Physiologic Mechanisms of Psychosomatic Phenomena." The second paper was read by O. Spurgeon English, Philadelphia, entitled "The Nature of the Emotional States that Disturb Bodily Functions." Moderator Weiss read the third paper, "The Application of This Knowledge to Medical Practice."

Numerous questions were directed to the speakers, which were adequately answered. The meeting adjourned at three o'clock.

The final Physiologic Basis of Medicine session, devoted to Pelvic Disease, convened in the ballroom of Convention Hall at three-thirty o'clock with J. Robert Willson, Philadelphia, as moderator, and three other Philadelphians as speakers. "The Physiology of Abortion" was presented by Abraham E. Rakoff. S. Leon Israel took up "The Physiology of the Menopause" in his paper. The third paper presented was by Jacob Hoffman entitled "The Physiology of Menstruation." The moderator, J. Robert Willson, gave the fourth paper entitled "The Physiology of Pregnancy." The usual question and answer period followed the presentation of these phases of pelvic disease. The meeting was adjourned at five-twenty o'clock.

SYMPOSIA

The symposium on "Modern Management of Thyroid Diseases" was called to order at eight-thirty o'clock, Tuesday morning, October 5, in the ballroom of Convention Hall, Philadelphia, with Gilson Colby Engel, Philadelphia, presiding. William L. Estes, Jr., Bethlehem, spoke first on "The Classification and Differential Diagnosis of the Thyroid." The second speaker, Robert C. Grauer, Pittsburgh, presented a paper entitled "The Use of Propyl-thiouracil and Radioactive Iodine." The third paper, entitled "The Surgical Treatment of Hyperthyroidism," was presented by Harold L. Foss, Danville. The guest speaker on the program was Elmer C. Bartels, Boston, Mass., who presented the final paper on "The Treatment of the Thyrocardiac with an Evaluation of Present-Day Antithyroid Drugs." An informative discussion period followed the formal presen-

tations and the meeting was adjourned at nine-fifty o'clock.

The symposium on "Treatment of Anemia" was called to order at eight-thirty o'clock, Wednesday morning, October 6, in the ballroom of Convention Hall. Thomas Fitz-Hugh, Philadelphia, acted as moderator for George J. Kastlin, Pittsburgh, who was unable to attend due to illness. Donald W. Bortz, Cleveland, Ohio, opened the program with a discussion of "Macrocytic Anemias and Their Management." A paper on "Indications for Splenectomy and Results of Splenectomy" was presented by Samuel P. Harbison, Pittsburgh. A lively question and answer forum followed and the meeting was adjourned at nine forty-five o'clock.

The symposium on "Modern Management of Radioactive Substances in Medicine" was called to order at eight-thirty o'clock, Thursday, October 7, in the ballroom of Convention Hall, by W. Edward Chamberlain, Philadelphia, moderator. Participating in this program were Richard H. Chamberlain, George C. Henny, Theodore P. Eberhard, all of Philadelphia, and Edith Quimby, Ph.D., New York City, who presented an interesting demonstration of how the field of nuclear physics applies to medicine. The meeting adjourned at nine-thirty o'clock.

CLINICOPATHOLOGIC CONFERENCES

Three clinicopathologic conferences were held on successive days—Tuesday, Wednesday, and Thursday, October 5, 6, and 7, in the Lecture Hall, Convention Hall, Philadelphia. A series of six cases were discussed, two at each session by two clinicians and one pathologist. Clinicians taking part were Frank J. Gregg, Pittsburgh, Francis C. Wood, Philadelphia, Carl E. Ervin, Harrisburg, Richard A. Kern, Charles L. Brown, and Truman G. Schnabel, Philadelphia. The pathologists were Ernest A. Aegerter, Warner F. Sheldon, and William E. Ehrich, all of Philadelphia.

WHAT'S NEW PROGRAM

A program of What's New in Medicine was held at three-thirty o'clock, Tuesday afternoon, October 5, in the ballroom of Convention Hall, Philadelphia. Frank A. Evans, Pittsburgh, presided. The presentation was in the form of questions directed to the participants who included Kenneth E. Quickel, Harrisburg, Roy R. Snowden, Pittsburgh, Joseph T. Beardwood, Jr., Philadelphia, Robert C. Grauer, Pittsburgh, and T. Grier Miller, Philadelphia. The session was adjourned at five twenty-five o'clock.

What's New in Surgery was presented at three-thirty o'clock on Wednesday afternoon, October 6, in the ballroom of Convention Hall, Isidor S. Ravdin, Philadelphia, presiding. Participating in the program were Arthur W. Allen, Boston, Mass., Alexander Brunswick, New York City, Jonathan E. Rhoads and Robert D. Dripps, Jr., Philadelphia, Samuel P. Harbison and Joseph A. Soffel, Pittsburgh, John Attlee, Jr., Lancaster, and Donald Guthrie, Sayre. The meeting adjourned at five-thirty o'clock.

What's New in Obstetrics and Gynecology was presented at one o'clock on Thursday afternoon, October 7, in the ballroom of Convention Hall, Philip F. Williams, Philadelphia, presiding. Participating in the program were Roy E. Nicodemus, Danville, John Y. Howson, Wayne, Eugene V. Helsel, Pittsburgh, Neva Abelson and William H. Perloff, Philadelphia. The session adjourned at two forty-five o'clock.

SECTION ON MEDICINE

Tuesday Afternoon, Oct. 5, 1948

The meeting convened at one o'clock in the ballroom of Convention Hall, Philadelphia, J. K. Williams Wood, Troy, chairman of the section, presiding.

The first paper, "The Evaluation of the Newer Vasodilators in Peripheral Vascular Disorders," was read by David W. Kramer, Philadelphia. Harold L. Tonkin, Williamsport, opened the discussion.

Roy R. Snowden, Pittsburgh, read the second paper entitled "Geriatrics," which was discussed by Joseph T. Freeman, Philadelphia.

The third paper, "Management and Treatment of Pulmonary Tuberculosis with Streptomycin," was read by George E. Martin, Pittsburgh, and discussed by Irvin E. Rosenberg, White Haven.

"Recent Advances in Our Knowledge of the Rickettsial Diseases" was presented by Maurice C. Pincoffs, Baltimore, Md., guest speaker.

The meeting adjourned at two forty-five o'clock.

Wednesday Afternoon, Oct. 6, 1948

The meeting convened at one o'clock, Dr. Wood presiding.

"Results of Conservative Treatment of Peptic Ulcer" was read by James A. Collins, Jr., Danville. Paul L. Shallenberger, Sayre, opened the discussion.

Herbert T. Kelly, Philadelphia, read a paper entitled "Psychosomatic Aspects of Nutritional Therapy." The discussion was opened by J. Franklin Robinson, Wilkes-Barre.

The third paper, "Histoplasmosis in Pennsylvania," by Hobart A. Reimann and Alison H. Price, Philadelphia, was read by Dr. Reimann. Edwin E. Ziegler, Lancaster, discussed this paper.

The final paper, "Renal Diseases and Dysfunctions: Some Clinical and Physiologic Problems," was read by Louis Leiter, guest speaker from New York City.

The meeting adjourned at two forty-five o'clock.

SECTION ON SURGERY

Tuesday Afternoon, Oct. 5, 1948

The meeting convened in the Lecture Hall of Convention Hall, Philadelphia, at one o'clock, Leonard F. Bush, Danville, chairman of the section, presiding.

The first paper, "Correction of Deformities Resulting from Trauma to Epiphyses," was read by John H. Wagner, Pittsburgh. John W. Fredette, Pittsburgh, read his prepared discussion.

"One-Stage Pharyngeal Diverticulectomy" was presented by Thomas A. Shallow, Philadelphia. W. Wayne Babcock, Philadelphia, opened the discussion.

Lewis K. Ferguson and Lloyd W. Stevens, Philadelphia, presented their paper entitled "The Role of Surgery in Solving the Peptic Ulcer Problem." Henry L. Bockus, Philadelphia, discussed this paper.

"Surgical Treatment of Hypertension—Present-Day Concept" was presented by the guest speaker, Robert C. Bassett, Ann Arbor, Mich.

The session adjourned at three-ten o'clock.

Wednesday Afternoon, Oct. 6, 1948

The meeting convened at one o'clock, Dr. Bush presiding.

William L. Estes, Jr., Bethlehem, spoke on "The Re-

duction of Mortality in Surgery in the Aged." Lewis K. Ferguson, Philadelphia, opened the discussion.

"Traumatic Arteriovenous Fistula of the Lower Extremity" was the subject of the paper read by James R. Watson, Pittsburgh. The discussion was opened by Harold A. Zintel, Philadelphia.

A paper on "Improved Treatment of Lung Abscess" was read by W. Emory Burnett, Philadelphia. His paper was discussed by Chairman Bush and John H. Gibbon, Jr., Philadelphia.

The guest speaker, Arthur W. Allen, Boston, Mass., read a paper entitled "The Present-Day Concept of the Treatment of Thrombosis and Embolism."

The meeting adjourned at three o'clock.

SECTION ON EYE, EAR, NOSE, AND THROAT DISEASES

Tuesday Morning, Oct. 5, 1948

The meeting convened at ten o'clock in Room 101 of Convention Hall, Philadelphia, Jay G. Linn, Pittsburgh, chairman of the section, presiding.

Harold M. Griffith, Johnstown, read his paper entitled "Management of Industrial Ocular Injuries." C. William Weisser, Pittsburgh, read his prepared discussion of Dr. Griffith's paper.

Benjamin F. Souders, Reading, read his paper entitled "Recent Trends in Enucleation: Modern Implants and Prostheses." P. Robb McDonald, Philadelphia, discussed this paper.

"American Onchocerciasis" was the title of the paper read by L. Pellman Glover, Altoona.

James H. Delaney, Erie, read a paper entitled "Treatment of Dendritic Corneal Ulcers," which was discussed by Wilfred E. Fry, Philadelphia.

The guest speaker, John M. McLean, New York City, read a paper entitled "The Present Status of Corneal Grafting."

The section adjourned at eleven-fifty o'clock.

Wednesday Morning, Oct. 6, 1948

The meeting convened at ten-five o'clock, Chairman Linn presiding.

C. Calvin Fox, Philadelphia, read his paper entitled "The Abused Diagnosis of Sinusitis," which was discussed by Daniel S. DeStio, Pittsburgh.

"Malignant Neoplasms of the Nasal Fossae and Sinuses—Diagnosis and Treatment" by Austin T. Smith and Theodore P. Eberhard, Philadelphia, was read in two parts. John O'Keefe, Philadelphia, discussed the papers of Dr. Smith and Dr. Eberhard, as did Isaac S. Tassman, Philadelphia, and Jay G. Linn, Pittsburgh.

Kenneth M. Day, Pittsburgh, presented a paper entitled "The Clinical Management of Deafness." George M. Coates, Philadelphia, opened the discussion.

Lyman G. Richards, Boston, Mass., presented the guest paper entitled "Current Trends in Otolaryngology."

James E. Landis, Reading, read a report of the work being done in the State of Pennsylvania to prevent deafness among school children.

The section adjourned at twelve-thirty o'clock.

SECTION ON PEDIATRICS

Tuesday Afternoon, Oct. 5, 1948

The meeting convened at one-fifteen o'clock in Room 101, Convention Hall, Philadelphia, Waldo E. Nelson,

Philadelphia, presiding. A symposium on "Antibacterial Therapy in Pediatrics" was presented by Robert R. Macdonald, Pittsburgh, Robert H. High, Earle H. Spaulding, and Andrew D. Hunt, Jr., Philadelphia, and the guest speaker, Horace L. Hodes, Baltimore, Md.

The section adjourned at three-ten o'clock.

Wednesday Afternoon, Oct. 6, 1948

The meeting convened at one-fifteen o'clock, Dr. Nelson presiding.

J. Albright Jones, Swarthmore, read his paper entitled "Intestinal Intubation in Pediatrics."

A paper entitled "Childhood Leukemia with Comments on New Proposals for Therapy" by Irving J. Wolman, Paul G. Eglick, and Benjamin Dickstein, Philadelphia, was read by Dr. Wolman. A discussion was participated in by Edward Smith, David A. Sampson, Herbert M. Sharkus, Philadelphia, and Joseph A. Gilmartin, Pittsburgh.

Jerome F. Grunagle, Pittsburgh, read his paper entitled "Subdural Hematoma in Infancy." Harry Lee and Israel Binder, Philadelphia, discussed the paper.

"Pediatric Education and the Practicing Physician" was read by John McK. Mitchell, Rosemont. The discussion was opened by Joseph A. Gilmartin, Pittsburgh.

Edward M. Bridge, Buffalo, N. Y., guest speaker, read his paper entitled "The Causes of Epilepsy."

The section adjourned at three twenty-five o'clock.

SECTION ON DERMATOLOGY

Tuesday Morning, Oct. 5, 1948

The meeting convened at ten o'clock in the ballroom of Convention Hall, Philadelphia, Jacques P. Guequierre, Bryn Mawr, chairman of the section, presiding.

"Endocrine Factors in Dermatology" was the subject of the paper read by Patricia H. Drant, Philadelphia. Discussion of this paper was opened by Charles Dunn, Philadelphia.

The second paper, "Eruptions of the Hands," by Frederick M. Jacob and William H. Guy, Pittsburgh, was presented by Dr. Jacob.

John H. Stokes, Philadelphia, read his paper entitled "Simplifying Dermatology for the Practicing Physician."

The guest speaker, Charles C. Dennie, Kansas City, Mo., presented his paper entitled "Man Defends Himself."

The meeting adjourned at twelve o'clock.

SECTION ON UROLOGY

Tuesday Afternoon, Oct. 5, 1948

The meeting convened at one o'clock in Room 200, Convention Hall, Philadelphia, Charles A. W. Uhle, Philadelphia, chairman of the section, presiding.

A paper on "Retropubic Prostatectomy" by Elmer Hess and Anthony F. Kaminsky, Erie, was read by Dr. Kaminsky. Discussion of this paper was opened by Stanford W. Mulholland, Philadelphia. Peter P. Mayock, Wilkes-Barre, also entered into the discussion.

Edward J. McCague, Pittsburgh, read a paper entitled "Injuries of the Genito-urinary Tract." Discussion was opened by Julius T. Waterman, Bradford.

"Socio-economic Aspects of the Practice of Urology" was read by Theodore R. Fetter, Philadelphia, followed by "Excerpts from the History of the Section on Urology," read by Joseph C. Birdsall, Philadelphia.

"The Choice of Cases for Uretero-intestinal Anastomosis" was the subject of the paper presented by the guest speaker, Simon A. Beisler, New York City. Discussion of Dr. Beisler's paper was opened by Joseph C. Birdsall, Philadelphia.

The meeting adjourned at 3:00 p.m.

Wednesday Afternoon, Oct. 6, 1948

The meeting convened at one o'clock, Chairman Uhle presiding.

The first paper, "Urinary Antiseptics" by Peter P. Mayock and Harry M. Burros, Wilkes-Barre, was presented by Dr. Mayock. Russell E. Allyn, Harrisburg, read his prepared discussion of Dr. Mayock's paper, which was followed by a discussion by Ralph M. LeComte, Washington, D. C.

Leon Herman, Philadelphia, read the paper entitled "Neoplasms of the Kidney," prepared by himself and Benjamin L. Hayllar. William J. Daw, Forty Fort, discussed this paper.

The executive committee nominated for chairman, William Baurys, Sayre, and for secretary, William W. Wightman, Pittsburgh. Both were elected.

"Experiences and Results in Total Perineal Prostatectomy for Carcinoma of the Prostate" was the subject presented by the guest speaker, George Gilbert Smith, Boston, Mass. George H. Strong, Philadelphia, opened the discussion.

The meeting adjourned at 3:30 p.m.

SECTION ON OBSTETRICS AND GYNECOLOGY

Wednesday Morning, Oct. 6, 1948

The session convened in the Lecture Hall, Convention Hall, Philadelphia, at ten o'clock, James S. Taylor, Altoona, chairman of the section, presiding.

The first paper was presented by Thaddeus L. Montgomery, Philadelphia, entitled "Further Experiences with the Rooming-in Project of Baby with Mother." Howard A. Power, Pittsburgh, Roland Porter, Abington, and James D. Stark, Erie, entered into the discussion of this paper.

"Pelvic Infection—Present Status of Treatment" was read by Mary DeWitt Pettit, Philadelphia. The discussion was presented by Robert A. Kimbrough, Philadelphia.

A paper on "Management of Excessive Weight Gain in Pregnancy" was read by J. Robert Willson, Philadelphia. Clifford B. Lull and Owen J. Toland, Philadelphia, and Delmar Palmer, Erie, discussed this paper.

"The Management and Treatment of Patients with Pre-eclampsia and Eclampsia" was the subject of the guest speaker, Duncan E. Reid, Boston, Mass.

The meeting adjourned at twelve forty-five o'clock.

Thursday Morning, Oct. 7, 1948

The meeting convened at ten o'clock, Dr. Taylor presiding.

"Contrasting Methods in the Management of Uterine Malignancy" was the title of the paper read by Lewis C. Scheffey, Philadelphia. Franklin L. Payne and Catharine Macfarlane, Philadelphia, discussed this paper.

Joseph A. Hepp, Pittsburgh, read his paper entitled "Improper Use of Estrogens in Gynecology." The discussion was opened by Fred Nugent, Reading.

Carl E. Bachman, Philadelphia, read a paper entitled "The Future of Cesarean Section." Discussors of this paper were Charles J. Barone, Pittsburgh, and James S. Taylor, Altoona.

George N. Papanicolaou, New York City, the guest speaker, spoke on "Cytologic Diagnosis of Uterine Cancer—Its Present Status."

The meeting adjourned at twelve-twenty o'clock.

SECTION ON PATHOLOGY AND RADIOLOGY

Tuesday Morning, Oct. 5, 1948

The meeting convened at ten o'clock in Room 200, Convention Hall, Philadelphia, Merl G. Colvin, Williamsport, chairman of the section, presiding.

Stanley P. Reimann, Philadelphia, presented his paper on "The Experimental Background in Approaches to Chemotherapy of Cancer."

Bettina B. Carter, M.S., Pittsburgh, presented the next paper entitled "Studies on the Rh Hapten in Relation to Rh Sensitization."

"Lupus Erythematosus and the 'Collagen Diseases'" was presented by Ernest E. Aegerter, Philadelphia.

The guest speaker, Bradley L. Coley, New York City, read his paper on "The Early Diagnosis of Tumors of Bone."

Peter A. Herbut, Philadelphia, presented his paper entitled "Cytologic Diagnosis of Carcinoma of the Lung."

The meeting adjourned at twelve-ten o'clock.

Wednesday Morning, Oct. 6, 1948

The meeting convened at ten o'clock, Charles L. Hinkel, Danville, secretary of the section, presiding.

D. Alan Sampson, Philadelphia, read his paper entitled "Urinary Tract Abnormalities."

"Inoperability versus Incurability in Tumor Management" was presented by S. Gordon Castigliano, Philadelphia.

The next paper, "Roentgen Findings in Injuries of the Wrist," was prepared by John T. Farrell, Jr., Burton L. Williams, and Mario A. Cinquino, Philadelphia, and read by Dr. Williams.

Barton R. Young, Philadelphia, spoke on "Roentgen Diagnosis of Middle Ear and Mastoid Disease in Infancy and Childhood."

Harry M. Weber, Rochester, Minn., guest speaker, presented his paper entitled "The Roentgenologic Manifestations of Neoplasm in Tubular Organs."

The meeting adjourned at twelve-thirty o'clock.

SECTION ON NERVOUS AND MENTAL DISEASES

Thursday Morning, Oct. 7, 1948

The meeting convened at ten-five o'clock in Room 101 of Convention Hall, Philadelphia, Robert S. Bookhammer, Philadelphia, chairman of the section, presiding.

A paper entitled "History of Psychiatry and Neurology in Pennsylvania" by Earl D. Bond and Benjamin Alpers, Philadelphia, was read by Dr. Bond.

Joseph C. Yaskin, Philadelphia, read his paper entitled "Vertigo: Some Practical Diagnostic and Therapeutic Considerations." This paper was discussed by John A. Malcolm, Pittsburgh, Rudolph Jaeger and James W. McConnell, Philadelphia, and Hans H. F. Reese, Madison, Wis.

Robert H. Israel, Warren, read his paper entitled

"The Role of the General Practitioner in Prevention of Psychiatric Disorders." Lauren H. Smith, Philadelphia, discussed this paper.

Hans H. F. Reese, Madison, Wis., guest speaker, read his paper entitled "Open Pages in Neurology."

The meeting adjourned at twelve-twenty o'clock.

SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH

Tuesday Morning, Oct. 5, 1948

The meeting convened in the Lecture Hall, Convention Hall, Philadelphia, Alfred C. LaBocchetta, Philadelphia, chairman of the section, presiding.

John V. Blady, Philadelphia, presented a paper entitled "Why Should the General Practitioner Be Interested in Cancer Control?" Discussion was opened by Bernard P. Widmann, Philadelphia.

"Survey of Diphtheria Immunization of 5661 Pupils in the Philadelphia Public Schools" was the title of the paper prepared by Hubley R. Owen and E. Douglass Burdick, Philadelphia, and presented by Dr. Owen. Claude P. Brown, A. Parker Hitchens, and Theodore Melnick, Philadelphia, joined in the discussion following the reading of a prepared discussion by Eli Eichelberger, York.

Roscoe P. Kandle, New York City, presented a "Preliminary Report of the Public Health Activities in Pennsylvania." Pascal F. Lucchesi, Philadelphia, discussed the paper.

T. Duckett Jones, New York City, guest speaker, presented a paper on "Rheumatic Fever and Rheumatic Heart Disease Programs of Care."

The meeting adjourned at twelve-forty o'clock.

SECTION ON GENERAL PRACTICE OF MEDICINE

Wednesday Morning, Oct. 6, 1948

The first meeting of the Section on General Practice of Medicine convened at ten o'clock in the ballroom of Convention Hall, Philadelphia, Alice E. Sheppard, Pottstown, chairman of the section, presiding.

The first paper, "Management of Pregnancy and Labor," was read by Clifford B. Lull, Philadelphia.

"Office Gynecology" was the title of the paper presented by Gerald J. Carlin, Pittsburgh.

The next paper, "Treatment of Arthritis," was given by Ralph Pemberton, Philadelphia.

The guest speaker, Waltman Walters, Rochester, Minn., spoke on "Differential Diagnosis of Acute Surgical Conditions of the Abdomen." William L. Estes, Jr., Bethlehem, lead the discussion of this paper.

The meeting adjourned at twelve-twenty o'clock.

Thursday Morning, Oct. 7, 1948

The meeting convened at ten o'clock, Dr. Sheppard presiding.

The first paper, "Changing Concepts in Immunization Procedures," was read by Aims C. McGuinness, Philadelphia.

The second paper, read by Louis E. Audet, Williamsport, was entitled "Office Management of the Patient with Diabetes Mellitus."

William D. Stroud, Philadelphia, presented a paper entitled "Diagnosis and Treatment of Coronary Heart Disease."

The guest speaker, Louis A. M. Krause, Baltimore, Md., presented his paper on "Peripheral Vascular Disease."

The meeting adjourned at eleven-fifty o'clock.

THE DECLARATION FROM GENEVA

From the *Connecticut State Medical Journal* for November, 1948, we glean some very interesting comments made by Dr. Creighton Barker on the recent session in Geneva of the World Medical Association. It is especially comforting to note comments which indicate that the true "professional" recognizes neither race, color, nor creed.

The agenda for the meetings included many matters of international medical interest and it was pleasing to see how little variation there was in the thinking and sentiment of the representatives from the many countries. The first major item to be considered was the approval of an international pledge in medicine that might be called a brief and modern Hippocratic Oath. However, this had to be called a pledge because there are countries where the meaning of the word oath is at variance with that usually accepted. There was debate over some of the points in this pledge, but finally it was accepted. It is to be called a Declaration of Geneva and says:

"At the time of being admitted as a member of the medical profession:

"I solemnly pledge myself to consecrate my life to the service of humanity;

"I will give to my teachers the respect and gratitude which is their due;

"I will practice my profession with conscience and dignity;

"The health of my patient will be my first consideration;

"I will respect the secrets which are confided in me;

"I will maintain, by all the means in my power, the honor and the noble traditions of the medical profession;

"My colleagues will be my brothers;

"I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;

"I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use any medical knowledge contrary to the laws of humanity;

"I make these promises solemnly, freely, and upon my honor."

Reports were presented on world-wide studies concerning "The Status of the Medical Profession in Twenty-three Countries," "The Advertisement of Patent Medicines," "Proposals Relative to Universal Medical Qualifications" (the impracticability of this was unanimously agreed to), "Unqualified Medical Practice," "Postgraduate Medical Education," "The Training of Specialists," "An International Code of Medical Ethics," and "Social Security and the Operation of National Health Insurance."

It was this last subject, national health insurance, which came in for the longest and the most detailed discussion and debate. There could be no question in anyone's mind, who heard what these people from all over the world had to say, that the lot of physicians in national health insurance countries was far from happy and, in spite of the impressive fact that each of them was trying to render the best possible service to his people, they knew in their hearts that in the system un-

der which they worked the quality of medical care had deteriorated. Finally, a twelve-point statement was written and adopted. It sets forth what the medical profession of the world thinks should be the rights of physicians in their relation to politically manipulated systems of medical care, and says that whenever medical care is provided as part of Social Security the following principles should govern:

1. Freedom of choice of physician by the patient. Liberty of physician to choose patient except in cases of urgency or humanitarianism.

2. No intervention of third party between physician and patient.

3. Where medical service is to be submitted to control, this control should be exercised by physicians.

4. Freedom of choice of hospital by patient.

5. Freedom of the physician to choose the location and type of his practice.

6. No restriction of medication or mode of treatment by physician except in case of abuse.

7. Appropriate representation of medical profession in every official body dealing with medical care.

8. It is not in the public interest that physicians should be full-time salaried servants of the government or Social Security bodies.

9. Remuneration of medical services ought not to depend directly on the financial condition of the insurance organization.

10. Any Social Security or insurance plan must be open to the participation of any licensed physician, and no physician should be compelled to participate if he does not wish to do so.

11. Compulsory health insurance plans should cover only those persons who are unable to make their own arrangements for medical care.

12. There shall be no exploitation of the physician, the physician's services, or the public by any person or organization.

There was no official consideration of the National Health Act of Great Britain that went into effect on July 5, this year, but there were many opportunities to discuss it with the British representatives. Mostly, they said, that the time of operation had been too short to make any valid observation, yet one could not help but note a tone of wan skepticism in all they had to say. Financially, the British physician may be as well, perhaps better off than he was before, but the amount of work which he has to do, the number of patients he has to see, since he has no choice whether he sees them or not, is staggering. The faults of mass social medicine which have been emphasized so vigorously by thoughtful and well-informed persons in America become obvious in discussions with colleagues who work under such systems.

The purposes of the World Medical Association are: (1) To promote closer ties among the national medical organizations and among the doctors of the world by personal contact and all other means available. (2) To maintain the honor and protect the interests of the medical profession. (3) To study and report on the professional problems which confront the medical profession in the different countries. (4) To organize an exchange of information on matters of interest to the medical profession. (5) To establish relations with, and to present the view of the medical profession to, the World Health Organization, UNESCO, and other appropriate bodies. (6) To assist all peoples of the world to attain the highest possible level of health. (7) To promote world peace and human freedom.

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*

8104 Jenkins Arcade

Pittsburgh 22, Pa.

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State From What It Is to What It Ought to Be.

INFORM, NOT INFURIATE

As has been printed elsewhere, the American Medical Association has become realistic. It will definitely, through funds provided by its nationwide membership, proceed promptly to demonstrate more widely the medical profession's complete understanding and interest in the health and sickness needs of all the people.

As evidence of its long expressed and more recently concentrated desire, determination, and effort to develop and implement, not "to fight," sound plans for ever-improved health and sickness service for all the people, the voice of the medical profession will soon be spread invitingly throughout the land.

In evidence please read carefully the appended.

FELLOW MEMBER:

Doubtless you have noted in the news columns of your paper during the first few days of this month information about a 1949 levy of \$25 by the American Medical Association against each of its more than 135,000 members. (All members of component county medical societies are members of a constituent state medical society and of the American Medical Association.)

The A.M.A. has never before required payment for *membership*, but the familiar annual Fellowship dues (\$12.00) will, of course, be continued. The payment that will soon be officially required is frankly stated as being for the purpose of public instruction throughout the nation "on the progress of American medicine, the importance of conservation of health, and the advantages of the American system in securing wide distribution of a high quality of medical care." In other words, the public will be given facts and more facts regarding the convincing contrasts between results attained under compulsory politically controlled sickness service in other countries and results attained in the United States under voluntary practice—the story to be told to the lay public in the words and style of lay experts in the field of public instruction.

A planning committee has been appointed to carry out the program of public instruction. This committee is composed of four members of the A.M.A. Board of Trustees and three members of the House of Delegates. Dr. William Bates, Philadelphia, has been appointed to this committee as one of the representatives of the House of Delegates.

The decision to levy this payment in 1949 came after (1) an all-day discussion on public relations attended by 200 state society and A.M.A. representatives on November 27, in St. Louis, (2) a two-day discussion in the conference of state medical society secretaries and editors held in the same city with an equally large attendance on November 28 and 29, and (3) after full discussion and unanimous vote of the 173 delegates to the A.M.A. (ten from Pennsylvania) on December 1.

The time and source through which the \$25 membership payment will be collected are to be announced later.

WALTER F. DONALDSON,
Secretary-Treasurer.

Dec. 4, 1948

P.S.—After listening to a three-hour debate between proponents and opponents of the proposed National Association of Blue Cross and Blue Shield, the reference committee to which the proposal had been referred reported back to the A.M.A. House of Delegates in closed session. Their recommendation to the House, unfavorable to the merger as proposed, was unanimously approved by the American Medical Association House of Delegates.

Officers from several state voluntary insurance plans had reported at the reference committee hearing (attended by two-thirds of the delegates) that no trouble had been experienced in insuring employees of national employers in distant states. The A.M.A. again gave its blessing to all such endeavors approved at state levels.

This action may be interpreted as leaving the

continued and ultimate complete success of voluntary insured medical service definitely in the hands of the members of the medical profession and their satisfied patients.

SECRETARY'S NOTE: At its December meeting the Board of Trustees of The Medical Society of the State of Pennsylvania unanimously accepted the request of the American Medical Association to implement the collection, through component societies, of the \$25 assessment unanimously approved by the A.M.A. House of Delegates at St. Louis on Dec. 1, 1948. Full details with statement for the assessment will be mailed to all Pennsylvania members in January, 1949.

THE BLUE CROSS-BLUE SHIELD PROPOSALS

By LESTER H. PERRY

For the information of our readers a brief factual summary of the background of the recent Blue Cross-Blue Shield proposals is presented. It is not the purpose of this report either to present details of the proposals or to evaluate them. Anyone desiring a copy of the brochure giving complete information about the proposals should write to Associated Medical Care Plans, Inc., 330 South Wells St., Chicago 6, Ill.

For several years, first with Blue Cross and later with Blue Shield, the enrolling of national accounts has presented several difficult problems. National accounts are considered to be those firms which have groups of employees in areas not served by a single plan. The national account problem consists of the following:

1. A central agency by which enrollment can be negotiated throughout the nation.
2. A central agency through which billing and collection can be handled.
3. Uniform rates for all employees regardless of place of residence.
4. Uniform minimum benefits for all employees regardless of place of residence.
5. Reasonably uniform regulations regarding enrollment, membership, and administration of contract benefits.

Blue Cross felt the impact of this problem earlier than Blue Shield because of its longer national experience with enrollment problems. Some years ago an approach was made to solution of the problem through a proposed uniform national contract for all Blue Cross plans, by means of which uniform benefits would have been possible. Although a uniform contract was agreed upon, only a portion of the plans accepted it and offered it to the public.

In 1945 the Blue Cross Commission estab-

lished a National Enrollment Division for the purpose of representing all Blue Cross plans in a common approach to national employers. Some success was experienced, although the division had no facilities for billing or collection work and was compelled to present a multiplicity of plan benefits with correspondingly different subscription rates. The director of the National Enrollment Division has been increasingly critical of the present method and has pointed out that the procedures involved are time-consuming, cumbersome, and ineffective.

Of much later origin, and outside of officially planned programs, has been the development of plan "syndicates," wherein an individual plan acts as a clearing agency for enrollment, billing, and collection with respect to a national account. The initiating plan is usually the one located in the same city with the home office of the national account concerned. These syndicate arrangements have been working fairly well, but are recognized to be limited in their application. Those concerned in them point out the duplication of effort in such arrangements, which require redesigning contract benefits for every new account and obtaining participation of plans concerned each time.

Other possible solutions of the problem have been considered by the Blue Cross and Blue Shield commissions. Each has been discarded for one reason or another, but in general the proposed solution always seemed to fail in some respect to meet all the demands of national accounts.

It was decided that a brokerage type of agency arrangement would not succeed. Although it might solve the problem of central enrollment, billing and collections, even uniform rates, it could not underwrite uniform benefits.

Various legal devices available in some states, including a cooperative statute in the District of Columbia, were examined but finally considered to be inadequate.

Purchase of or cooperative arrangements with already existing insurance companies was considered, but both were discarded to avoid involving Blue Cross and Blue Shield with third parties whose own interests would come first.

Legal difficulties made it appear impossible for the Blue Cross and Blue Shield commissions to solve the problem within their present structures without prejudicing one or another of the several interests involved.

The Los Angeles Conference of Blue Cross and Blue Shield plans in April, 1948, directed the Blue Cross and Blue Shield commissions to revise the proposals submitted there for a na-

tional association of Blue Cross and Blue Shield plans, and to submit this revision to the individual plans within a period of six months.

The Council on Medical Service of the American Medical Association held a meeting in Chicago on June 19, 1948, attended by official representatives of thirty-six constituent state medical societies, the Hawaii Territorial Medical Association, and Associated Medical Care Plans to consider problems relative to prepayment medical and hospital care plans. The topic under discussion was the proposed organization of two national corporations, to be known as Blue Cross-Blue Shield Association and Blue Cross-Blue Shield Health Service.

Presented at the meeting, in evolutionary form, were the Articles of Incorporation and By-laws of these two proposed organizations as developed by the Blue Cross and Blue Shield commissions. The Blue Cross-Blue Shield Association is designed as a holding company with authority to establish and maintain a national agency to service and supplement Blue Cross-Blue Shield plans while Blue Cross-Blue Shield Health Service, the national agency to be organized by the Association, is a national indemnity insurance company empowered to provide medical and hospital indemnity coverage in excess of any coverage offered by an existing plan, to provide coverage in areas not covered by existing plans, and to assist existing plans by promoting enrollment and acting as a collection agency for the subscription income of existing plans.

No definite affirmative or negative action was taken by the group attending the June 19 meeting, but the consensus expressed informally by the majority was opposed to the idea of a national insurance company. After discussion, the entire matter was referred to the Council on Medical Service and the Associated Medical Care Plans for further study.

At the 1948 annual meeting of the American Medical Association this matter was presented to the Reference Committee of the House of Delegates as consisting of the organization of "a national enrollment organization to implement the hospital and medical health insurance coverage of the employees of national employers. It was agreed by those attending the meeting that there was need for such organization." The Reference Committee approved the "principles enunciated and actions taken at the June 19 meeting," and the committee report was adopted by the House of Delegates.

The proposals for the Blue Cross-Blue Shield Association and the Blue Cross-Blue Shield Health Service, Inc., were approved by both

commissions on August 20, 1948, for submission to Blue Cross and Blue Shield plans. A brochure giving complete details of the proposals was distributed during September to the officers and directors of the plans.

At the Blue Shield Conference of Plans held on October 25-28, 1948, at French Lick Springs, Ind., it was voted unanimously to refer these proposals to the House of Delegates of the American Medical Association at the St. Louis Interim Session or any subsequent session. There was no definite action taken on the proposals by the Blue Shield Conference of Plans.

The Blue Cross Conference of Plans met at French Lick Springs simultaneously with Blue Shield, but in separate business sessions. At its business session on October 26, the Blue Cross Conference of Plans passed the following resolution:

Be it resolved that the Blue Cross Commission be authorized to proceed with the organization of an association, having purposes and powers and being controlled in a manner not inconsistent with the proposals approved by the Commission on August 20, 1948, all in such form as it shall consider will enable Blue Cross plans best to serve their subscribers.

This resolution authorizes the implementation of the proposals essentially as presented to both Blue Cross and Blue Shield plans with such minor changes in form as would be necessary to concur with the many suggestions which were received but which do not alter the substance of the proposals. It was understood that, under this authorization, the Blue Cross Commission would have authority to proceed only if concurrent action were taken by Blue Shield plans.

At the business session on October 27, a discussion was held concerning the action, if any, that would be desirable in the event Blue Shield did not authorize the implementation of these proposals. It was reported to the Blue Shield group by the chairman of the Blue Cross Commission that the intent of the action taken at this session by the Blue Cross Conference was to instruct the Blue Cross Commission to pursue all possible avenues of concurrent action with Blue Shield plans and to give all possible opportunity for the consummation of such concurrent action. The resolution adopted is as follows:

Having long felt the urgent need for an instrument such as that contained in the proposals approved by the Blue Cross Commission on August 20, 1948, and

Recognizing that its aims can be best achieved if such instrument is created by both Blue Cross and Blue Shield plans,

However, it is the sense of this meeting that the need is so urgent that it is hereby resolved that:

If concurrent action is not feasible following adjournment of the 1948 Interim Session of the House of Delegates of the American Medical Association, the Blue Cross Commission be authorized to organize an association to serve Blue Cross plans in a manner substantially similar to that heretofore approved, on the express understanding that the form of organization shall permit its revision at a later date to include Blue Shield plans on an equal basis, and also

That, in the interim, all possible assistance and cooperation shall be extended to Blue Shield plans.

On December 1, 1948, at the Interim Session of the A.M.A. House of Delegates, action was taken to approve the formation of a national enrollment agency and further development of coordination and reciprocity among local plans but to disapprove the proposal for the formation of a national insurance company.

THE STATE DINNER

On Monday evening, October 4, 1948, the State Dinner was held in the well-adapted ballroom of the Bellevue-Stratford Hotel, Philadelphia, with its spacious balconies and stage. Six hundred persons attended the dinner. The Ambassadors, a male quintette, with the Howard Lanin Concert String Ensemble, provided the evening's entertainment and were recalled again and again for encores of operatic, light classical and popular selections. The presidents of various state medical societies, with other distinguished guests, were introduced. The Montgomery County Medical Bulletin made the following comments on the speaker of the evening:

"Dr. Ralph Cooper Hutchison, president of Lafayette College, gave an inspiring talk in which he pointed out some of the problems facing the medical profession and urged the medical profession to do something or someone else, perhaps the government, will do it. He pointed out the qualifications and high standards of physicians and praised them for their chief interest of ministering to the ill even without remuneration. The profession has started to help individuals take care of long-term illness and the high cost of hospitalization and medical care by establishing prepayment plans. It must continue to the finish. The population has increased and there is a shortage of doctors. There is a shortage of doctors to take care of the negro population. There is a great deal to be done in the field of preventive medicine. There is a shortage of

research workers. Millions of dollars are available for research, but nothing for training research workers. The title of Dr. Hutchison's talk was 'Physician Heal Thyself' and he again urged that the physicians correct these problems or someone else will."

The official representatives of state medical associations in attendance at the dinner were: District of Columbia, John Minor, M.D.; Georgia, Edgar H. Greene, M.D.; Indiana, A. P. Hauss, M.D.; Maryland, Charles W. Maxson, M.D.; Massachusetts, Daniel B. Reardon, M.D.; New York, Leo F. Simpson, M.D., and J. Stanley Kenney, M.D.; North Carolina, James F. Robertson, M.D.; Ohio, A. A. Brindley, M.D.; West Virginia, Thomas F. E. Bess, M.D. James R. Miller, M.D., Hartford, Conn., and Mr. Lawrence W. Rember, Chicago, Ill., represented the American Medical Association.

Other distinguished guests were: Mr. Merle M. Odgers, Mr. Herman S. Mehling, Capt. Howard H. Montgomery, U.S.N., Capt. James R. Thomas, U.S.N., Mr. Furey Ellis, Mr. Erwin Steubner, William N. Parkinson, M.D., Marion Fay, Ph.D., William S. Parker, M.D., Mr. William A. Banks, and Mr. Henry N. Cocker, Philadelphia; Harry L. Willits, D.D.S., Reading; Mr. Edwin J. Heath, Mr. Martin D. Whitaker, Judge William G. Barthold, and Mr. H. P. McFadden, Bethlehem; Mr. Willard Allen, Scranton; Mr. Dean Hoffman, Luther H. Ketels, Th.D., and Mr. Martin Keener, Lancaster; Mr. George H. Parkes and Mr. John W. Long, Williamsport; Mr. A. E. Siedel, Erie; Mr. Elmer J. Halberg, Kittanning; Mr. Heath S. Clark and Mr. Robert M. Fisher, Indiana; Mr. Roy C. McKenna, Latrobe; Jessie J. Turnbull, R.N., Pittsburgh; Mr. Earl M. Craig, Freedom; Judge Morgan H. Sohn, Beaver; Mr. Louis B. Round, New Castle; Mr. Frank B. Miller and Mr. Joseph D. Wentling, Greensburg; Mr. Thomas F. Lansberry, Somerset; Drs. Rufus S. Reeves, J. Parsons Schaeffer, Theodore R. Fetter, Charles L. Brown, and John McK. Mitchell, Philadelphia; Drs. Norris W. Vaux and J. Arthur Daugherty, Harrisburg.

It was announced that congratulatory messages had been received from the American Medical Association, the Indiana, Michigan, Nebraska, and Vermont State Medical Societies, Indianapolis Medical Society, Philadelphia County Dental Society, and the Pennsylvania State Nurses Association.

The unique centenary gift of a gavel presented after the dinner by the Georgia State Medical Association is described in the November PENNSYLVANIA MEDICAL JOURNAL, page 146.

Physicians from foreign countries who registered during the Centennial Session follow: Argentina, Eugenio Romero Diaz, M.D., Marta DeMazey, M.D., and Manuel F. Guitarte, M.D.; Belgium, Helen Goudsmit, M.D.; Bolivia, Hugo del Castillo Morales, M.D.; Brazil, Ewaldo Loureiro, M.D., and Capistrano Pereira, M.D.; Canada, William E. Dionne, M.D., D. S. Malen, M.D., and Donald M. Munroe, M.D.; Chile, Jose Cadi, M.D., and Luis Richard, M.D.; China, P. S. Yao, M.D., Gerald K. I. Doo, M.D., Marc K. P. Sin, M.D., and Dora Zee, M.D.; Columbia, Jose Rafael Meoz, M.D.; Cuba, Ovidio Laosa, M.D., and Fernado Santamarina, M.D.; Dominican Republic, Dino Campagan, M.D., Simon Hoffic, M.D., and Dr. Tavares; El Salvador, Antonio Pineda Martinez, M.D.; England, G. D. Knight, M.D.; Hungary, Dezso Kassay, M.D.; India, J. M. Master, M.D.; Panama, T. C. Suescum, M.D.; Peru, Fernando Cabiese-Molina, M.D.; Philippines, Carlos Sin, M.D.; Puerto Rico, C. Jimenez-Torres, M.D., Manuel A. Iguina-Jimenez, M.D., and Dr. Balles; South Africa, N. Sacks, M.D.; and Turkey, S. Kuthay, M.D.

SENSITIZING THE 81ST CONGRESS

A bulletin dated November 9 from the Washington, D. C., office of the American Medical Association, Council on Medical Service, contains the following anent newly elected legislators:

"... In our opinion, it would be neither wise nor safe to attempt to forecast what this Congress will do in the health field before we read what the President will recommend in his message to Congress. Both political platforms recommended liberal changes in the present methods of providing medical care and a governmental responsibility for making adequate medical care more available to the public. We must wait and see how Congress will undertake to implement the platform plank.

"In the meantime the medical profession should recognize its opportunity and responsibility to inform the members of Congress, and especially the new members, on the problems involved in changing our medical care program. It must be recognized that we are actively changing the system ourselves through our development of prepayment plans and group practice. Our Congressmen should be familiar with the progress we are making and the plans we have for the future in this direction. They should also know of the hospital construction plans in their

communities, and it is exceedingly important that they be thoroughly familiar with the local methods of providing medical care for veterans.

"In thus providing our Congressmen with information, it would be well to enlist the assistance of public leaders. If a Congressman recognizes that the profession has the good will and support of other influential segments of his constituency, it can expect his assistance in promoting legislation favorable to public welfare. It is essential, therefore, that the public be so fully convinced that our program is for the improvement of the general welfare, rather than the advancement of our private interests, that it will heartily give its open approval and join with us in accomplishing its realization.

"... Obviously, the advocates of Federal health insurance programs will interpret the results of the present election as favorable to their programs, but they may be mistaken. We owe it to our patients to aid in organizing public sentiment for what we know to be to their best interests."

KNOW YOUR CONGRESSMAN

The Committee on Public Health Legislation has previously sent to its parallel committee in each county medical society full information regarding the Congressmen from Pennsylvania.

We append a list of the Pennsylvania members of the 81st Congress with limited information. When a constituent communicates with his legislative representative in the Federal Congress or in the Pennsylvania Legislature on a health subject, he need not think of political party affiliations. Each doctor of medicine in Pennsylvania should promptly become an alert, helpful, and intelligent constituent of his own Congressman. Be he a Democrat or a Republican, the statesman will consider you not as a political partisan but as a constituent well informed on health and sickness problems.

Members of 81st Federal Congress

U. S. SENATE

Edward Martin, 147 Lemoyne Ave., Washington, Pa.
Francis J. Myers, Broad and Chestnut Sts., Philadelphia 10, Pa.

U. S. HOUSE OF REPRESENTATIVES

* Newly elected † Re-elected

*William A. Barrett, 2324 Reed St., Philadelphia, 1st district

*William T. Granahan, 2491 N. 50th St., Philadelphia, 2nd district

†Hardie Scott, 699 N. Broad St., Philadelphia, 3rd district

- *Earl Chudoff, 3214 W. Susquehanna Ave., Philadelphia, 4th district
 *William J. Green, Jr., 3309 "G" St., Philadelphia, 5th district
 †Hugh D. Scott, Jr., 44 Hillcrest Ave., Philadelphia, 6th district
 *Benjamin F. James, Hilldale and Spring Mill Rds., P. O. Box 513, Villanova, 7th district
 †Franklin H. Lichtenwalter, Center Valley, 8th district
 †Paul B. Dague, East Caln Twp., R. D., Downingtown, 9th district
 *Harry P. O'Neill, 1235 Clay Ave., Dunmore, 10th district
 *Daniel J. Flood, 77 Madison St., Wilkes-Barre, 11th district
 †Ivor D. Fenton, 520 E. Centre St., Mahanoy City, 12th district
 *George M. Rhodes, 505 Brighton Ave., Pennside, Reading, 13th district
 †Wilson D. Gillette, 102 York Ave., Towanda, 14th district
 †Robert F. Rich, Woolrich, 15th district
 †Samuel K. McConnell, Jr., 301 Hathaway Lane, Wynnewood, 16th district
 †Richard M. Simpson, Oneida Twp., Huntingdon, 17th district
 †John C. Kunkel, 112 State St., Harrisburg, 18th district
 †Leon H. Gavin, 314 Innis St., Oil City, 19th district
 †Francis E. Walter, 806 Hamilton St., Easton, 20th district
 *James F. Lind, 141 N. Keesey St., York, 21st district
 †James E. Van Zandt, 1017 18th Ave., Altoona, 22nd district
 *Anthony Cavalcante, 63 Prospect St., Uniontown, 23rd district
 †Thomas E. Morgan, Fredericktown, 24th district
 †Louis E. Graham, 328 East End Ave., Beaver, 25th district
 *Robert L. Coffey, Jr., Upper Yoder Twp. No. 3, R. D. 5, Johnstown, 26th district
 †Augustine B. Kelley, 231 Westmoreland Ave., Greensburg, 27th district
 †Carroll D. Kearns, 818 Park Ave., Farrell, 28th district
 *Harry J. Davenport, 5700 Jackson St., Pittsburgh 6, 29th district
 †Robert J. Corbett, 64 N. Euclid Ave., Pittsburgh 2, 30th district
 †James G. Fulton, 2850 Epsy Ave., Pittsburgh 16, 31st district
 †Herman P. Eberharter, 3408 Parkview Ave., Pittsburgh, 32nd district
 †Frank Buchanan, 1121 Washington St., McKeesport, 33rd district

APPROXIMATE NUMBER OF LIVING PHYSICIANS IN THE UNITED STATES BY STATES—MAY-JUNE, 1948

State	No. Living
Alabama	2,238
Arizona	802
Arkansas	1,750
California	16,069
Colorado	2,202
Connecticut	3,261

State	No. Living
Delaware	439
District of Columbia	4,130
Florida	2,931
Georgia	3,145
Idaho	470
Illinois	13,307
Indiana	4,396
Iowa	2,933
Kansas	2,223
Kentucky	2,683
Louisiana	3,080
Maine	1,010
Maryland	3,696
Massachusetts	9,102
Michigan	7,127
Minnesota	4,263
Mississippi	1,525
Missouri	5,352
Montana	544
Nebraska	1,625
Nevada	198
New Hampshire	727
New Jersey	6,585
New Mexico	506
New York	30,970
North Carolina	3,377
North Dakota	467
Ohio	10,091
Oklahoma	2,266
Oregon	1,852
Pennsylvania	14,633
Rhode Island	1,039
South Carolina	1,550
South Dakota	517
Tennessee	3,549
Texas	7,621
Utah	831
Vermont	589
Virginia	3,306
Washington	2,814
West Virginia	1,839
Wisconsin	3,873
Wyoming	252
Total	199,755

—J.A.M.A., August 21, 1948.

THE 1949 HONOR ROLL

On December 20 the office of the State Society secretary-treasurer had received the 1949 dues of 1141 members. On the same date last year the dues of 300 members had been received. Practically all of the dues received to date have been forwarded by the secretaries of five county societies as listed below, with Montgomery County Medical Society again at the top of the honor roll.

County Society	No. of Members	Per Cent Paid
Montgomery	335	58
York	173	45
Allegheny	1704	42
Bucks	93	40
Delaware	291	32

State society dues become delinquent after March first instead of March 31, as formerly.

ACKNOWLEDGMENT

During the Centennial Celebration, in Philadelphia, in October, the members of the staff of the Harrisburg and Pittsburgh offices of The Medical Society of the State of Pennsylvania met under the chairmanship of Executive Secretary Perry and presented to Secretary-Treasurer Donaldson a handsome jet crystal desk set bearing the inscription—

Walter F. Donaldson, M.D.
to express our affection and high esteem
Employees of MSSP
—Pittsburgh Medical Bulletin.

1949 STANDING COMMITTEES

COMMITTEE ON SCIENTIFIC WORK

William A. Bradshaw, 121 University Place, Pittsburgh 13,
Chairman (for personnel, see page 190)

COMMITTEE ON SCIENTIFIC EXHIBIT

Elwyn L. Heller, 230 Lothrop St., Pittsburgh 13, *Chairman*

COMMITTEE ON ARCHIVES

Walter F. Donaldson, 8104 Jenkins Arcade, Pittsburgh 22,
Chairman
Elwood T. Quinn, Jenkintown
Clarence R. Phillips, Harrisburg

COMMITTEE ON EDUCATIONAL FUND

(To be appointed)

COMMITTEE ON HOSPITAL RELATIONS

Elmer Hess, 501 Commerce Building, Erie, *Chairman*
Louis E. Audet, Williamsport
William Bates, Philadelphia
William F. Brennan, Pittsburgh
Charles L. Johnston, Catawissa
Thomas W. McCreary, Rochester
Pauline K. Wenner, Allentown

COMMITTEE ON MEDICAL BENEVOLENCE

E. Roger Samuel, 103 N. Hickory St., Mt. Carmel, *Chairman*
Francis J. Conahan, Bethlehem, *Treasurer*
Laurie D. Sargent, Washington
Walter F. Donaldson, Pittsburgh, *Secretary*

COMMITTEE ON MEDICAL ECONOMICS

Louis W. Jones, 314 E. South St., Wilkes-Barre, *Chairman*
Dudley P. Walker, Bethlehem
John T. Farrell, Jr., Philadelphia
LaRue M. Hoffman, Williamsport
Norman C. Ochsenhirt, Pittsburgh
Thomas W. McCreary, Rochester
Edgar W. Meiser, Lancaster
Ex Officio: John W. Barr, Johnstown

COMMITTEE ON MILITARY AFFAIRS

Richard A. Kern, 3401 N. Broad St., Philadelphia 40, *Chairman*
Constantine P. Faller, Harrisburg
Gerald N. Flugel, Wilkes-Barre
James M. Henninger, Pittsburgh
Edward Lyon, Jr., Williamsport

COMMITTEE ON NECROLOGY

M. Fraser Percival, 2332 S. Broad St., Philadelphia 45, *Chairman*
Walter F. Donaldson, Pittsburgh
Herman A. Gailley, York
Francis S. Mainzer, Huntingdon
Hugh R. Robertson, Warren

COMMITTEE TO NOMINATE DELEGATES AND ALTERNATES TO THE AMERICAN MEDICAL ASSOCIATION

(To be appointed)

COMMITTEE ON PSYCHIATRIC SERVICES TO CRIMINAL COURTS

Philip O. Roche, 255 S. 17th St., Philadelphia 3, *Chairman*
Frederick H. Allen, Philadelphia
Frederick S. Baldi, Philadelphia
Herbert H. Herskovitz, Reading
Robert H. Israel, Warren
Rodney H. Kiefer, Pittsburgh
LeRoy M. A. Maeder, Philadelphia

COMMITTEE ON PUBLIC RELATIONS

Term Expires

Howard K. Petry, Harrisburg State Hospital, Harrisburg, <i>Chairman</i>	1950
Allen W. Cowley, Harrisburg	1949
Archibald Laird, Wellsboro	1949
J. Hart Toland, Philadelphia	1949
Leo H. Crip, Pittsburgh	1950
James M. Mayhew, Greensburg	1950
Frederic B. Davies, Scranton	1951
J. Van S. Donaldson, Butler	1951
Samuel B. Hadden, Philadelphia	1951

Ex officio:

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Transfers (10), Resignations (8), Deaths (10)

ALLEGHENY: *Transfers*—Eugene W. Hodgson, Oakdale, and William H. Tomaseki, Wilmerding, from Washington County Society. *Resignations*—Robert R. Cohen, Denver, Colo.; Milton Singer, San Francisco, Calif.; Carmelo L. Terlizzi, Huntingdon, Va. *Deaths*—Bender Z. Cashman, Pittsburgh (Johns Hopkins Univ. '09), October 7, aged 62; John P. Hall, Pittsburgh (Coll. Phys. & Surg., Balt. '92), October 21, aged 81; Harry H. Rittenhouse, Bridgeville (Univ. Pgh. '11), October 19, aged 63; Edward A. Weissner, Pittsburgh (Univ. Pa. '98), October 18, aged 72.

CAMBRIA: *Transfer*—William T. Corey, Johnstown, from Allegheny County Society.

DAUPHIN: *Transfers*—George L. Gleason, Harrisburg, from Mercer County Society; Edward C. Rafensperger, Harrisburg, from Philadelphia County Society. *Death*—Hewitt C. Myers, Steelton (Univ. Pa. '00), October 24, aged 73.

ERIE: *Resignation*—Charles A. Bream, North East.

INDIANA: *Transfer*—William G. Evans, Jr., Dixonville, from Luzerne County Society.

LACKAWANNA: *Transfer*—Charles A. Gibbons, Scranton, from Luzerne County Society. *Death*—Bruce G. Hamlin, Scranton (Hahn. Med. Coll. '00), July 30, aged 67.

LANCASTER: *Death*—Wayne S. Regar, Ephrata (Med.-Chi. Coll., Phila. '07), October 3, aged 77.

LYCOMING: *Death*—Ella N. Ritter, Williamsport (Woman's Med. Coll., Phila. '93), September 30, aged 82.

NORTHAMPTON: *Resignation*—John D. Battle, Jr., Cleveland, Ohio.

NORTHUMBERLAND: *Death*—Sterling C. King, Watsonstown (Temple Univ. '22), September 16, aged 53.

PHILADELPHIA: *Resignations*—Thomas C. Garrett, Sarasota, Fla.; F. Wm. Sunderman, Cleveland, Ohio. *Transfers*—Jane M. Leibfried, Philadelphia, from Northampton County Society; John L. Mulherin, Philadel-

phia, from Luzerne County Society; Alex S. Vujan, Philadelphia, from Allegheny County Society.

WARREN: *Resignation*—Herman C. Rogers, Scotch Plains, N. J.

YORK: *Death*—Lawton M. Hartman, York (Univ. Pa. '02), October 6, aged 69.

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since September 30. Figures in first column indicate county society numbers; second column, State Society numbers.

Sept. 30	Dauphin	251	10411	\$7.50
Oct. 6	Montour	39	10412	15.00
	Blair	128-129	10413-10414	15.00
7	Philadelphia	3136-3152	10415-10431	127.50
11	Delaware	283-286	10432-10435	30.00
13	York	1-2	1-2	30.00
14	Luzerne	372	10436	15.00
18	Mifflin	34	10437	7.50
20	Lackawanna	276	10438	15.00
	Berks	260	10439	7.50
22	Northampton	208	10440	7.50
28	Luzerne	373-377	10441-10445	37.50

CONTRIBUTIONS TO MEDICAL BENEVOLENCE FUND

The Committee on Medical Benevolence makes grateful acknowledgment of the following contributions to the fund. These have also been previously acknowledged individually.

Woman's Auxiliary, Allegheny County	.....	\$100.68
Woman's Auxiliary, Montgomery County		100.00

Total contributions since 1948 report \$200.68

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ten months of this year there have been 985 requests.

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Subjects requested between October 1 and October 31 were:

Dysmenorrhea	Leukemia
Hypertension	Malaria
Porphyria	Prematurity
Pernicious anemia	Treatment of arthritis
Lead toxicity	Medical research
Gastric mucosa	Electrocardiography
Modern drugs	Diabetes
Adaptation syndrome	Shock therapy
Genital prolapse	Psychosomatic medicine
Mycosis fungoides	Use of manogin
Myasthenia gravis	Pheochromocytoma
Mustard gas	Social psychiatry
Heart diseases	Rheumatic fever
Rh factor	The psychotic child
Hodgkin's disease	Yellow fever
Tattooing	Social hygiene
Osteo-arthritis	Premarital advice
Diagnosis of pregnancy	Estrogenic therapy
Cataract extraction	Middle-aged child
Infant feeding	

Fluorine and dental caries
 Etiology of poliomyelitis
 Dislocation of the head of the fibula
 Atomic energy and medicine
 Methods of detecting lead in the urine
 Treatment of children's diseases
 Intramedullary fixation of fractures
 Periodic health examinations
 Use of vitamins in surgery
 Rheumatic heart disease
 Penicillin aerosol in treatment of chronic sinusitis
 Histamine therapy in headache
 Use of wire sutures in herniorrhaphy
 Biography of Benjamin Rush
 Rice diet in hypertension (3)
 Pathology of poliomyelitis
 Dissolution of common duct stones
 Legal aspects of autopsies—operative procedures and physical examinations
 Therapy of the common cold
 Socialized medicine (2)
 Mistreatment of common skin diseases
 Model by-laws for component societies
 Sternal puncture as a diagnostic procedure
 Repair of inguinal hernia
 External ocular injuries
 Diagnosis and treatment of bronchiectasis
 Diseases of the fallopian tube
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 The life of Florence Nightingale
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Research in the Service of Medicine

1. Orgain, E. S.: The Treatment of Congestive Heart Failure, North Carolina M. J. 8:125 (March) 1947.

*Searle Aminophyllin contains at least 80% of anhydrous theophylline.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the co-operation of the Pennsylvania Tuberculosis Society
and The Medical Society of the State of Pennsylvania

THE control of pulmonary tuberculosis depends on the early diagnosis, isolation, and treatment of the active cases. Nothing has been added to our knowledge in recent years to change this fundamental fact. In its early stage, tuberculosis has no characteristic symptoms and no significant physical findings. X-ray examination is necessary for its detection.

THE DIAGNOSIS OF PULMONARY TUBERCULOSIS

It is important to place pulmonary tuberculosis near the top of the list of diagnostic possibilities in cases giving a history of nervousness, digestive disturbance, loss of weight, productive cough, and pulmonary hemorrhage. When the disease is accompanied by such symptoms, it is usually easy to find tubercle bacilli in the sputum, and chest films show extensive infiltration and cavitation. Such patients still make up a large majority of those admitted for sanatorium treatment. Extensive surgical procedures are frequently required for permanent arrest of the infection. Treatment periods run to two and three years with significant mortality rates. The patient with arrested advanced disease is a handicapped individual whose rehabilitation offers further problems. Reactivation of the infection in later years occurs with disappointing frequency. Everyone around such a patient has been exposed to tubercle bacilli for weeks or months. The disease perpetuates itself in this way.

The early case offers a pleasant contrast to the above picture. There has been little opportunity for spread of infection, and arrest of the disease can be achieved much more frequently with shorter periods of treatment. When collapse therapy is necessary, the simpler procedures are usually sufficient. The residual handicap is slight and recurrence of active disease in later life is exceptional.

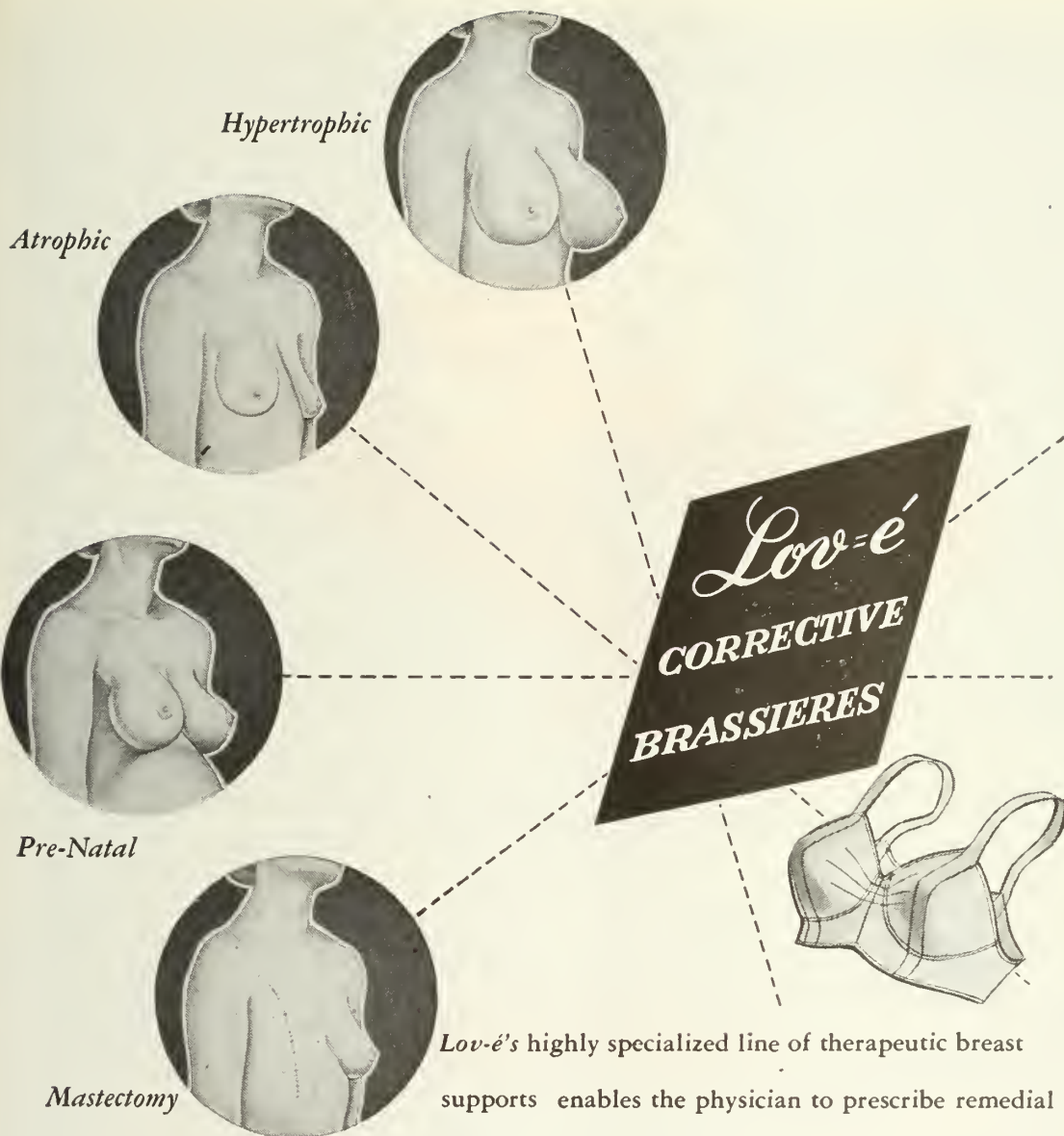
It is therefore of basic importance in the diagnosis of pulmonary tuberculosis to find it in the early stages. Failure in early diagnosis has often occurred because physicians had a low index of suspicion of its presence. It is not unusual for the first search for tuberculosis to be made at the

suggestion, or even at the insistence, of the patient. At other times tuberculosis may have an acute onset and advanced disease is discovered soon after the first symptoms.

However, the majority of cases of pulmonary tuberculosis develop slowly. Symptoms are absent or so slight that the individuals seldom go to doctors and their examination must be brought about by education and community endeavor. When patients seek medical advice, the diagnosis of pulmonary tuberculosis becomes a direct professional responsibility which can be met only by considering the possibility of tuberculosis in every patient. The private physician has been a leader in tuberculosis case-finding in the past. Routine methods will be required to maintain this position in the face of the decreasing morbidity of the disease.

Misplaced confidence in physical examination is another common cause for delay in the discovery of pulmonary tuberculosis. Too much stress cannot be placed on the limitations of physical diagnosis. In almost every case of early or latent pulmonary disease, percussion and auscultation are so inadequate as to be practically a waste of time. Doctors continue to be surprised at the extent of pulmonary lesions as shown by x-ray examination. Most minimal and many advanced cases of active pulmonary tuberculosis would easily be missed in even a careful physical examination.

There are two methods of screening out the few cases without depending on symptoms and physical findings. These are the tuberculin test and the x-ray examination of the chest. One or the other should be used routinely. The chest



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film appeals to most doctors because it also reveals cardiac and other pulmonary abnormalities at once. These advantages have led to the present campaign for x-ray examination of all hospital admissions. In office practice the tuberculin test is very helpful as it takes little time. A positive reaction indicates previous exposure to tuberculosis and is an indication for proceeding with x-ray examination. [Another screening method for physicians in general practice is the use of the fluoroscope. If the fluoroscope shows suspicious findings, the patient can then be tuberculin-tested and a chest x-ray made.—Author's note.]

The patients with suspicious x-ray shadows are found by these screening methods. Evaluation of the film findings in each instance requires a complete history and careful clinical study including a tuberculin test. For practical purposes a negative tuberculin reaction rules out active tuberculosis.

It is necessary to determine not only the presence of tuberculosis but also the degree of activity of the lesion. Recovery of tubercle bacilli from pulmonary secretions gives absolute proof

of active disease. Culture or guinea pig inoculation of one or more fasting gastric specimens may be required in the absence of a productive cough. Serial chest films are always more helpful than any single examination. An unstable tuberculous lesion, even though retrogressive, must be considered active.

The search for pulmonary tuberculosis has been greatly stimulated by the practical application of small film photofluorography. This trend will probably continue with community and industrial surveys and with the study of hospital admissions. All physicians will be having these chest x-ray problems brought to their attention. Tuberculosis will be outnumbered by other abnormalities of the lungs, mediastinum, and cardiovascular system. More frequent opportunities will be available for early diagnosis of malignant tumors, especially bronchogenic carcinoma. Here, everything depends on prompt referral for surgical exploration and resection.

The Diagnosis of Pulmonary Tuberculosis, George H. Vernon, M.D., Illinois Medical Journal, December, 1947.

75 YEARS OF NURSING PROGRESS

How can 75 years of nursing progress be measured? Imagine yourself a patient in the year 1873. You would take it for granted if the nurse slapped onion poultices, turpentine stupes, mustard pastes, leeches, or hot flat-irons on your ailing body. Your family would also take for granted your slow rate of recovery. Today, these quaint nursing treatments are almost unheard of and the life span increases with each passing decade.

Seventy-five years ago a nurse would have been mystified if she were asked to give a patient a basal metabolism test, take someone's blood pressure, or handle such modern equipment as respirators, oxygen tents, and penicillin nebulizers. In 1873 these things were not yet invented.

The discoveries of science and technology in the past three-quarters of a century have transformed the nurse into a highly skilled member of the medical team.

Small wonder that today's nurse must attend a school of nursing from three to five years and must keep abreast of almost daily discoveries in medical procedure. Before the birth of modern nursing education, a girl was considered qualified to care for the sick if she spent six months as an apprentice in a medical ward and six months in a surgical ward without any formal schooling.

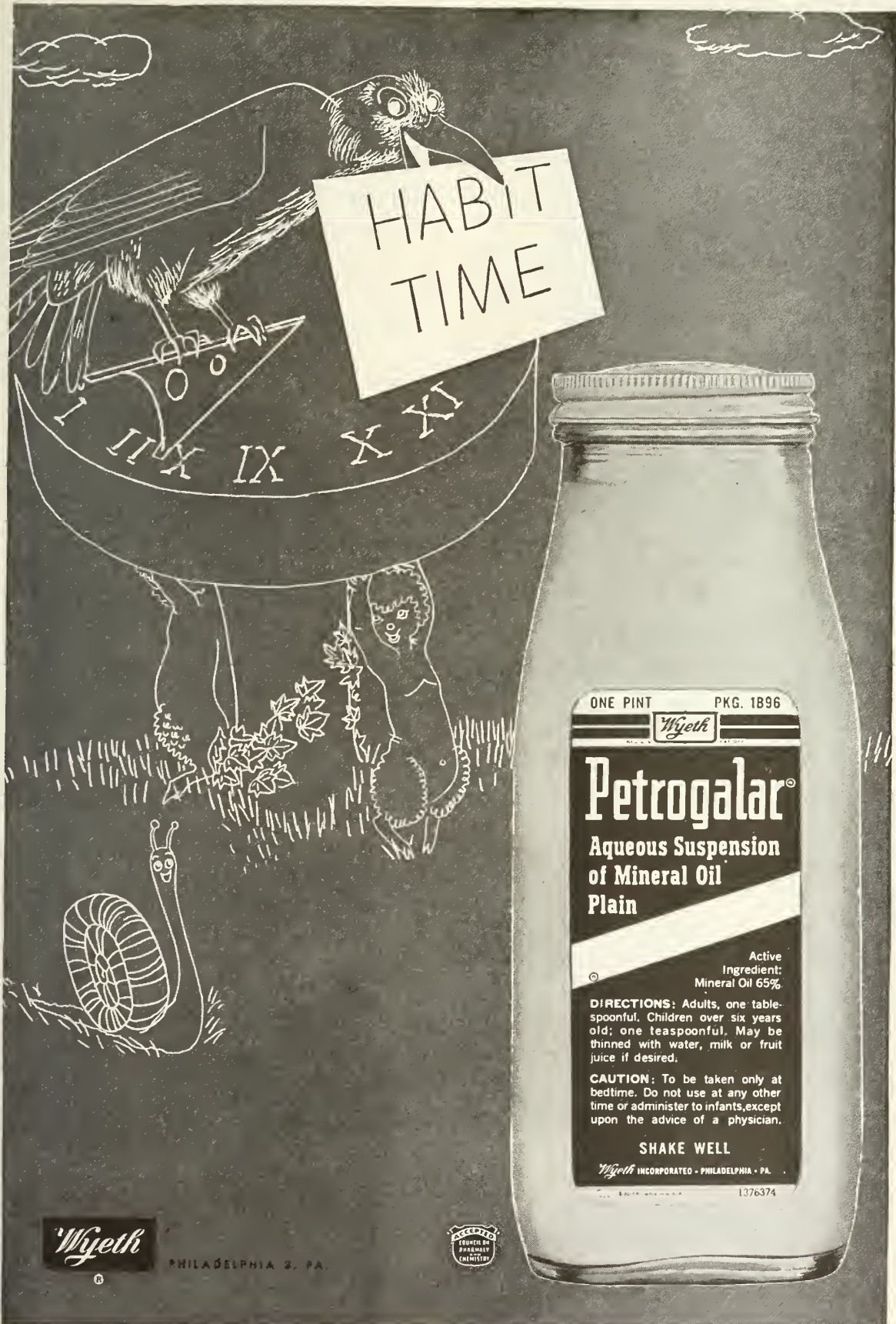
Even after the establishment of the first schools of nursing based on the Florence Nightingale system, progress was slow. By 1879 only 11 such schools, educating 298 student nurses, were in existence. But under

the leadership of such pioneers as Linda Richards the concept of professional nursing took firm hold. As the years went by, more and better schools of nursing were set up throughout the country. Thousands of nurses were graduated for duties not only in hospitals and sick rooms but in new fields of curative and preventive medicine—for work in public health nursing and in industrial, psychiatric, orthopedic, pediatric, and other highly specialized branches of nursing demanded by the modern hospital. Two hundred and ninety-eight student nurses were enrolled in 1879; 106,900, including men students, were working for an R.N. in 1947.

With the great increase in numbers came corresponding increases in teaching techniques. Sixty-six university schools of nursing are now in existence; extra years of specialized training have been added to curricula. And with the great improvement in nursing care have come the many added years to the average life span of the American people.

All the facts and figures, the contrasts between then and now, focus our attention on this main achievement of the professional nurses of America in the past seventy-five years—their devoted service in winning the battle for human health.—American Nurses Association.

Under the new British medical plan the physicians will receive a \$1,200 basic annual salary plus approximately \$3 annually for each public patient.



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THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

547 Water Street

Indiana, Pa.

SEASON'S GREETINGS

That you have a holiday within your family group full of memories to cherish is my Christmas wish for each Auxiliary member. Then I hope that with the New Year we will all turn to life and activity within our communities. The beginning of a new year is a time to evaluate plans and to decide how best to carry them out in the light of previous accomplishments and current need.

These are urgent times in government and in all areas of life. The medical profession, working for the best health interests of the people of this country, is being misquoted and their purposes and actions misinterpreted. Abraham Lincoln said, "With public sentiment, nothing can fail; without it, nothing can succeed." Believing this to be true, our course is laid out and tasks are set for every one of us.

Several projects have been given to us to work on this year: first, publicizing the value of medical research so that necessary legislation can be passed to further scientific advancement; second, and probably the most important, interesting people in Blue Shield and letting them know that the medical profession is back of this voluntary nonprofit insured medical service plan; finally, evaluating and interpreting distorted newspaper statements affecting our doctors and balancing such misinformation with proper facts.

Medical Research.—The Medical Society of the State of Pennsylvania is sponsoring a bill to be introduced in the 1949 Pennsylvania Legislature to provide for licensing and inspecting of laboratories and to permit them to legally acquire impounded animals about to be destroyed. These animals, while being humanely cared for, will contribute invaluable service to humanity.

Last summer *The Saturday Evening Post* ran an article called "They're Trifling with Your Life," pointing out the fallacies in the thinking of the antivivisectionists. They were asked to write on the other side of the question, but replied that there is no valid argument in support of the antivivisectionist viewpoint.

Let us tell the elementary story of scientific investigation for our husbands. For instance,

75,000 individuals would have died last winter from pneumonia had it not been for the availability of the sulfa drugs, developed through controlled experimental use of animals.

Dr. C. L. Palmer, chairman of the Committee on Public Health Legislation, has sent additional information on this subject and petition forms to each county auxiliary. As an individual you can take a petition to each meeting of a lay group that you attend and obtain signatures. The facts are no more controversial than that one must use a microscope to see bacteria. You can't see bacteria without a microscope; you can't do medical research without animal experimentation.

Blue Shield.—The Blue Shield Plan of the Medical Service Association of Pennsylvania is the "doctors' plan." It is sold all over Pennsylvania. Be sure that you understand the functioning of Blue Cross-Blue Shield in your area. Blue Shield is the medical profession's partial answer to the cost of medical care. But to be successful, it must have the support of the doctors. Often employers planning subscription want to know if the local doctors belong. Doctors have the confidence of their patients. Agents selling Blue Shield have to first build up the confidence of the group to which they are talking. Company officers want to be sure the doctors are cooperating with the plan.

Things we are not for, we seem to be against. So let's be sure that our husbands belong to this plan, that they speak articulately for it when the occasion arises, and that they take into consideration the patient's income when they add to the basic fee allowed. Do you know that the \$3.25 per month charged by voluntary plans is a more reasonable rate for a family than the \$1.90 weekly rate quoted by Oscar Ewing, which does not even consider that paid by the employer and the probable deficit to be underwritten by the taxpayers?

Mrs. Frederic B. Davies, postwar planning (Blue Shield) chairman for the Auxiliary, recently sent an excellent questionnaire to county chairmen answering basic questions. We hope that each one of you will become familiar with the details.

Then, a final request—read and discuss with your husband valid facts about medical care, progress in preventive medicine, and standards of medical service in countries with a compulsory tax-supported program. This will explain the need for the educational program and the twenty-five dollar per member assessment recently voted by the American Medical Association.

If we work diligently on these projects, the coming months will bring the fulfillment of my wish that the new year will be one of satisfying achievement for each Auxiliary member.

(MRS. PAUL C.) CATHARINE PALMER CRAIG,
President.

OUR HONORARY MEMBER

The first honorary member of our organization, Mrs. Edgar S. Buyers, is the epitome of friendliness in Auxiliary circles. Her winning smile and twinkling eyes have greeted us at meetings and spelled welcome to newcomers all through the years.

Not one State Auxiliary convention has Mary Buyers missed; and in her own Montgomery County, she has been absent from only three auxiliary meetings in fourteen years. At other county meetings she is frequently seen, and even at other state conventions, having attended both New York and New Jersey annual meetings this past year. As a roving delegate and ambassador of good will, she lives and breathes Auxiliary and lends untold support to the promotion of interest and friendliness among doctors' wives.

Mary Buyers was born in Norristown in 1879, the daughter of George and Emma (Moir) Kite. She was educated in Norristown schools. On September 15, 1909, she was married to Edgar S. Buyers, M.D., in the house where they now live. Though they have not lived there continuously, they bought the home eighteen years ago, which incidentally is next door to the Montgomery County Medical Society Building on DeKalb Street in Norristown.

The Octave and Garden Clubs of Norristown also claim Mrs. Buyers as a member, but the medical auxiliary is her life. She saw the birth of the organization at the meeting in Philadelphia in December, 1924. She was a director on the first board of the State Auxiliary, and some years later she served as vice-president.

In recognition of her lively and continuous interest through the years, Mrs. Buyers was honored at a tea held on Wednesday afternoon, October 6, at the Bellevue-Stratford Hotel. It was a gala occasion. The guest of honor is at a



Honorary member, Mary Buyers, right, is shown receiving the engraved silver tray from President Clara Bierly.

loss to know whether that day or her wedding day deserves to be called the happiest day of her life. Those of you who were there will long remember little Mary Buyers receiving, with a somewhat trembling smile, the engraved silver tray from her Auxiliary friends. You will recall the cozy sociability of the gathering, the delicious punch and cookies, and you will chuckle again at the procession of "gay nineties" beauties who modeled for us.

Who says a woman can't keep a secret? Mary Buyers was completely surprised; yet plans were begun at the mid-year board meeting during a short closed session and culminated in a resolution unanimously adopted at the Wednesday morning convention meeting. Drawn up by Mrs. Jay G. Linn as chairman, working with Mrs. Charles J. Swalm and Mrs. Frank P. Dwyer, the last paragraph of the resolution reads as follows:

"Her beautiful smile greets us as we enter any meeting. Its warmth stimulates us while we are there and the memory lingers with us when we leave. Her post cards with the news of what is happening over the State are instructive, entertaining, and make one think of magnum in parvum—and everyone knows, I am sure, how much she can crowd on a postal. Therefore, be it resolved that it is the consensus of opinion of the members at this meeting that the honor of being made an honorary life member of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania be conferred upon Mary Buyers at the Auxiliary session of the 100th anniversary meeting of The Medical Society of the State of Pennsylvania, October 6, 1948, at Philadelphia."

(MRS. RUFUS M.) CLARA R. BIERLY.

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March 17-18, 1949

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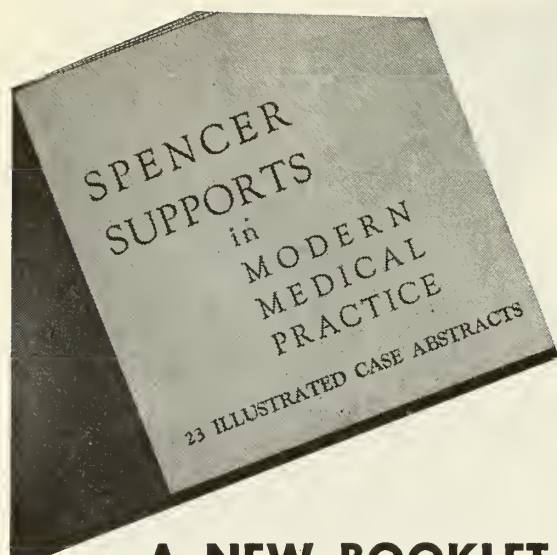
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INTRODUCING THE BOARD MEMBERS

President-elect: Mrs. Drury Hinton, of Drexel Hill, has been active in the State Auxiliary, as councilor of the Second District for four years and as first vice-president during the past year. She is Chairman of Councilors and Organization during the present administration. As president-elect, her biography will appear later.

First Vice-President: Mrs. Howard A. Power has served as Chairman of Finance on the State Auxiliary Board for five years. She is on the Board of Directors of the Twentieth Century Club and first vice-president and chairman of the Public Affairs Committee of the College Club of Pittsburgh. Her hobbies are antique glass and silver.

Second Vice-President: Mrs. Morgan D. Person was *National Bulletin* chairman of the State Auxiliary from 1943-48. She has been financial secretary, recording secretary, and president of the Lehigh County Auxiliary. A graduate of the University of Pennsylvania Training School for Nurses, she is active in the Allentown Woman's Club and many civic organizations. Dr. and Mrs. Person have two daughters, Radell, age seven, and Karen, age three and a half.

Third Vice-President: Mrs. Charles E. Peach, of Pine Grove, was Public Relations Chairman of the State Auxiliary the past year and has held many offices, including the presidency, in the Schuylkill County Auxiliary. Mrs. Peach was a teacher of home economics at Warren High School, Warren, Ill., and a dietitian at Memorial Hospital, Cumberland, Md. She is chairman of the Conservation and Gardens Committee of the Schuylkill County Federation of Woman's Clubs. Her hobbies are gardening, campanology, and traveling.

Recording Secretary: Mrs. Frank P. Dwyer is a member of the Organization Committee of the Woman's Auxiliary to the A.M.A. In the State Auxiliary she has served as recording secretary for the past fourteen years. Mrs. Dwyer was a teacher and at present is president of the Renovo Monday Night Club, treasurer of the Clinton County Federation of Woman's Clubs, and a member of the Community Chest Committee and the Red Cross Board. She is also a past county president and state chairman of the Federation of Woman's Clubs. Dr. and Mrs. Dwyer have two sons who are doctors and one daughter.

Corresponding Secretary: Mrs. John C. Stolz, of Wyomissing, has been secretary and public relations chairman of Berks County Auxiliary. She studied at the Philadelphia Academy of Fine Arts. While Dr. Stolz took his residency in Detroit, she served as an x-ray technician. The Stoltz's have one son, Jonathan, six years of age. Her hobbies are sewing, reading, and art. She is "just a plain wife and mother." Mrs. Stolz designed the auxiliary scal, carrying out Mrs. Bierly's ideas.

Treasurer: Mrs. Edmund C. Boots, of Pittsburgh, has served as treasurer of the State Auxiliary for three years. She was president of the Allegheny County Auxiliary 1947-48 and is now a director. One of her outside interests is the Louise Home for Babies, on whose board she is a director. She is interested in painting and modeling.

Parliamentarian: Mrs. Walter F. Donaldson is a past state president and has been on the State Board in many capacities, including councilor of the Tenth Dis-

trict. She is the wife of the Secretary-Treasurer of The Medical Society of the State of Pennsylvania. In Pittsburgh she is chairman of the Public Affairs Committee of the Twentieth Century Club, a member of the Association for the Care of Cardiac Children, and a former president of this organization. The Donaldsons have four sons, one a physician, two daughters, and three grandchildren.

Directors for One Year

Mrs. Gilson Colby Engel, a member of the Philadelphia County Auxiliary, has been active in the Emergency Aid of Pennsylvania and is now its vice-president. She is a member of the board of the Germantown Visiting Nurse Association and the Citizens' Planning Commission of Philadelphia. Since 1932 Mrs. Engel has been vice-president of the Woman's Auxiliary of the Cancer Research Institute of Lankenau Hospital. She is a member of the Society of Colonial Dames of America and of the Mayflower Society. Her hobbies are "gardening and antiques." Mrs. Engel is the wife of the distinguished President of The Medical Society of the State of Pennsylvania.

Mrs. Albert A. Martucci, a past president of the Philadelphia County Auxiliary, served as chairman of their "Formula," Welfare, and Public Relations Committees. She was convention chairman for the State Auxiliary in 1946. Before her marriage, Mrs. Martucci was Supervisor of Nurseries at Kensington Hospital for Women. She is first vice-president of the Associate Board of Women of Stetson Hospital, as well as chairman of the Hospital Committee. Her most interesting hobbies are the study of genealogy and the collecting of Madonnas of the Renaissance. Dr. and Mrs. Martucci have a son sixteen years of age and a daughter, thirteen.

Mrs. William B. West of Huntingdon, a former teacher, has served her county auxiliary as secretary and president and is at present chairman of the *National Bulletin*. Her various civic interests vary from music and membership in the A.A.U.W. and Women's League of Juniata College to many church activities. For relaxation she prefers reading and knitting. William, Jr., is aged fourteen and Mary Helen, twelve.

Directors for Two Years

Mrs. Albert J. Blair, a past president of her county auxiliary, finds time to conduct two clinical laboratories in Greene County. She is a past president of the Twentieth Century Club, an active member of the Social Service League, and first chairman of the local Cancer Society. Last year she won the Woman's Golf Championship in Waynesburg. The Blairs have a fifteen-year-old son and a daughter, ten.

Mrs. Robert S. Lucas, president of her local auxiliary two years ago, was formerly a teacher in the Lansdowne schools, and has lived in Butler for eighteen years. Mrs. Lucas is now senior advisor for the Junior Woman's Club and a director on the Library and Garden Club boards. For three years she served as superintendent of the children's department in the First Presbyterian Church. Dr. and Mrs. Lucas have a fifteen-year-old daughter. Collecting old glass is Mrs. Lucas' hobby.

Mrs. Charles L. Shafer, of Kingston, brings honor to Pennsylvania, serving the Woman's Auxiliary to the A.M.A. as legislation chairman this year. A past president of the Luzerne County group, she participates in many community activities, including the Council of

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Social Agencies, Visiting Nurse Association, League of Women Voters, and A.A.U.W. She says that she was a social worker—"all grades from lowly case worker to executive director in the Family Welfare Society and Red Cross." Her hobby is being "a grandmother by remote control." She finds time to be secretary to two doctors—her husband, who is chairman of the State Board of Medical Education and Licensure, and young Dr. Shafer.

MINUTES OF TWENTY-FOURTH ANNUAL CONVENTION

October 5, 1948

The general sessions of the twenty-fourth annual convention of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania were called to order on Tuesday, October 5, in Philadelphia.

After the invocation and the pledge of loyalty, Dr. Theodore R. Fetter, president of the Philadelphia County Medical Society, and Mrs. James J. Waygood, president of the Philadelphia Auxiliary, welcomed the assembly. Mrs. Albert F. Doyle, past president of Cambria County Auxiliary, responded to the welcomes.

Mrs. William Bates conducted a solemn "In Memoriam" for the thirty-six members who have passed on since the last convention. Miss Elmira Edwards sang "The Lord's Prayer."

Mrs. James L. Whitehill, of Beaver County, gave a detailed report of the convention of the Auxiliary to the American Medical Association held in Chicago in June, 1948.

The first credential report by Mrs. Charles J. Swalm, chairman of convention, was 369 members and guests. Mrs. Rufus M. Bierly, twenty-fourth president of the Auxiliary, gave a report of her year's work, the results of her planning for the year, and the Auxiliary advances made in all fields of endeavor.

Mrs. Paul C. Craig, president-elect, Mrs. George W. Krick, corresponding secretary, Mrs. Frank P. Dwyer, recording secretary, and Mrs. Edmund C. Boots, treasurer, gave detailed reports of their year's work. Mrs. S. Dale Spotts read the auditor's report on the treasurer's report.

Mrs. Jay G. Linn read the slate of nominees as chosen by her committee and posted the list as required by the by-laws.

For the first time, county reports were given in informal fashion, by councilor groups, led by the councilor of each group. There was a "District Skule" replete with auxiliary pupils, blackboards, and benevolence problems (arithmetic problems), and a question and answer quiz. A radio program, a walkie-talkie street scene, a forum, a gossip hour at the Woman's Club on the fine programs of medical auxiliary groups, and a chance meeting of wives attending the postgraduate centers with their husbands, were other ways the reporting was carried out.

The by-law changes approved by the Executive Board



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for presentation to the convention were read by Mrs. Bierly in the absence of the chairman. The changes provide for branch auxiliaries, members at large, honorary members, and a raise in dues. All changes were approved after discussion. Mrs. John C. Stolz gave an amusing sketch on the inconsistencies of women's spending habits, apropos of the dues question.

October 6, 1948

The second day of the convention, October 6, found a number of guests from neighboring states and the president of the Auxiliary to the American Medical Association, Mrs. Luther S. Kice of New York, in the assembly.

Twenty-seven members of the Auxiliary were nominated and elected delegates to the annual convention of the Auxiliary to the American Medical Association to be held in June, 1949, at Atlantic City.

The various committee chairmen gave their reports in detail, with a number of recommendations. They were accepted on motion and filed.

The budget, approved by the Executive Board and presented to the convention body, was accepted without change.

A resolutions committee gave a complete report of the acknowledgment of courtesies received during the convention with a list of special mentions.

Mrs. Jay G. Linn, chairman of a special committee, brought to the convention a recommendation to confer honorary membership on Mrs. Edgar S. Buyers, of Norristown, whose friendly spirit and welcoming smile have greeted convention-goers for twenty-four years of Auxiliary meetings, and whose postal cards have been a source of joy to members and officers of the organization. The motion was seconded by Mrs. Shilling of Mrs. Buyers' home auxiliary, and passed unanimously.

Mrs. Swalm announced a registration of 515 members and guests.

Four councilor districts presented slates of officers for election. The following were elected:

First: Mrs. Francis F. Borzell, Councilor; Mrs. John C. Howell, Executive Assistant.

Fourth: Mrs. William J. Jacoby, Councilor; Mrs. I. E. Smigelsky, Executive Assistant.

Tenth: Mrs. Howard H. Hamman, Councilor; Mrs. Herbert J. Goodrich, Executive Assistant.

Twelfth: Mrs. Xavier K. Collmann, Councilor; Mrs. Herman A. Fischer, Jr., Executive Assistant.

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January 31, 1949

The following slate, named by the nominating committee, was declared elected when there were no further nominations for any post:

President-elect: Mrs. Drury Hinton, Delaware County.
First Vice-President: Mrs. Howard A. Power, Allegheny County.

Second Vice-President: Mrs. Morgan D. Person, Lehigh County.

Third Vice-President: Mrs. Charles E. Peach, Schuylkill County.

Recording Secretary: Mrs. Frank P. Dwyer, Clinton County.

Treasurer: Mrs. Edmund C. Boots, Allegheny County.

Directors: Mrs. Albert J. Blair, Greene County; Mrs. Robert S. Lucas, Butler County; Mrs. Charles L. Shafer, Luzerne County; Mrs. Gilson Colby Engel, Philadelphia County.

Mrs. Jay G. Linn conducted an impressive installation service for the elected officers and Mrs. Bierly handed over the gavel to the twenty-fifth president, Mrs. Paul C. Craig. Mrs. Leon C. Darrah presented Mrs. Bierly with the past president's pin.

Mrs. Craig asked the cooperation of the Auxiliary members assembled and gave an outline of her plans for the coming year.

The twenty-fourth convention of the Auxiliary to The Medical Society of the State of Pennsylvania adjourned at 3:45 p.m., October 6, 1948.

MRS. PAUL C. CRAIG, *President*,
MRS. FRANK P. DWYER, *Secretary*.

FIRST MEDICAL STUDENTS' LOANS

Three premedical students have received loans of \$5,000 to finance their medical education under the \$100,000 joint medical student loan fund set up by Illinois Agricultural Association and the Illinois State Medical Society. The students and the universities which they will attend are: Burton E. Bagby of Mounds, Loyola University Stritch College of Medicine, Chicago; L. C. Fiene of Sparta and Lawrence Irish of Blandensville, the University of Illinois. Men from rural communities who have completed premedical courses, who are approved by local farm bureaus and medical societies, and who will agree to practice in rural communities are eligible for \$5,000 loans at the rate of \$1,000 a year to complete their four-year medical courses and one-year internships. A list of twenty priority counties, where the situation is worse than usual, has been set up for Illinois. All three candidates are from such counties. The scholarship loan plan for medical training was established late in 1947. (*Journal A.M.A.*, January 1, page 48).

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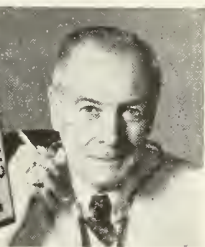
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Further investigation disclosed its great penetrative and photographic powers. His first photograph recorded the bones of Frau Röntgen's hand. A "preliminary communication" on his discovery was released on

December 28, 1895, to the president of the Physical Medical Society of Würzburg—and the X-ray, so named by Röntgen for want of anything more definitive, was promptly welcomed in medical and dental circles.

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MEDICAL NEWS

Future Meeting Calendar

SECRETARIES-EDITORS CONFERENCE—Penn-Harris Hotel, Harrisburg, March 3 and 4, 1949.

AMERICAN ACADEMY OF GENERAL PRACTICE—Cincinnati, March 7 to 9, 1949.

AMERICAN COLLEGE OF PHYSICIANS—New York, March 28 to April 1, 1949.

Births

TO DR. AND MRS. HARRISON F. HARBACH, of Gettysburg, a daughter, November 28.

TO DR. AND MRS. GEORGE H. STEIN, of Harrisburg, a son, Douglas Ogle Stein, November 5.

TO DR. AND MRS. JOEL GOLDMAN, of Lewistown, a daughter, Judith Behney Goldman, November 22.

Engagements

MISS ANNE ELIZABETH READ, of Bryn Mawr, to John Joyce Sayen, M.D., of Wynnewood.

MISS MARY KAY MILLER, daughter of Dr. and Mrs. Richard J. Miller, to Mr. Charles B. Fager, IV, son of Dr. and Mrs. Charles B. Fager, III, all of Harrisburg.

MISS DEBORAH M. BENJAMIN, daughter of Dr. and Mrs. Marion W. Benjamin, of Philadelphia, to Mr. Louis A. Pegel, Jr., a senior medical student at New York University.

MISS HEDVAH RAY COHEN, of Philadelphia, to M. Price Margolies, M.D., son of Dr. and Mrs. Michael Margolies, of Coatesville. Dr. Margolies is chief resident physician of the Graduate Hospital of the University of Pennsylvania.

MISS HELEN KLEBERG, daughter of the owner of the famed King Ranch in Texas, to J. Deaver Alexander, M.D., of Philadelphia, son of the late Dr. Emory Graham Alexander, chief surgeon of Abington Memorial Hospital and associate professor at the University of Pennsylvania Medical School, and grandson of the late Dr. John B. Deaver, internationally famous Philadelphia surgeon. Dr. Alexander is on the staff of Bellevue Hospital, New York City.

Marriages

MRS. DANIEL CRAWFORD to Henry B. Kobler, M.D., both of Philadelphia, November 24.

MISS BARBARA CATHERINE PERFECT, daughter of Dr. and Mrs. Fred R. Perfect, of Wyomissing, to Mr. Donald Roderick Smith, of Penn Yan, N. Y., October 30.

URSULA M. LEDEN, M.D., daughter of Dr. and Mrs. Peter Leden, of Chicago, to Edward Montgomery Krusen, Jr., M.D., grandson of the late Dr. and Mrs. Wilmer Krusen, of Philadelphia, November 13. Dr. Krusen and his bride are at present associated with the Mayo Clinic in Rochester, Minn.

Deaths

○ *Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.*

○ **William E. Matthews**, Johnstown; Jefferson Medical College of Philadelphia, 1887; aged 88; died Oct. 29, 1948. Dr. Matthews began practice in Johnstown two months prior to the great flood which struck that city in May of 1889, and lost all of his possessions as a result of the water. He served forty-five years as county medical director, and was a past chief of staff of Conemaugh Valley Memorial Hospital. He was

active in the Y.M.C.A. and the Presbyterian Church. In 1937 he was awarded the fifty-year certificate by the State Medical Society. Dr. Matthews is survived by his widow.

○ **Adelbert E. Torrens**, West View; University of Pittsburgh School of Medicine, 1902; aged 72; died Nov. 13, 1948. Dr. Torrens practiced roentgenology for twenty-five years at the Allegheny General Hospital, Pittsburgh. He retired from active practice five years ago. Having lived in West View for thirty-five years, Dr. Torrens was active in community affairs, and served on the school board and as an elder in the Presbyterian Church. He was a veteran of World War I. Dr. Torrens is survived by his widow, a daughter, and a son.

Ralph Bernstein, Philadelphia; University of Pennsylvania School of Medicine, 1903; Hahnemann Medical College and Hospital of Philadelphia, 1904; aged 71; died Nov. 19, 1948. Dr. Bernstein, professor of dermatology at Hahnemann, will long be remembered for his unorthodox and entertaining methods of instruction. He was a Fellow of the American College of Physicians and the American Academy of Dermatology and Syphilology.

○ **Theodore C. Fegley**, Tremont; University of Pennsylvania School of Medicine, 1899; aged 72; died Nov. 17, 1948. Dr. Fegley was an active and respected citizen of Tremont, where he served as county coroner for eight years. He saw service in the Mexican Border campaign and in World War I. He is survived by his widow and two daughters.

William J. Gatti, Philadelphia; College of Physicians and Surgeons, Baltimore, Md., 1914; aged 55; died Nov. 6, 1948, from a heart ailment. Dr. Gatti was a member of Jefferson County Medical Society while practicing in Punxsutawney. He is survived by a son.

○ **Montrose B. Magoffin**, Mercer; University of Pennsylvania School of Medicine, 1912; aged 63; died Nov. 14, 1948. Dr. Magoffin served overseas in World War I and was active in church affairs in Mercer. He is survived by his sister.

○ **Russell C. Gourley**, Punxsutawney; University of Pittsburgh School of Medicine, 1894; aged 78; died Nov. 17, 1948. He is survived by his widow, a daughter, and two sons.

○ **Leo T. McKee**, St. Marys; Georgetown University School of Medicine, 1928; aged 45; died Oct. 26, 1948. Dr. McKee had served as secretary of the Elk County Medical Society.

○ **Frank A. Pugliese**, Punxsutawney; Temple University School of Medicine, 1935; aged 40; died Nov. 17, 1948. He was pathologist at Adrian Hospital.

○ **Horace C. Bare**, Philadelphia; University of Pennsylvania School of Medicine, 1901; aged 70; died Nov. 18, 1948. He is survived by his sister.

○ **Joseph M. Steim**, New Kensington; Medico-Chirurgical College of Philadelphia, 1898; aged 71; died Nov. 13, 1948. Dr. Steim was recently awarded the fifty-year certificate of the State Medical Society. He was a life member of the American Academy of Ophthalmology and a member of the Pittsburgh Academy of Ophthalmology. He is survived by his widow and one son, a medical student.

Miscellaneous

THE EIGHTY-SIXTH MEETING OF THE READING EYE, EAR, NOSE AND THROAT SOCIETY was held on November 24. The speaker was Philip R. Wiest, M.D., of Reading, who discussed "The Sphenopalatine Ganglion."

A SECOND SHEET SUPPLEMENT TO THE UNITED STATES PHARMACOPOEIA XIII was issued on November 10. All owners of Pharmacopoeias may secure this supplement by writing to Adley B. Nichols, Secretary, U.S.P. Convention, 4738 Kingsessing Ave., Philadelphia 43, Pa.

THE WILL OF DR. M. GREGORY CHADMAN, of Lancaster, who died Nov. 15, 1948, stated the following: "In the settlement of my estate it is my desire that my executors do not institute any litigation nor use any other forceful means in an endeavor to collect any bills which may then be due me for medical expenses."

THE FIFTH ANNUAL CLINICAL CONFERENCE OF THE CHICAGO MEDICAL SOCIETY will be held in Chicago at the Palmer House, March 1 to 4, 1949. The scientific program promises to be most outstanding with well-known speakers from all sections of the country discussing subjects which will be of interest to all physicians. Many scientific exhibits are being planned and the technical exhibits will be well displayed. Sufficient time will be given for viewing both of these exhibits. Physicians of other states and cities are cordially invited to attend this important medical meeting. Reservations should be made direct with the Palmer House.

THE VALLEY FORGE GENERAL HOSPITAL, Phoenixville, has been designated as the U. S. Army's hepatic and metabolic center, according to a recent announcement by Col. Kenneth A. Brewer, the hospital's commanding officer. The purpose of the new center will be to study all liver diseases, but special emphasis at present will be placed on the diagnosis and treatment of acute and chronic hepatitis. The center will be housed in a four-ward unit with a minimum bed capacity of 96. It will not replace any of the present facilities of Valley Forge, but rather will augment the hospital's facilities as a center for various types of professional specialties including plastic surgery, orthopedics, and neuropsychiatry.

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Residency.—A.M.A. approved general residency open January 1, 1949, in 135-bed ACS approved hospital 35 miles from Philadelphia. Salary \$250.00 per month plus full maintenance. Pennsylvania license preferred. Write outline of training and experience. POTTSTOWN HOSPITAL, Pottstown, Pa.

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Wanted.—Laboratory technician for Masonic Homes Hospital, Elizabethtown, Pa. Preference given to middle-aged person not interested in matrimony who wants to make her home in small community. Must be able to do usual routine hospital laboratory tests and be experienced or willing to be trained in giving physical therapy treatments with heat lamps, massage, etc., to aged guests numbering 165. Fixed salary plus full maintenance. Communicate with MR. SCOTT C. REA, 5th and Orange Sts., Northumberland, Pa.

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1. New York State J. Med. 47:1003

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BOOK REVIEWS

THE SKULL, SINUSES, AND MASTOIDS. A Handbook of Roentgen Diagnosis. By BARTON R. YOUNG, M.D., Professor of Radiology, Temple University Medical School. 328 pages with 141 illustrations. Chicago: The Year Book Publishers, Inc., 1948. Price, \$6.50.

More than just another in a series of handbooks on roentgen diagnosis, this book is worthy of the attention of otorhinolaryngologists and roentgenologists alike. There is presented in this small book made up of three parts the x-ray appearance of (1) the normal skull, (2) the sinuses, and (3) the mastoids at significant stages of development from birth to adult life, their normal variants, anomalies, and diseases.

The many photographs and x-ray reproductions splendidly illustrate the text throughout. The printing and paper are both good. A bibliography and an index round out this book. It is recommended to all interested persons.

SYNOPSIS OF PEDIATRICS. By JOHN ZAHORSKY, A.B., M.D., F.A.C.P., Professor of Pediatrics and Director of the Department of Pediatrics, St. Louis University School of Medicine, and Pediatrician-in-Chief to the St. Mary's Group of Hospitals; Fellow of the American Academy of Pediatrics. Assisted by T. S. ZAHORSKY, B.S., M.D., Senior Instructor in Pediatrics, St. Louis University School of Medicine, and Assistant Pediatrician to the St. Mary's Group of Hospitals. Fifth edition with 158 text illustrations and 9 color plates. St. Louis: The C. V. Mosby Company, 1948. Price, \$5.50.

This synopsis like all other so-called synopses has many shortcomings. The physician purchases such a book with the idea of having a time-saver for reference work during the busy day in practice. He is usually disappointed in his efforts to find the answer to his problem and ends up searching further into a standard text on the subject.

This particular synopsis, however, has many virtues which recommend it. The section on infant feeding is lucid and thorough. The illustrations of stools are excellent and most helpful to the practitioner first facing these enigmas of the diaper. Most of the chapters dealing with therapeutics and disorders of nutrition, growth, and development are barely adequate. The infectious diseases are comprehensively covered. Therapy of pertussis barely mentions what is promising to be the most effective single weapon against this disease—human immune serum. Even more recent advances using the newer antibiotics, of course, are too new to have been included in this fifth edition. Very little detail is offered in the use of penicillin in such diseases as meningitis and congenital syphilis. There is no mention of Alexander's serum in connection with influenzal meningitis.

There are other omissions in regard to modern therapy throughout the book. There is bare mention of the new antihistaminic drugs in regard to allergy. The colored plates illustrating oral and pharyngeal processes are very good. In view of the recent acceptance of

fluoride prophylaxis of dental decay, it bears inclusion in any pediatric text. The sections on the circulatory system, genito-urinary organs, and nervous system are crammed with abbreviated facts about the disorders in each category. The chapters dealing with behavior problems and other psychologic disorders might as well have been omitted. There is little more to be said for the section on skin diseases.

Although an appendix listing drugs and doses for children is to be found in this book, a formulary listing a few simple prescriptions for the medical tyro would be a most useful addition.

In view of the rapid progress of pediatric therapeutics, a further revision of this book must soon be undertaken.

CONDITIONED REFLEXES AND NEURON ORGANIZATION. By JERZY KONORSKI, head of the Department of Neurophysiology in the Mencki Institute of Experimental Biology and Professor of the University of Lodz. Translated from the Polish manuscript under the author's supervision by Stephen Garry. 267 pages. Cambridge, at the University Press; New York, The Macmillan Company, 1948. Price, \$4.00.

The task which the author has set for himself in writing this book is "to extend the Sherrington conception of the function of the nervous system to the field of higher nervous activity." He finds that the Pavlovian theory fails to stand up because of not taking into account the fact that the "cerebral cortex possesses a neuron structure."

He first devotes several chapters to Pavlov's theory of the activity of the cerebral cortex and then proceeds to criticize the theory in its essentials, or, as he puts it, "those of Pavlov's conceptions which he continued to affirm to the end, and which constitute the core of the theory." He points to such essentials as the concept of inhibition which is accepted by contemporary physiology as "a synoptic process," but not so in the Pavlov theory. He goes on to show a number of other disparities which cannot be taken up in a brief review. He also mentions several other followers of Pavlov and even Pavlov himself, who "struggled tragically to eliminate them." He thinks, however, that the experimental facts of Pavlov can be systematized and explained on the basis of the conceptions and data of neurophysiology, and that the system which can thus be developed, being a logical complement of the system of physiology of lower nervous activity, will make it possible to "lead the science of conditioned reflexes out of the dead end in which it is at present."

He then proceeds to reconstruct in a way the physiology of higher nervous activity and harmonizes it with the general physiology of the nervous system, i.e., the neuron theory. The steps by which he accomplishes this are highly technical and have no place in a review of this kind. We shall only record the additional fact that the author concedes that the phenomena "least accessible to the physiologic approach in the present state of our knowledge are those, of course, associated with human mental activity," but that there are some

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even in this field that can be studied, namely, "the pathophysiology of higher nervous activity," and "that in the course of further study, the method of the conditioned reflex should yield better and richer results than are gained by the present methods of investigation of spinal reflexes."

He fears that without fundamental adjustment, such as he attempted in its basic concepts and standpoints, "the physiology of higher nervous activity is found to suffer degradation in status, and Pavlov's priceless heritage will be largely wasted," but he derives comfort from the fact that "many investigators both inside and outside of Pavlov's school realize the necessity for such a readjustment."

The book is well written, but highly technical and suitable only for special students of the subject. It certainly could not be intended for the average medical practitioner, and one doubts whether even the average neuropsychiatrist would take the time to read and digest the contents of such a book, be its contribution ever so valuable to the workers in the field.

THE HEALTHY HUNZAS. A testament and textbook about a little known people. By J. I. RODALE, author of *Pay Dirt*, and editor of *Organic Gardening*. Illustrated with rare photographs and issued by Rodale Press, 1948, Emmaus, Pa. Price, \$2.75.

Tucked away in a part of northern India, not far from Tibet and much farther away from most tourist

routes, the Hunzukuts or Hunzas, a tribe of some 22,000, live in a state resembling Shangri-La. In a lively volume of 255 pages the author discusses the reasons for the unusual superiority of these mountaineers who seem to have solved all of the problems of living. Beginning with the use of compost fertilization, which he feels is the keynote of their sound health and culture, he describes their manner of living in words that will make most of his readers wish there was an easy way to reach this inaccessible Utopia.

For all of those who are interested in growing foods without chemical fertilizers, and indeed for all who are interested in the growing of foods, this book will be a cheerful and instructive piece of reading.

TREATMENT BY MANIPULATION. In General and Consulting Practice. By A. G. TIMBRELL FISCHER, M.C., M.B., Ch.B., F.R.C.S. (Eng.), Commander of The Order of St. John of Jerusalem; Fellow of the International College of Surgeons; Member of the American Academy of Orthopedic Surgeons; Orthopedic Surgeon to the Rheumatic Unit, St. Stephen's Hospital; Trustee and Member of Executive and Scientific Advisory Committees of Empire Rheumatism Council; Late Hunterian Professor of the Royal College of Surgeons of England; Chairman of Nomenclature Committee, Royal College of Physicians' Committee on Rheumatism, etc. Being the fifth edition of *Manipulative Surgery*, with 126



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GOSHEN "INTERPINES" NEW YORK

DISORDERS OF THE NERVOUS SYSTEM. WRITE FOR BOOKLET.

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FREDERICK T. SEWARD, M.D., and CLARENCE A. POTTER, M.D., Resident Physicians



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illustrations. New York: Paul B. Hoeber, Inc., Medical Book Department of Harper and Brothers, 1948. Price, \$5.00.

In this book the author has presented to the medical profession the basic value of manipulative treatment for carefully selected cases. His introductory chapter reviews, rather sketchily, the role played by bone-setters whose origin is really lost in the mists of antiquity, plus the contributing influences of such figures as John Hunter, John Hilton, H. O. Thomas, Sir James Paget, and Wharton Hood.

Following a chapter on pathology, wherein articular and periarticular disturbances are reviewed, there is a comprehensive discussion of the prevention and diagnosis of adhesions. Supplementing this are detailed presentations of manipulative techniques for the various joints, plus many case histories illustrating the merits of these procedures. As a caution, the author points out the dangers encountered when unsuitable cases are thusly treated, and at the same time stresses the importance of proper after-treatment.

Although seemingly superfluous, a final chapter is included discussing the origin of the osteopathic cult and why it is founded on an unsound and unscientific hy-

pothesis. In addition, he charges the medical profession with the responsibility of protecting the public from the inroads of cultists.

This book is recommended to all physicians treating arthritis and allied rheumatic diseases because it contains information which, if integrated with a broad and all-inclusive program for the treatment of joint diseases, will offer a somewhat brighter outlook for many patients whose problems have been a painful enigma to the medical profession for centuries.

PEDIATRIC ANESTHESIA. By M. DIGBY LEIGH, M.D., director of Anesthesia, Vancouver General Hospital, Vancouver, Canada; Diplomate of the American Board of Anesthesiology; formerly Director of Anesthesia, Children's Memorial Hospital, Montreal, Canada; formerly Assistant Professor of Anesthesia, McGill University, Montreal, Canada; and M. KATHLEEN BELTON, M.D., Supervisor of Pediatric Anesthesia, Vancouver General Hospital, Vancouver, Canada; formerly Assistant Director of Anesthesia, Children's Memorial Hospital, Montreal, Canada; formerly Demonstrator in Anesthesia, McGill University, Montreal, Canada. Foreword by



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**THE DENVER CHEMICAL
MANUFACTURING COMPANY, INC.
163 Varick St., New York 13, N. Y.**

Wesley Bourne, M.D. 232 pages and 84 illustrations. New York: The Macmillan Company, 1948. Price, \$5.50.

There has long been a definite need for a book on pediatric anesthesia. This book is well written and easy to read. Considerable space is devoted to a discussion on preoperative preparations, intravenous and inhalation anesthesia, agents and techniques.

The manual is well organized and points out important facts, such as physiologic processes in the infant with special emphasis on circulation, respiration, oxygenation, and blood replacement.

The authors not only describe all anesthetic techniques used in infants and children but they discuss many of the methods which they have employed satisfactorily over a period of years.

The reviewer unreservedly recommends this book for its clarity, completeness, and a practical addition to one's reference library.

TECHNIQUE OF TREATMENT FOR THE CEREBRAL PALSY CHILD. By PAULA F. EGEL, Cerebral Palsy Director, Children's Hospital, Buffalo, N. Y. Introduction by Winthrop M. Phelps, M.D., Medical Director, Children's Rehabilitation Institute, Baltimore, Md. Appendix by Moir P. Tanner, F.A.C.H.A., Superintendent, Children's Hospital, Buffalo, N. Y. Drawings by Dorothea Mintline. St. Louis: The C. V. Mosby Company, 1948. Price, \$3.50.

The author's explanation in the preface that "this work will perform two functions; one, that it will introduce this form of treatment and in so doing interest

some one in taking the necessary course of study" (to prepare to apply it) "and second, that it may be used as a guide to those already trained in the field" seems to fit this work very well.

The book is a detailed account of the technique of treating the cerebral palsied child as prescribed by Dr. Winthrop M. Phelps, Medical Director, Children's Rehabilitation Institute, Baltimore, Md., plus valuable additions made by the author who has had varied experiences applying it for many years.

Beginning with a brief history of cerebral palsy and cerebral palsy classification and differentiation, the author takes the reader through the entire course of treatment of the cerebral palsied child. Where words will not suffice, hand-drawn illustrations are used, and these are fortified with photographs of "technique in action." In many cases a separate chapter is devoted to apparatus and equipment. Many pieces of apparatus are shown by photographic reproduction throughout the book.

This book should be of great value to anyone, professional or lay, interested in the treatment and welfare of the cerebral palsy child.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

PEDIATRICS AND THE EMOTIONAL NEEDS OF THE CHILD. As discussed by pediatricians and psychiatrists at Hershey, Pa., March 6-8, 1947. Edited by HELEN L. WITMER. New York: The Commonwealth Fund, 1948.

MANUAL FOR MEDICAL RECORDS LIBRARIANS. By EDNA K. HUFFMAN, R.R.L., Medical Records Consultant and Director, Program in Medical Records Library Science, Northwestern University, Chicago, Ill. Chicago: Physicians' Record Company, 1948. Price, \$4.50.

A.M.A. INTERNS' MANUAL. 209 pages. Philadelphia: W. B. Saunders Company, 1948. Price, \$2.25.

HANDBOOK OF ORTHOPEDIC SURGERY. By ALFRED RIVES SHANDS, JR., B.A., M.D., Medical Director of the Alfred I. duPont Institute of the Nemours Foundation, Wilmington, Del.; Visiting Professor of Orthopedic Surgery, University of Pennsylvania School of Medicine, Philadelphia. In collaboration with Richard Beverly Raney, B.A., M.D., Associate in Orthopedic Surgery, Duke University School of Medicine, Durham, N. C.; Lecturer in Orthopedic Surgery, University of North Carolina School of Medicine, Chapel Hill, N. C. Illustrated by Jack Bonacker Wilson. Third edition. St. Louis: The C. V. Mosby Company, 1948. Price, \$6.00.

MICROBIOLOGY AND PATHOLOGY. By CHARLES F. CARTER, B.S., M.D., Instructor in Pathology and Applied Microbiology, Parkland Hospital School of Nursing, Dallas, Tex.; Director, Carter's Clinical Laboratory, Dallas, Tex.; Consulting Pathologist, St. Louis Southwestern Railway Hospital, Texarkana, Ark.; Consulting Pathologist, Mother Frances Hospital, Tyler, Tex. With 216 text illustrations and 25 color plates. Fourth edition. St. Louis: The C. V. Mosby Company, 1948. Price, \$5.00.

A-B-C's OF SULFONAMIDE AND ANTIBIOTIC THERAPY. By PERRIN H. LONG, M.D., F.R.C.P., Professor of Preventive Medicine, The Johns Hopkins University School of Medicine; Physician, The Johns Hopkins Hospital. 231 pages. Philadelphia: W. B. Saunders Company, 1948. Price, \$3.50.

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ABDOMINAL OPERATIONS. By RODNEY MAINGOT, F.R.C.S. Eng., Surgeon to the Royal Free Hospital, London, and to the Southend General Hospital. Second edition. New York: Appleton-Century-Crofts, Inc., 1948. Price, \$16.00.

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OCCUPATIONAL THERAPY SOURCE BOOK. Edited by SIDNEY LIGHT, M.D. With an introduction by C. Charles Burlingame, M.D., Psychiatrist-in-Chief, The Institute of Living, Baltimore: The Williams & Wilkins Company, 1948. Price, \$1.00.

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Waltman Walters



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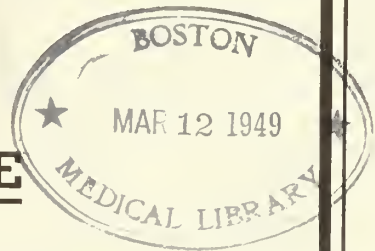
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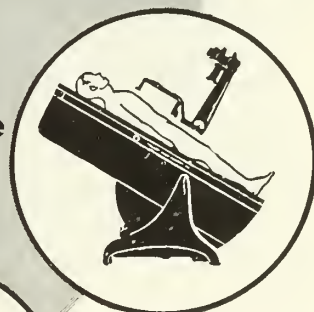


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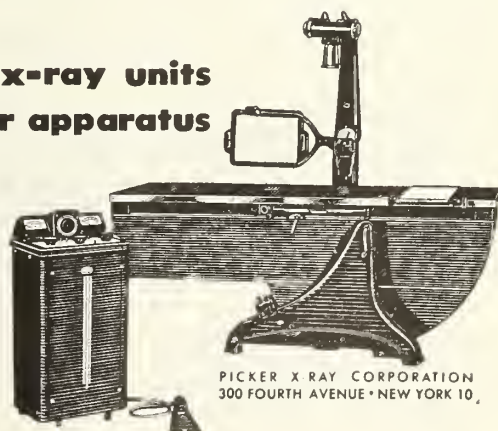
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LETTERS

Correction

GENTLEMEN:

Recently I had occasion to go over one of the reprints of the article "Management of Allergic Diseases of the Respiratory Tract in Children" (*Pennsylvania M. J.*, 51:739-746, April, 1948).

I note that there is an error in Table IV regarding the concentration of epinephrine. As is common knowledge, this should be 1-1000 instead of 1-100. I have checked the final copy which was sent to us and find that the concentration is correctly given, so I suspect that the mistake was present in the galley proof which we failed to pick up.

This is a rather small correction and the concentration is correctly given in the text. Perhaps it might be best to put a correction in a subsequent issue.

GEORGE B. LOGAN, M.D.,
Mayo Clinic,
Rochester, Minn.

Medical Officer Wanted

GENTLEMEN:

The Olmsted Air Force Base at Middletown, Pa., has an opening under civil service for a Medical Officer, P-4, \$5,232 per annum, at the Base Hospital.

Efforts to fill this position have so far been unsuccessful. The following description of duties may be of help in finding qualified personnel who might be interested in applying for this position:

Gives pre-employment or placement examinations to all civilian employees to determine physical fitness for employment. On the basis of examination determines type of work for which qualified, such as arduous, moderate, or light; if additional clinical or laboratory procedures need to be accomplished and whether special periodic rechecks are necessary.

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Makes ward rounds with other members of the professional staff and the Base Surgeon and determines which cases need more specialized care and makes administrative arrangements for their transfer and admission to general hospitals. Supervises the ward nurses on duty in the hospital and outlines in detail the various plans for treatment in the care of sick and wounded who are patients in the hospital. Supervises and maintains and regularly checks narcotics and narcotic register in the ward and is responsible for the accurate administration of these and all other types of medication.

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given to part-time employment at the applicable proportionate salary. Your interest in this matter is very much appreciated by this headquarters, and if you desire any further information concerning the position, it is suggested that you call Col. Frederick C. Kelly, Post Surgeon, this headquarters, phone—Middletown 200—Extension 4211.

JOHN G. GRAY,
Chief, Employee Utilization Branch,
Civilian Personnel Section,
Middletown Air Material Area,
Olmsted Air Force Base,
Middletown, Pa.

Anyone interested in this position is requested to communicate directly with Mr. Gray.

'48 FORGES ALONG

Medicine in '48 shuffled along still reaping the benefits of the war years, but not at its former accelerated pace. Three new antibiotics were added to the growing list. *Aurcomycin*, so called because of its golden color, derived from a newly identified species of mold, is effective in psittacosis, spotted fever, scrub typhus, and the "Q-fever" group. *Chloromycetin*, which comes from a mold like penicillin, is unlike its cousin by being potent against both typhoid fever and scrub typhus. *Aerosporin*, derived from bacteria found in the air, soil, and Chicago tap water, proved effective in treating whooping cough.

The greatest advance against cholera was the development in Bombay, India, of "6257," a new sulfonamide. It was successful in 96 per cent of bacteriologically established cases of Asiatic cholera in 27 Indian villages—an extremely simple treatment for the population-teeming but relatively medically barren regions of India. Another cholera cure effective in the Egyptian epidemic of late 1947 and early 1948 was one of the sulfacetimides, helpful also against bacillary dysentery, colitis, ulcerative colitis, and other intestinal diseases.

Against malaria, British investigators have discovered that the human liver is an incubator for malarial parasites, thus for the first time finding the elusive hiding place of that all-important parasite. From California has come the first reproduction of a virus apart from live cells—Dr. A. P. Krueger's successful cultivation of bacteriophage away from living matter.

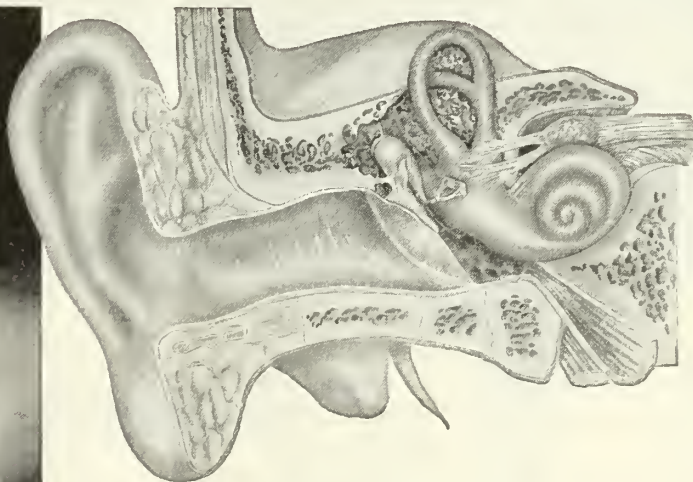
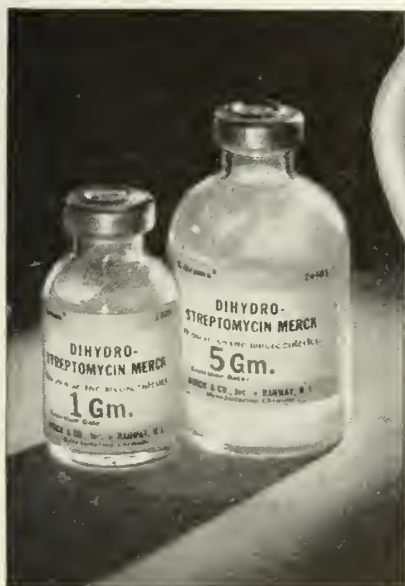
Pernicious anemia has been further attacked. From a microbe chemists have derived APF (animal protein factor) which builds red blood cells in pernicious anemia victims. Independently, other workers isolated vitamin B-12 from the same mold that produces streptomycin. It is probable that APF and B-12 are the same substance.

Although the medical headlines are not quite as large as during and immediately after the war, medicine still forges ahead with nothing much to bother it but failing research incomes at universities, political pressure to change the economic structure of medical practice, and the hurly-burly of just living in '49.—NORMAN R. GOLD-SMITH, M.D., Lancaster, Pa., in *Pittsburgh Medical Bulletin*.

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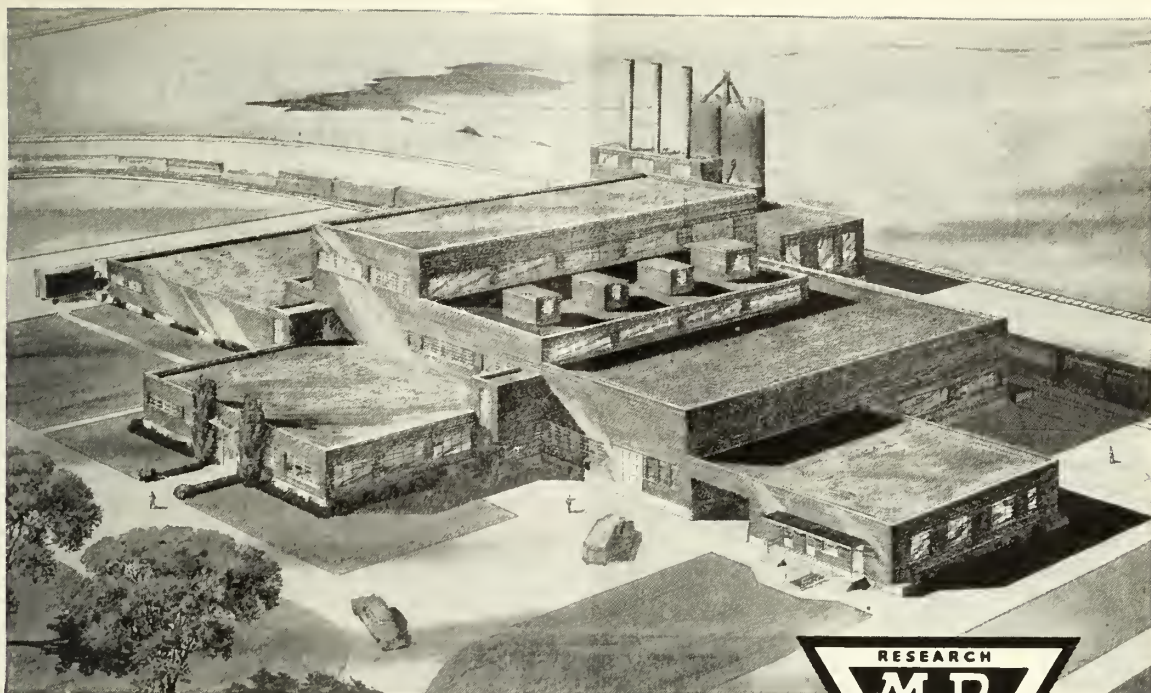
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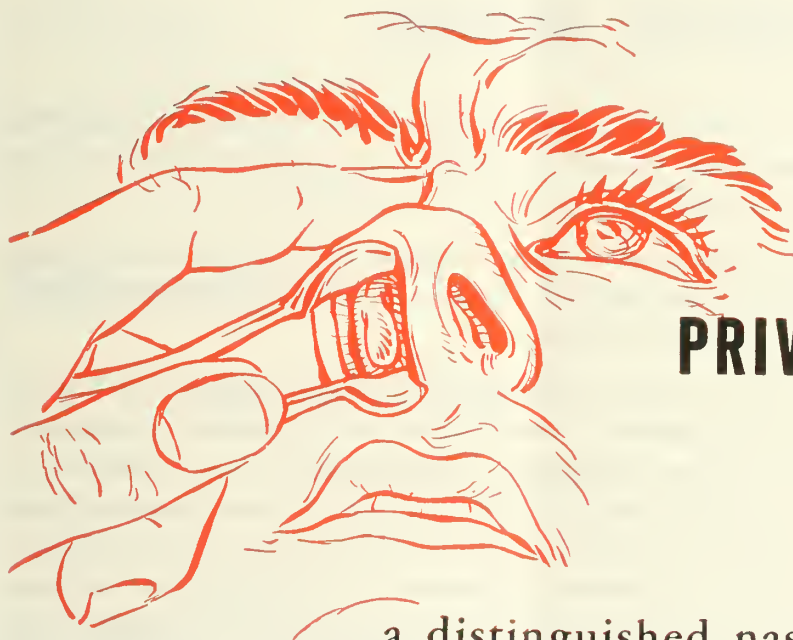
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¹Nutrition in Diabetes, Nutrition Rev. 6:257 (Sept.) 1948.

²Diabetes and Arteriosclerosis in Youth, Editorial, J.A.M.A. 135:1074 (Dec. 20) 1947.

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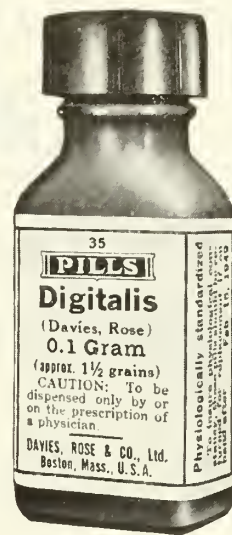
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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154;
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Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ.
Med., Vol. 35, 6-1-25, No. 11, 590-592.

THE PENNSYLVANIA MEDICAL JOURNAL

VOLUME 52

JANUARY, 1949

NUMBER 4

Differential Diagnosis of Acute Surgical Conditions of the Abdomen

WALTMAN WALTERS, M.D.,
Rochester, Minn.



IN PRESENTING the material on acute surgical conditions of the abdomen, I shall try to emphasize the recent developments in the recognition of the conditions and in management of the clinical problems, and I shall report certain clinical experiences related to the topic or growing out of it. For this reason I shall take up the material in an unusual order and begin with a recent experience which has bearing on the subject. This will lead me into discussion of the value of the scout film to diagnosis and then into other principles in the diagnosis. After that I shall take up the acute conditions which I have not already covered adequately.

Roentgenograms

Barium Contraindicated.—I recently performed partial gastrectomy for recurring chronic perforating duodenal ulcer. The preoperative roentgenogram of the abdomen showed barium outside the stomach. This was not unexpected since the patient in giving his history said that barium was given to him by mouth at the time of the first acute perforation of the ulcer. At that

time roentgenoscopic examination disclosed that the barium was leaving the stomach and going into the abdominal cavity. Immediate operation had been carried out and the perforation closed. Although the barium in the peritoneal cavity apparently did not interfere with the initial operative procedure or the patient's recovery from it, nor did it cause gastro-intestinal disturbances, it was still present when I operated on him and removed the ulcer and a portion of the stomach.

This case, of course, immediately emphasizes the point that a patient who is suspected of having an acute abdominal condition should not be given barium by mouth or rectum. In cases in which perforation has occurred, and especially in cases of perforated duodenal ulcer, the preliminary roentgenogram of the abdomen or scout film usually reveals the presence of air under the diaphragm.

Scout Film.—In the early part of the war, while on duty at a naval hospital in the western part of the country, I was called one evening by one of the surgeons and was told that one of his patients had given a typical history of perforating ulcer, that the roentgenographic scout film of the abdomen showed evidence of air under the diaphragm, and that he recommended immediate operation. Being at some distance from the hospital, I suggested that he go ahead, which he did. No ulcer was encountered at operation. On reviewing the scout films with the surgeon subsequently, we found that the gas bubble so fre-

Read before the Section on General Practice of Medicine at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 6, 1948.

From the Division of Surgery, Mayo Clinic, Rochester, Minn.
Dr. John V. Triolo, my first assistant, was helpful in assembling the cases which form the basis of this report and also in the preparation of the slides presented at the meeting.

quently present in the fundic end of an empty stomach had misled the surgeon into thinking that there was free air under the diaphragm. The differential diagnosis between the two conditions largely rests on the fact that air usually is found under the right half of the diaphragm from a perforated duodenal ulcer and that it produces a very thin elongated shadow, whereas the shadow made by air or gas in the fundic end of the stomach is much shorter and much thicker.

Not only is the scout film important in assisting in the diagnosis of a perforating lesion but it is of great value in the differential diagnosis of obstruction of the small intestine from that of the large intestine. The two different patterns associated with these two different lesions are well known to all. When the obstruction is in the small intestine, the coils frequently take on a so-called ladder-like appearance and occasionally the fluid level can be distinguished. The larger size of the colon and its position at the periphery of the abdomen usually distinguish the large intestinal obstruction from the small.

Clinical Signs and Symptoms

In spite of the aid given by laboratory procedures, in my own opinion, the history of the onset of the patient's illness, his age, the history of previous attacks, and the duration of the present symptoms, particularly in their relation to the patient's condition and the physical findings, on the abdomen particularly, are of most importance in the making of a diagnosis of an acute intra-abdominal lesion or excluding one when the patient has an inflammatory lesion of the lung, diaphragm, or kidney. It must be remembered too that symptoms of appendicitis and occasionally of intestinal obstruction may be produced by a ureteral calculus.

Some months ago I saw, in consultation with one of my younger colleagues, a patient who had acute abdominal symptoms of ten to twelve hours' duration. About ten years previously a tentative diagnosis of chronic perforation of a duodenal ulcer had been made. At that time I had advised operation for this patient, but he had elected to follow a medical regimen which he did religiously with surprisingly good results. These results had continued until the onset of his present illness. There had been no dietary indiscretions, no increase in his mental stimulation, and no reason from the recent history to suspect that a perforating ulcer might have developed.

On examination I noted that his facial expression was not that of a patient with peritonitis. His pulse was slightly elevated but of good volume, and palpation of his abdomen, although it

revealed some rigidity of the muscles in the upper part, did not disclose any rigidity in the lower part. The abdomen was more tender to superficial palpation than to deep palpation. The leukocyte count was only slightly elevated and I could hear some sounds of intestinal activity. As ten to twelve hours had elapsed since the onset of his illness and since his condition apparently was not becoming worse, I suggested that continuous gastric suction be instituted, that the patient be observed, and that I see him again in two or three hours. A scout film already taken of his abdomen showed no evidence of air under the diaphragm. Under these conditions I recommended that we wait for a few hours to see what would develop. No physical signs of inflammation were heard in his lungs and the roentgenogram of the thorax did not reveal any pulmonary lesions. To make a long story short, the patient's condition improved during the next few hours and continued to improve after that. In about forty-eight hours roentgenographic examination of the lungs showed a small area of pneumonia in the base of the left lung. This is, I think, a classical example of how pneumonia, and more recently the virus pneumonias, may produce symptoms suggesting a perforated abdominal viscus, particularly if the patient is known to have had a peptic ulcer.

The condition of this patient ten to twelve hours after the onset of symptoms did not correspond to that usually seen in patients who have a perforated viscus after such an interval. Since the patient was improving from hour to hour, postponement of an emergency operation on the abdomen seemed advisable.

Surgical Procedures

I think that the safest procedure in the presence of contamination of the peritoneal cavity is the one which requires the least amount of manipulation and is least disturbing to the patient. Such a surgical procedure is always best in emergency conditions. This does not always mean that it will require the least time. In making this statement I am speaking of inflammatory lesions and not malignant ones, because in the presence of the latter it may be advisable to remove the lesion which has perforated, for there is usually no other way to close the perforation. Whenever there is a question as to whether the patient can stand removal of a malignant lesion of the bowel, the exteriorization of the lesion of the loop of bowel can be done with a minimal risk and extra-peritoneal resection can be performed at a later time.

That partial gastrectomy has a place in the

treatment of an acute perforated ulcer, there is no doubt. The experience of the surgeon, the condition of the patient, the size of the perforation, and the time which has elapsed from the onset of the perforation all are points to be considered. Whenever there is doubt about the procedure, the safest method is to close the perforation and reserve the resection until a later time.

What is the incidence of recurrence of ulceration when a gastric or duodenal ulcer has perforated and a simple suture closure is made? It is at least 50 per cent, in my experience, and is probably higher. The incidence of recurrence of ulcerations depends on the age of the patient and the duration of symptoms prior to the perforation. In the young individual with a short history and acute perforation there is less likelihood of recurring ulceration than in the older, middle-aged adult who has had a long history of peptic ulceration and in whom the perforation was but an incident in the course of the disease. In such patients symptoms of recurrent ulceration usually develop in a variable time after the perforation and, when they do, surgical treatment is always indicated.

Acute Cholecystitis with Manifestations of Perforation

The patient with cholecystitis and perforation of the gallbladder usually is extremely sick, has severe pain, and gives a typical history of biliary colic as far as location and extension of pain and suddenness of onset are concerned. Most of these patients have had previous attacks of pain for many years. Delayed operation in such cases is treated kindly by nature by surrounding the gallbladder with the lower third of the stomach, the duodenum, hepatic flexure of the colon and usually the omentum, and encapsulating the inflammatory tumor so that if perforation occurs, a localized abscess usually results, or if the obstruction lasts long enough, perforation of the gallbladder into the duodenum or colon may occur with a persisting fistulous communication. Extreme tenderness in the upper part of the abdomen, particularly on the right side, sometimes secondary paralytic ileus and distention complicate both acute cholecystitis and the acute perforation of the gallbladder.

A few hours of observation frequently will assist the surgeon in deciding whether immediate operation is necessary. When the temperature and pulse rate are high, the leukocyte count is increased and continues to increase, and when the patient's general condition is becoming worse, an emergency exploration of the biliary tract should be carried out. In such cases, drainage of

the pericholecystic region, incision into the gallbladder in order to allow the accumulated secretion or pus to escape, the introduction of a finger into the gallbladder to remove, if possible, the obstructing stone or stones, which practically always can be done, and insertion of a drainage tube from the gallbladder to the outside usually suffice to insure recovery of the patient. If drainage from the gallbladder continues for any period of time, the inference is that a stone in the cystic duct has been overlooked. Injection of the gallbladder sinus with a radiopaque substance will show obstruction of the cystic duct and will confirm the clinical diagnosis. Secondary cholecystectomy usually is required in such cases.

I recently operated on a patient who had allowed the cholecystic fistula to exist for ten years. When I asked her why she had not had the gallbladder removed in order to get rid of it, she said that she thought the secondary operation on the gallbladder was much more serious than the initial one. With this viewpoint I cannot agree and I think it is worth while to explain to patients, for whom drainage of the gallbladder instead of removal is necessary, that the drainage may be life-saving and that secondary removal of the gallbladder can be done at a later time when the inflammation has subsided with much less risk than as an initial procedure, and with less chance of injury of adjacent structures, particularly the common bile duct.

Acute Appendicitis

Acute appendicitis is frequently encountered and all have much experience with it. I shall, therefore, pass over it quickly. The diagnosis is made from the history and physical findings. Urinalysis, leukocyte counts, and a roentgenogram of the thorax are of help in the differential diagnosis. Operation is indicated even when doubt exists.

Intestinal Obstruction

Since the Miller-Abbott tube was developed and its great contribution to intestinal deflation was recognized in Philadelphia, its advantages in the treatment of acute intestinal obstruction are known to you all, I am sure. Several years ago, in the symposium on intestinal obstruction at a surgical meeting I attended, Dr. Whipple, then head of the Department of Surgery at Columbia, stated that the Miller-Abbott tube was one of the greatest contributions to the treatment of intestinal obstruction of all times, for it enabled the physician by means of the tube which had been passed through the stomach and into the intestine to deflate the latter. This resulted in improve-

ment of the patient's general condition and made a difficult operation much easier by removing the fluid and gases from the intestines and allowing them to collapse.

Those of you who have operated on patients with intestinal obstruction know how important it is to have the intestines free of fluids and gas and without inflammation or congestion of the walls secondary to obstruction. In Whipple's statistics, if I remember correctly, the mortality rate in cases of acute obstruction of the small intestine decreased from about 35 per cent to 8 per cent after use of the Miller-Abbott tube was instituted. Use of the tube is indicated for a wide group of lesions. Time does not permit a thorough discussion of scarcely any of these, hence I must be concerned largely with the general principles. While one is awaiting the passage of the Miller-Abbott tube from the stomach into the intestine, the dehydration can be combated by parenteral administration of fluids. The deficiency of vitamins, proteins, and chlorides can be compensated for by parenteral injection, and with the deflation of the intestine the operation can be postponed until the patient reaches the maximal degree of improvement. Frequently it is worth while in these cases to give the patient prophylactic injections of penicillin and streptomycin.

The obstruction of the small intestine is distinguished from obstruction of the large intestine not only by the history, the age of the patient, and variation in physical findings but also, as I previously mentioned, by the characteristic appearance of the distended loops of intestine when a scout film is made of the abdomen. However, on occasions the clinical evidence may not indicate obstruction but the scout film may, as in the following case. In this case it appeared in the scout film as though obstruction of the small intestine was present and was due to an adherent loop of intestine in the pelvis. The patient had undergone gastro-enterostomy and vagotomy for a large duodenal ulcer. At exploration an adynamic ileus probably associated with vagotomy was found and there were no adherent loops of intestine in the pelvis. This case is an excellent example of the importance of reliance on clinical judgment even when it is contrary to seemingly accurate roentgenographic evidence of a different lesion.

To emphasize this point further I have included some scout films of the abdomen of a patient on whom I recently performed ureterosigmoidal transplantation in the treatment of urinary incontinence. Five days after operation the patient looked as though he might have an in-

testinal obstruction. A scout film of the abdomen showed distention of the loops of small intestine and the roentgenologist reported intestinal obstruction. The patient, however, had a postoperative respiratory infection which developed into pneumonia. Clinically, the abdominal distention was due to ileus and not to obstruction. Here again clinical judgment made a surgical exploration of the abdomen inadvisable, and complete recovery followed continuous gastric aspiration and antibiotic therapy. In other words, although the roentgenologic examinations in cases of this sort are of great value, it must not be assumed in every instance that they give an exact pattern of a certain lesion. Errors can occur in interpretation of roentgenologic findings as well as in clinical diagnoses.

Another frequent cause of paralytic ileus which may simulate a mechanical intestinal obstruction is a lesion of the urinary tract, such as ureteral calculus. I have seen some such cases in which not only was the erroneous impression given that the patient had acute appendicitis but in other cases in which a reflex ileus was suggestive of the presence of a dynamic intestinal obstruction. Examination of the urine and of a roentgenogram of the kidney, ureter, and bladder frequently will demonstrate the presence of a lesion of the urinary tract.

Such patients frequently have had other attacks suggestive of lesions of the urinary tract.

Another point deserves emphasis in this discussion of obstructing lesions of the intestine. This is well illustrated by a woman on whom I recently operated. On entering the hospital she gave a history suggesting an obstructive lesion of the duodenum. She was badly dehydrated and anemic, and had a protein deficiency and an impending renal insufficiency. Although the chemical constituents of the blood responded to the appropriate intravenous injections, she was losing so much gastric and intestinal fluid through the indwelling gastric suction tube that it was almost impossible to maintain a positive fluid balance. This was done, however, and then a mild degree of jaundice occurred. In spite of the fact that her general condition was serious and the risk of an operation almost prohibitive, seemingly, we felt that she was entitled to an abdominal exploratory operation. We were fearful that we would find an inoperable obstructing lesion either at the lower end of the stomach or pancreas. The obstruction proved to be in the jejunum and was due to a small circular carcinoma which was causing intussusception. The intussusception was reduced, the tumor removed, and an end-to-end anastomosis made of the intestine.

An uneventful recovery ensued. I am sure that if surgical treatment had been postponed in this case more than a few days longer the patient would have succumbed to the toxemia associated with obstruction, in spite of the fact that by means of heroic procedures a positive fluid balance was maintained.

Obstruction of the large bowel practically never produces the degree of toxemia associated with obstruction of the small intestine. In such cases it is imperative that the obstruction be relieved by colonic stoma proximal to the lesion, when it is shown that the obstruction cannot be relieved by repeated enemas. Whether transverse colostomy or cecostomy under local anesthesia is performed usually depends on the surgeon's experience and results. Although use of a Miller-Abbott tube or an indwelling gastric nasal suction tube produces some decrease in the accumulation of swallowed air in the intestines, it does little to relieve the effects of the obstruction in the cecum if the ileocecal valve is competent. I have seen some cases in which delayed relief of obstruction of the colon due to neoplasm of the sigmoid or rectum has resulted in perforation of the cecum, secondary to formation of an avascular ulcer. These ulcers always are located beneath the longitudinal bands where, as a result of overdistention of the cecum, loss of circulation is pronounced and ulceration and perforation then occur.

Comment and Summary

The age and condition of the patient, the duration of abdominal symptoms, and the progress since the onset of symptoms are of the greatest importance in making a differential diagnosis of the particular type of acute abdominal condition that exists. With the many aids to the surgeon which have been developed during recent years, namely, the sulfonamides, the antibiotics in the control of both intra-abdominal and intrathoracic infection, with the improvements in anesthesia, with the control of anemia and shock by blood transfusions, it is now advisable to carry out an exploratory operation whenever the nature of the intra-abdominal lesion is in doubt.

On many occasions, even after a period of preparation for the operation had improved the patient's condition, the patients remained desperately ill and it appeared as though a surgical exploratory procedure would end fatally. In many of these cases, however, operable lesions were found which were removed and the patients recovered. The most frequent perforating lesions of the abdomen are appendicitis, peptic ulcer, and perforating cholecystitis. Strangulated hernias

are, of course, exceedingly frequent, but the diagnosis of such a lesion is usually not difficult because of the presentation of a tumor in the hernia opening. In most instances a few hours' delay in an emergency operation serves a most useful purpose. It allows time to compensate for the loss of fluids and electrolytes by parenteral administration, the administration of blood and plasma, and the determination of whether or not the patient's condition is becoming worse. In cases of obstruction it also allows the introduction of a tube into the stomach or, better still, a tube of the Miller-Abbott type into the intestine to effect decompression.

Cecostomy or transverse colostomy is preferable to tube drainage of the intestine when the obstructing lesion is in the large bowel and medical measures such as repeated enemas do not relieve the obstruction. Roentgenologic examinations of the abdomen without the administration of barium are of the greatest value in determining the presence of air under the diaphragm and the presence of distended loops of small and large intestine when ileus either of the adynamic or dynamic type is present. Such examinations should be a routine procedure in every case in which an acute intra-abdominal lesion is suspected. Roentgenologic examination of the respiratory and urinary tracts must not be overlooked in order to exclude pneumonia or renal or ureteral stones.

ABSTRACT OF DISCUSSION

WILLIAM L. ESTES, JR. (Bethlehem): Dr. Walters has presented a fascinating and interesting discussion of an important problem. The essential diagnostic details of the acute abdomen have been described so well—and the hour is late—that there would seem to be but little further that need be added.

However, it might be well to re-emphasize the importance of a thorough and complete physical examination of the suspected patient and in cases where the indications for operation are not clear—*repeated* examinations. Don't delay "until morning" reobservation of a doubtful abdomen; check again within fifteen or twenty minutes. There may be rapid changes in the physical signs to make clear the evidence of a ruptured viscus, of a beginning peritonitis, and the need for immediate operation, that the primary observation failed to show. In most instances, as Dr. Walters has pointed out, by careful physical examination the decision can be made as to whether operation is indicated or not, and that is a matter of paramount importance in these acute emergencies. X-ray observations may be helpful adjuncts in the diagnosis of some of these cases, but our greatest reliance must be upon a careful history and upon the evidence and accurate interpretation of the physical signs that the patient presents.

QUESTION: How do you account for the jaundice in the napkin ring carcinoma case?

DR. WALTERS (in closing): That is a very good

question. We couldn't account for the jaundice. It was an indirect reaction, which would indicate that it was in the liver.

I operated some weeks ago on a girl who had an intrahepatic jaundice. I thought she had an extrahepatic obstruction. With a normal gallbladder and normal common duct, I realized that we hadn't gained anything by operation, although her symptoms were those of extrahepatic biliary tract disease, so I took her gallbladder out and put a tube in the common duct. Nine days later the jaundice increased. A cholangiogram through the T tube indicated that the duct was normal; no stones had been overlooked. You are supposed to have a direct reaction only when you have an extrahepatic obstruction.

Nowadays people are getting so many things that we

are not absolutely sure what the pharmacologic activity is, and when you couple that with prolonged obstruction and its manifestations, even when controlled seemingly by chemical tests and by parenteral injections, there are, I am sure, many things we don't understand about the condition of such patients. They are a much worse risk than you would think, even though an equilibrium has been brought about by parenteral injection, if they have had an obstruction for a long time and haven't had any food through the alimentary tract absorbed in the normal way. I am sure that is the experience of most surgeons.

What that jaundice was due to, I don't know. Whether it was due to the large doses of penicillin or the streptomycin, I haven't the slightest idea, and I don't know any way that we could have found out.

MENTAL HEALTH INSTITUTIONS ARE NOT SNAKE PITs

Some time during the next few weeks a highly tense, dramatic motion picture of the institutional treatment and care of mentally ill patients will be viewed by thousands. It is called "The Snake Pit," the same title under which the book appeared and caused such a furor. Letters are being printed by the editors of *Life* magazine at this time concerning the "movie."

This picture is an indictment of society's attitude toward mental illness. By paying the least money, using outmoded buildings, hiring poorly paid personnel, and keeping all budgets to a disgraceful minimum, the mentally ill are our "forgotten people."

Many of our mental hospitals are outdated, and due to the "pinch-penny" attitude of governing bodies, mental institutions as a whole have not kept pace with our general hospitals. Even where monies have been lavishly expended at some particular time, the public has forgotten about the increase in the number of mentally ill and feels that buildings of twenty years ago should still be adequate.

"Out of sight, out of mind" has been the attitude for too long concerning this type of patient. The public will now be aroused and indignant, forgetting that the situations as pictured actually exist due to the public's apathy in the past.

Mental illness is treatable. Cures are effected, and the return to society and competitive work is possible with modern methods. In order to obtain high-type personnel, specially trained nurses and attendants, better pay and living quarters must be provided. Funds alone are not the

answer. The public needs to have more interest in mental hospitals and in mental health. Information should be more accessible and more acceptable to the public. In this way a proper perspective would be obtained and a healthy attitude maintained toward the continual improvement of the care of the mentally ill.—JOHN N. FREDERICK, M.D., in *Pittsburgh Medical Bulletin*.

A.M.A. MEMBERSHIP AND FELLOWSHIP

"Every member in good standing in the constituent medical association of the state in which he is engaged in practice whose name is officially reported to the Secretary of the American Medical Association for enrollment becomes automatically a member of the American Medical Association and is not called on, as such, to pay any dues or to contribute financially to the Association.

"To qualify as a Fellow, a member in good standing is required to make formal application for Fellowship, to pay Fellowship dues, and to subscribe for *The Journal*. Applications must be approved by the Judicial Council. Fellowship dues and subscriptions to *The Journal* are both included in the one annual payment of \$12.00, which is the cost of *The Journal* to subscribers who are not Fellows.

"Only those members who qualify as Fellows are eligible for election as officers, may serve as members of the House of Delegates, may register at the annual sessions of the Association, or may participate in the work of its scientific sections.

"Members of constituent state medical associations pay dues to those bodies, but as members they pay nothing to the American Medical Association. Fellows pay dues and subscription to *The Journal* in the sum of \$12.00 a year, which has nothing to do with county or state dues."

HISTOPLASMOSIS IN PENNSYLVANIA

Confusion with Sarcoidosis and Experimental Therapy with Bacillomycin

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HISTOPLASMOSIS, once thought to be a fatal disease localized to certain regions, has been found to be widely distributed in this country and elsewhere in the world. Many more mild unrecognized infections than fatal ones apparently occur and many fatal cases, no doubt, have been misdiagnosed. The development of knowledge about this fungus disease closely parallels that of coccidioidomycosis which also was once thought to be a rare, fatal disease until the discovery of great numbers of previously unrecognized mild cases. The distribution of coccidioidomycosis is limited by apparent preference of the causative fungus for arid climates. Both *Coccidioides immitis* and *Histoplasma capsulatum*^{1, 2} have been found in naturally infected dogs and rodents, but unlike *C. immitis*, *H. capsulatum* has not yet been found outside the animal body.

Most of the ninety-odd cases of histoplasmosis thus far reported came from the east-central states. Epidemiologic studies with the histoplasmin skin test, despite doubt of its specificity, also show the percentage of persons who react thereto, and who probably have had the disease in mild form, to be the highest in the same region. As many as 78 per cent of persons react to the test in parts of Missouri, but only 3 per cent do in northern California and 9 to 11 per cent in Pennsylvania,³ suggesting that conditions in certain regions are more favorable than others to the growth and to the spread of the fungus. The report of four cases indigenous to Pennsylvania since 1944,⁴ the existence of at least three unreported ones, and the present two cases raise the usual question as to whether the disease is spreading; it is almost certainly not. Histoplasmosis is probably endemic in Pennsylvania, but has seldom been recognized. Its close clinical and pathologic resemblance to tuberculosis and sarcoidosis easily causes diagnostic confusion as

in the cases described here. In the past, diagnoses were missed probably because clinicians were unaware of histoplasmosis or did not recognize it and pathologists seldom examined granulomatous tissue routinely with the highest power of the microscope. Furthermore, histoplasma bodies are often so few and scattered in tissues that prolonged search is needed.

Report of 2 Cases

CASE 1.—A man, aged 38, was admitted to the hospital in March, 1947, to the service of Dr. Louis H. Clerf, because of hoarseness, pain on swallowing, continuous cough, and loss of weight for eight weeks.

Present History.—In January, 1947, he began to have non-productive cough and pain in the calves and knees. Hoarseness then came on and a painful spot in the middle of his tongue appeared which soon ulcerated. Dysphagia gradually developed.

On examination there was mucopus in the left naris, an elevated necrotic lesion 2 centimeters in diameter on the tongue, and extensive infiltration with ulceration covered with an exudate on both sides of the larynx, cords, and ventricular bands. The entire mucosa of the larynx was granular, suggestive of tuberculosis. Biopsy revealed chronic non-specific granulation tissue. No tubercle bacilli were seen in or cultivated from the tissue.

There were systolic and diastolic murmurs over the aortic area. A roentgenogram showed an enlarged heart and a probable aneurysm of the ascending aorta. The liver and the submaxillary lymph nodes were enlarged. There was no fever and the pulse rate averaged 80. The erythrocytes numbered 3,900,000, the leukocytes 6800, with a normal proportion of cells. The Wassermann and Kahn tests repeatedly gave negative results. A diagnosis of aortic aneurysm and probable tuberculosis of the larynx was made.

The patient was re-examined in June, but little change had occurred. Shortly after, he had a tarry stool and vomited a large amount of blood, suggesting erosion of the aneurysm into the esophagus. He was then transferred to the medical service.

He was in shock-like state from the hemorrhage, aphonic, and had a stridulous cough. The granulating lesion on the tongue was unchanged. A lymph node in the right axilla was enlarged, but on removal and histologic examination showed only fibrosis. The spleen was palpable. Vomiting of blood recurred, but esophagoscopy by Dr. Clerf revealed no lesions. Scrapings of the tongue showed no fungi, but banal *Monilia* were cultivated from the bronchial and esophageal secretions.

Read before the Section on Medicine at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 6, 1948.

From the Jefferson Medical College and Hospital, Philadelphia, Pa.

By July, 1947, the liver had enlarged to 4 or 5 centimeters below the costal margin. The spleen was palpable. Biopsy of the lesion on the tongue showed hyperplastic, irregular, stratified, squamous epithelium with sudden transition to ulcerated areas covered with fibrinous exudate. A few nests of epithelial cells were scattered beneath the epithelium. The underlying stroma was composed of granulomatous tissue with dense infiltration of pleomorphic cells, many fibroblasts, large and small plasma cells, lymphocytes, polymorphonuclear cells, and large epithelioid cells. There were a few foci of irregular multinucleated giant cells. The granulomatous changes involved the deep underlying muscle layer. The lesion was regarded as an ulcerating granuloma probably tuberculous. Repeated resectioning and re-examination of tissue several months later after *H. capsulatum* had been seen in tissues at necropsy revealed no unusual structures. Roentgenography showed an area suspected as being an ulcer in the duodenum to account for the hemorrhage. In August laryngoscopy by Dr. Clerf again revealed lesions suggestive of tuberculosis, but on repeated search no acid-fast bacilli were found. The cough became worse and intermittent; irregular fever was present. A histoplasmin skin test gave a negative result.

The red cells numbered 1,300,000 after the hemorrhage, but by repeated transfusions were increased to 3,500,000 by September. The leukocytes on various occasions numbered 7000, 4000, 8000, 2000, 3500, and 4000, with a normal proportion of component cells. Sternal puncture revealed nothing unusual. The sedimentation rate averaged 25 mm. in fifty minutes in several readings. The urine occasionally showed only traces of albumin. Tests of function of the liver on several occasions showed no abnormality; the blood proteins were never greatly altered and three routine blood cultures were sterile.

In September purified protein derivative of tuberculin in the usual dilutions gave negative results. Peritoneoscopy revealed an enlarged smooth liver, apparently normal otherwise. His condition gradually became worse and dysphagia became troublesome. The lesion on the tongue healed. In October laryngoscopy revealed a spread of the ulcerative process in the larynx. In December the lesion on the tongue recurred and dysphagia became so serious that gastrostomy was done. The patient failed steadily and died several weeks later.

The clinical course during ten months of observation was complicated by the aneurysm, cardiovalvular disease, a supposed peptic ulcer with severe hemorrhages, anemia, dysphagia, cachexia, and the presumed tuberculous laryngitis. Histoplasmosis was considered in August, but a negative histoplasmin skin test and absence of the fungus in sections or cultures from any of the three biopsy specimens led away from the diagnosis.

Necropsy Report.—There was emaciation. Ulcers were present on the palate, uvula, and pharynx. The mucosa of the pharynx, larynx, and upper part of the trachea was involved in a destructive ulcerative process. Portions of the epiglottis and vocal cords were destroyed. There were several deep ulcers in the trachea with destruction of first and second rings.

The enlarged heart showed scarring of the aortic valve with sclerosis and calcification and the ascending aorta was dilated. The lungs and spleen were not remarkable except for an old infarct in the latter. The liver was enlarged, but like the stomach and duodenum showed no changes. However, an ulcerative colitis in the form of eleven discrete ulcers averaging 5 to 8 mm.

in diameter was present in the mucosa of the cecum and ascending colon. The edges of the ulcers were raised and clean, their bases shallow, pink, and granular.

Bodies like those of *Histoplasma capsulatum* were found after prolonged search in the lesions in the pharynx, larynx, colon, and both adrenal glands (Fig. 1). They were sparse and would have been overlooked if not sought. The adrenal glands appeared uninvolved grossly. Unfortunately, since histoplasmosis was no longer considered at the time of death, no cultures were made. The laryngologic aspects of Cases 1 and 2 will be reported elsewhere in greater detail by Drs. Breckenridge and Gammell.

COMMENT: As in many other reported cases of histoplasmosis, the lesions in the throat were mistaken for those of tuberculosis. The prolonged course and systemic reaction seemed compatible with the diagnosis, yet *M. tuberculosis* was never demonstrated. Histoplasmosis was considered, but discarded for want of specific evidence. The intestinal hemorrhages were unusual for histoplasmosis, but have been recorded. Vomiting of blood may have resulted from bleeding of a transient duodenal ulcer or from the ulcers in the throat. Diagnosis was made at necropsy by the presence of bodies characteristic of *H. capsulatum*.

CASE 2.—A Negress, aged 28, was delivered of a normal infant, but had a local infection of the uterus and mastitis in May, 1941. Fever lasted five days and was treated with sulfathiazole. She was discharged May 10 in good condition. She weighed 152 pounds.

During the next year she became aware of papules and nodules on her extremities which gradually increased in number. At a visit to the outpatient department in 1943, the lesions were present over the arms and legs. They varied from light-colored macules, barely visible, to areas 2 to 3 centimeters in diameter with dark indurated centers. There was no crusting, discharge, or ulceration.

She complained of pain in the chest, productive cough, night sweats, chilly sensations, and loss of weight. Roentgenograms showed a great increase in the density of the hilar markings and diffuse nodular shadows in both lungs resembling those of sarcoidosis, but no lesions of the bones in the hands or feet.

The patient was studied in the hospital for a week in June, 1944, at which time the condition had progressed. The leukocytes numbered 4000 with no disturbance of the component cells. The serologic tests for syphilis gave negative results. Skin tests with the first and second strength of purified protein derivative of tuberculin gave negative results. Biopsy of a skin lesion showed a circumscribed lesion composed of epithelial cells and a margin of mononuclear cells. There were no giant cells and no caseation. The lesion resembled that of sarcoidosis. Because of the clinical course, the roentgenographic changes in the lung, and the nature of the lesion found at biopsy, a diagnosis of sarcoidosis was made.

During the next three years she visited the outpatient department repeatedly with similar complaints. There had been several attacks of "colds" and hoarseness. In June, 1946, the leukocytes numbered 3500 and 5000. A roentgenogram of the lungs showed little change. By

July, 1947, she weighed 99 pounds, representing a gradual loss of 52 pounds since 1941. The inguinal lymph nodes were enlarged and the spleen was palpable. There were transient pains in the joints of the extremities. The leukocytes numbered 7200; the red cells 3,700,000.

General lymph node swelling appeared in October, 1947. Roentgenography now showed punched-out lesions in several metatarsal bones and in the head of the radius characteristic of sarcoid disease. Hoarseness recurred in May, 1948. Cough, sweating, and pains in the chest came and went, but orthopnea and palpitation began to be distressing. The lesions on the arms and legs and buttocks now were only depigmented areas with thickening of the skin. The spleen was palpable.

She was again admitted to the hospital in June, 1948, because of aphonia and weakness. She weighed 95 pounds, but did not appear to be sick. The temperature was normal except for occasional low fever and the pulse rate averaged 90. The pharynx was injected. The spleen was not palpable and the pelvic organs were normal.

Mirror laryngoscopy by Dr. Gammell showed an ulcerating, fixed lesion on the left side of the larynx resembling that of tuberculosis or syphilis. A biopsy was made. In the granulomatous tissue of the vocal cord there were many fibroblasts, a few monocytes, polymorphonuclear and giant cells, but no well-formed tubercles. Intracellular bodies resembling *H. capsulatum* were seen in several monocytes. This discovery led to re-examination of the biopsy specimen of the skin removed in 1944 wherein there now were found similar histoplasma-like bodies, which then had been overlooked. The red cells numbered 3,700,000, the hemoglobin 11 grams, the leukocytes 5000 on three occasions with a normal proportion of cells; the total proteins measured 8.2 grams per cent, the albumin 3.5, and the globulin 4.7. Tests of the function of the liver gave normal results. The sedimentation rate was 25 mm. in fifty minutes. Roentgenography showed progression of lesions in the chest with greater infiltrative densities and new nodules in the lungs. No calcification was visualized. There were new lucent areas in several phalanges and destruction of the entire base and shaft of the terminal phalanx of the fifth left finger. Several of the old lesions had disappeared. A histoplasmin skin test gave faint erythema in twenty-four hours and was considered to be slightly positive. Complement-fixation tests made in June and July by Dr. S. B. Salvin, of the

National Institute of Health, gave a titer of 1:64 on both occasions. Another biopsy of the vocal cord was made for histologic examination and culture. Histoplasma bodies were found in tissue from the vocal cord, and the fungus was cultivated therefrom. Its identification as such was confirmed by Dr. N. F. Conant.

In July orthopnea became distressing. Hepatomegaly, ascites, edema of the feet, pulmonary congestion, and distention of the cervical veins were caused probably by cor pulmonale. Improvement followed therapy with digitalis and a mercurial diuretic.

The patient's general condition remained unchanged. Orthopnea, dyspnea, edema, and ascites recurred and death occurred suddenly on October 4, apparently from heart failure.

Necropsy Report.—In brief, there was acute dilation of the right chambers of the heart, generalized capillo-venous congestion, granulomatous involvement of the lungs, liver, adrenal glands, and lymph nodes of the mediastinum and abdomen, splenomegaly, effusion into the serous cavities, and bilateral fibrous adhesions of the pleura of the upper lobes. A non-specific granulomatous reaction by coalescence caused consolidation of both upper lobes and was diffusely distributed as nodules from 0.4 to 0.7 cm. in diameter elsewhere. They consisted of cellular fibrous connective tissue surrounded by a slight cellular infiltration and a few giant cells. Lesions found in both adrenal glands were similar except for central necrosis and greater cellular infiltration. The normal cortico-medullary pattern was nearly obliterated. In several places near the rim of the nodules were large nucleated cells containing numerous indistinct bodies resembling *H. capsulatum*.

The mucous membrane of the larynx was intact. The enlarged lymph nodes showed only infiltration by inflammatory cells and the spleen was hyperemic. Central congestion and necrosis were found in the liver. Diligent search failed to reveal *H. capsulatum* elsewhere except the adrenal glands. The changes did not resemble those of sarcoidosis.

Bacillomycin Therapy

Through the courtesy of Dr. J. Seifter, of Wyeth and Company, a supply of bacillomycin was obtained for experimental therapy. Bacillomycin is an antibiotic derived from *B. subtilis* which lacks antibacterial action but attacks many pathogenic fungi.⁶

The patient was given three courses of bacillomycin—from August 12 to 17, from August 20 to September 7, and from September 9 to 13—in doses of 50 mg. intramuscularly every six hours. Injections caused pain and fever in the early period as high as 104 F. Later the febrile response lessened and disappeared when therapy was stopped. Sloughs developed in two areas about September 13.

In late August or about two weeks after treatment was started the patient began to phonate and a laryngoscopic examination on September 14 showed complete healing of the ulcerated areas. At necropsy, in October, as stated, *H. capsulatum* was found only in the adrenals and

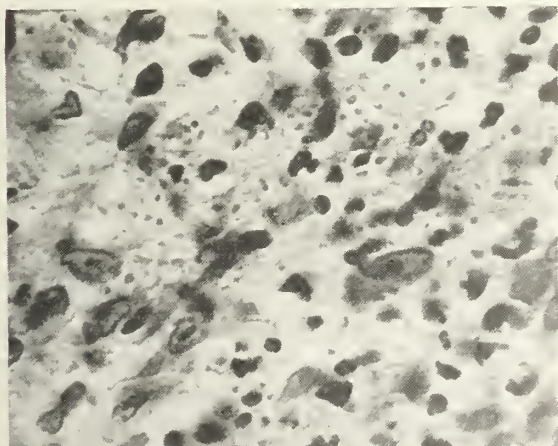


Fig. 1. Characteristic bodies of *Histoplasma capsulatum* in cells in granulomatous tissue from the larynx (x 900).

was much less distinctly seen than it was in the laryngeal tissue in June. No growth was obtained in cultures made from material from the adrenal glands. It is impossible to know whether or not bacillomycin was responsible for the healing of the larynx or the paucity and lack of viability of the fungus. It must be recalled that the lingual ulcer in Case 1 healed spontaneously and recurred after several months.

Comment

The clinical course and duration of seven years, the roentgenologic changes in the lungs and bones, lesions of the skin, the microscopic changes in the biopsy specimens, the lymphadenopathy, the normal leukocyte count, the high sedimentation rate, and hyperglobulinemia were characteristic enough of sarcoid disease to warrant that diagnosis, especially in a Negress. Yet all of these features also are characteristic of histoplasmosis. The laryngeal ulceration was especially suggestive of the latter disease, and the visualization in, and the cultivation of, *H. capsulatum* from the biopsy specimen from the vocal cord proved the diagnosis of histoplasmosis. *H. capsulatum* was known to have been present for four years. The questions arise as to whether the case was that of sarcoid disease and secondary invasion by *H. capsulatum* occurred or if histoplasmosis was the primary and sole cause of the disease resembling sarcoidosis of seven years' duration in this instance. No pulmonary calcification had occurred during four years since *H. capsulatum* was known to be present. Death probably was caused by heart failure induced by the extensive pulmonary lesions and adrenal insufficiency,^{4d} both induced by long-standing histoplasmosis. At necropsy *H. capsulatum* was seen only in the adrenals.

Discussion

In most of the cases reported thus far, *H. capsulatum* appeared to be the primary cause of the disease described. Yet in at least 15 cases, histoplasmosis was, or appeared to be, a secondary infection in patients with diabetes, aortitis, pyelonephritis, tuberculosis, carcinoma, leukemia, anemia, Hodgkin's disease, prostatic hypertrophy, and Cushing's syndrome. In our own cases, aneurysm and sarcoidosis appeared to be the primary diseases. In such instances, histoplasmosis may represent the invasion of the fungus into tissues whose resistance is impaired by other chronic disease. Under these circumstances, diagnosis is even more obscure and difficult to make than in uncomplicated cases. Comment was made on the clinical and pathologic similar-

ity of tuberculosis, sarcoidosis, and histoplasmosis. In Case 1 diagnosis was made at necropsy by the presence of characteristic capsulated bodies without cultural proof. But the clinical course, the involvement of the larynx, and the lingual ulcer^{6, 7, 8} are often found in histoplasmosis. In Case 2 the patient may have had sarcoidosis with superinvasion of *H. capsulatum*, known to have been present at least four years. This case together with four others lasting four, eight, ten, and sixteen years as cited by Parsons and Zarafonitis⁹ indicate the existence of a chronic form of histoplasmosis.

It is probable that cases of histoplasmosis have occurred unrecognized in Pennsylvania and elsewhere for years. A search of records and a review of histologic sections obtained from patients with suspected but unproved tuberculous laryngitis or other chronic granulomatous disease would almost certainly reveal instances of histoplasmosis. The disease should be suspected in patients with a wide variety of clinical conditions lasting weeks, months, or years with ulcerative laryngitis, glossitis or colitis, enlargement of the liver, spleen and lymph nodes, lesions of the skin, abnormal shadows in the lungs, with other evidence of pulmonary disease, irregular fever, loss of weight, pains in the joints, chest, or abdomen, adrenal insufficiency, anemia, and a normal or diminished number of leukocytes.

Diagnosis can be made only by demonstrating the characteristic, minute, capsulated bodies in the leukocytes of the circulating blood or of the marrow, or in the granulomatous tissue at biopsy or necropsy, and can be proved by the cultivation and identification of the fungus obtained therefrom. The histoplasmin skin test is helpful in case finding in mass surveys, but it often gives equivocal or negative results in known cases. A complement-fixation test, recently introduced, is said to be of diagnostic value.¹⁰

Summary

Two cases of histoplasmosis of the nine known thus far in Pennsylvania are described. In one, aortic aneurysm was present, and after an illness of ten months a diagnosis of histoplasmosis was made by demonstrating the fungus in lesions at necropsy. In the other case, sarcoidosis was suspected for seven years until the discovery of *H. capsulatum* in ulcerated laryngeal tissue late in the disease led to re-examination of similar tissue removed four years ago wherein the fungus previously overlooked was also found. Bacillomycin was used as an experimental therapeutic agent. Histoplasmosis probably occurs more often in Pennsylvania and elsewhere than the

few published case reports indicate. The disease is of world-wide distribution and will probably be found wherever the brown rat and house mouse as reservoirs of the infection are found.¹¹ It can be diagnosed presumptively by various clinical and pathologic features and positively by the demonstration and identification of the causative fungus.

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ABSTRACT OF DISCUSSION

EDWIN E. ZIEGLER (Lancaster): Dr. Reimann has given an interesting description of a highly lethal and important disease. Too little is known about this disease even now. One might say that histoplasmosis is an infectious, fatal, granulomatous disease.

As far as the incidence of this disease is concerned, it varies considerably, and the distribution is quite interesting. The majority of the cases have been reported from Michigan, Missouri, and Tennessee. In a thirty-two-year period from 1906 to 1938, only 12 cases of this disease were reported in the world literature. However, in the ten-year period from 1938 to date, there have been in the neighborhood of 100 or more such cases. We believe that that is due largely to the increase in awareness on the part of physicians with regard to this disease.

The diagnosis cannot be made unless one has the disease in mind and is looking for it. That is just as true of the pathologist as the clinician. As Dr. Reimann said, these organisms can readily be missed if one does not examine a section with the oil immersion lens. This encapsulated fungus form averages about 3 microns in diameter and varies from 1 to 6 microns. A good portion of the organism is made up of a translucent capsule and the only readily visible portion is the nucleus which usually runs about 1 to 3 microns in diameter, so that

it is readily missed until the pathologist looks for it with oil immersion. It appears to be quite certain that in some cases the disease has been passed off as sarcoid or tuberculosis or some other infectious granuloma.

In the time allotted I cannot give a complete review of this disease. All I can do is give a few random observations which may prove of some interest.

Dr. Reimann has already told you about the means of making the diagnosis. It has been made in life in only about one-quarter of the cases. The rest of the cases have been diagnosed at autopsy.

We don't know how this disease is spread. That is one of the mysteries. It does not occur free in nature. It has been found in wild mice, however, and in domestic dogs. The theory is that the dogs eat the wild mice and then transmit the disease to man. It has also been found in ferrets and a few other species of wild animals. The disease appears to be spreading all over the United States. Whether the spread is an actual increase in incidence or not, we do not know. It may have been with us for a long time and we are just becoming aware of it.

There is another puzzling thing about this disease. The first three cases reported by Darling from Panama in 1906 to 1908 have not been duplicated. What has happened to this disease in Panama? Has it disappeared? Is there no one there to discover it?

Another interesting observation is that five-sixths of all the cases of histoplasmosis in the world literature have been reported from the United States. Is that because the physicians in this country are more aware of this disease, or doesn't it exist in other countries? One case was reported from Austria, but it is not too well established. Another case was reported from England, but that was imported from another place.

One more point. There have been no cases of this disease reported which have recovered. The disease ordinarily runs from a few weeks to a few months, from the time it is diagnosed until the patient dies. It is highly fatal.

With regard to the histoplasmin skin test, it has been assumed by many that this test indicates infection by histoplasmosis. I am not prepared to accept that theory until there is further data to support it. The main reason, of course, is that there have been no mild or intermediate cases which have been diagnosed and then have recovered. It is also well known that there are cross-immunity reactions between histoplasmin and other fungi.

So far as the world literature indicates, this is a fatal disease. It is suggested that the public health authorities pay some attention to it. It should, no doubt, be made a reportable disease. We always get highly excited about plague, but here is a disease just as fatal as plague, if not more so. Much more is to be learned about it, and something must be done about it.

ADDENDUM: The foregoing discussion reflected the situation with regard to histoplasmosis as we knew it up to about 1946. More recently there have been reported several mild to severe cases with apparent recovery.

If we can rely on the assumption that positive skin tests with histoplasmin indicate infection with histoplasmosis, then it is very probable, as Dr. Reimann believes, that there may be as many as 100 or more mild or subclinical cases of histoplasmosis to each fatal case. The recent surveys made by skin testing would seem to indicate that the manifestations of histoplasmosis infection are quite analogous to those of another fungus infection, i.e., coccidioidomycosis.—E. E. Z.

The Virus Diagnostic Research Laboratory

Considerations of Its Importance in Maintaining Community Health Based on Two Years' Actual Operation

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General Considerations

BACTERIOLOGIC and serologic laboratories have become an indispensable part of medicine. No hospital can function without skillfully run laboratories to provide information needed by the physician in the care of his patients. Similarly, the laboratories of a public health department are equally important in providing information for the authorities to use in the care of the community. As Smillie¹ says, "An official public health department cannot function without its own public health laboratory. The laboratory is a direct link between the health department and the public, and can make or mar the reputation of the whole organization."

The public health program, as well as the practice of medicine by the individual physician, are not complete without the diagnostic and epidemiologic services of a virus laboratory. The need for the establishment of a special unit for the diagnosis of viral and rickettsial diseases is evident from the observation of recent trends in infectious diseases. In the early days of organized public health, the major problems were bacterial in origin. It was outbreaks of streptococcal infection, the enteric fevers, and diphtheria that took up the time of the laboratory and, of course, these diseases still do occur and are still problems for the established laboratory. However, they form a much smaller percentage of the total due to the successful application of prophylactic measures. Indeed, as shown by the list of reportable diseases issued by the health department of Philadelphia for 1947 (exclusive of non-infectious diseases), about one-third of the reportable diseases are caused by viral or rickettsial agents, and these agents accounted for about one-third of the reported cases.

If the venereal diseases are excluded from the non-virus group, the cases due to viral and rickettsial agents equal, in number, cases from all other infectious agents. In other words, a public health department is being faced with a high percentage of threats to community health due to viral diseases. In this connection it should be mentioned that the list of reportable diseases only includes some of the more common viral and rickettsial diseases with which most clinicians are familiar. However, we are made increasingly aware of the presence of new viral and rickettsial diseases in this country that may at any time involve the health of any community. For example, Q fever caused by *Rickettsia burneti* was thought to be primarily a disease of Australia, then it involved our troops in the Mediterranean Theater, and now has been reported in several states in this country, including Pennsylvania.* Another new disease, Rickettsial pox caused by *Rickettsia akari*, has occurred in a sharp but geographically localized epidemic in a section of New York City.

Another point to be considered in trying to estimate the need for a virus diagnostic laboratory concerns the perennial recurrence of clinical syndromes that are epidemic in the community, but which have no scientific name because the etiologic agent is not known. Physicians recurrently become aware of the presence of clinical syndromes which plague the community in epidemic fashion. These may take the form of respiratory diseases and can be called, clinically, influenza. If this be the case, a correct diagnosis can be furnished with relative ease by a laboratory equipped for virus diagnosis. If it is diagnosed early, prophylactic measures may be possible and a tremendous loss of man-, woman-, and children-hours of work or school saved. Often, it is not influenza, so that specific prophylaxis against true influenza is economically unsound. It may not be any one of the recognized

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* To be reported in a separate publication.

diseases, and in this case the loss due to morbidity will go on, and the community be prey to such ravages until the causative organism is found. Such a problem would be part of the investigative function of a virus diagnostic laboratory.

A virus diagnostic laboratory should thus be available for a community in order for the health departments to fulfill their responsibility of diagnosing communicable diseases and applying protective measures, and for the physician to give the best possible care to his patients. Certain standards should be imposed so that a laboratory of the highest quality may result. The handling of viruses in the laboratory is rather different from the handling of bacteria; the use of animals and embryonated eggs for demonstration of the presence of a virus, or the making of antigens for serologic tests demand a specialized technical training. Therefore, a well-trained personnel is essential. The equipment is somewhat different from that of an ordinary bacteriologic laboratory, since it must include greater facilities for animal care, the incubation of embryonated eggs, preservation of viruses and sera in the frozen state, safety devices for the prevention of cross-infection of the experimental animals and for the safety of the workers.

The demands made on such a laboratory may vary to some extent according to the geographic region which it serves. However, in general diagnostic procedures, the tests fall into two categories: (1) the *in vitro* serologic tests, and (2) the tests for the isolation of the virus. These tests will be discussed in somewhat greater detail later. Many of the tests in the first group can be handled without special virus training, using the few antigens that are now commercially available. Nevertheless, the antigenic differences between strains of virus constitute a still relatively uncharted field in which exploration is continuing all the time, so that intimate familiarity with the problems connected with even these few antigens is necessary to avoid errors in the interpretation of results. The second group of tests demands the specialized training and special equipment discussed above.

From the above considerations, it is obvious that the establishment of a virus diagnostic laboratory requires considerable funds in order to fulfill its routine and research obligations. The requirement of specialized personnel and equipment prevents the widespread introduction of such laboratories. The few which could be properly staffed and equipped should be strategically situated in large centers of population, such as

the larger cities or at state capitals. They may possibly be incorporated into the already functioning health department laboratory in such communities. On the other hand, it may be more convenient to use facilities of medical schools and universities in a cooperative project. This has the advantage of providing trained personnel in the field of viral diseases, and also trained personnel in allied fields who can aid in research projects. It is in the universities, too, that the spirit of investigation, so essential for the proper functioning of a public health laboratory, has the greatest chance of flourishing.

Wherever it is situated, there should exist certain administrative patterns that, if not absolutely necessary, are highly conducive to efficient and progressive functioning.

1. The laboratory should be under the direct charge of a competent urologist.

2. He should decide the type of tests to be run as routine procedures; should decide on a course of action when unusual requests come in, as they frequently will in such a rapidly growing field; and should work closely with both the practicing physician and the health department diagnosticians and epidemiologists, so that specimens are collected, preserved, and conveyed properly to the laboratory. This last point is very important, since the collection of specimens for the diagnosis of a viral disease must be rather more meticulously performed than for most bacterial diseases.

3. There should be the closest liaison between this routine diagnostic laboratory with the nearest center of viral research so that (a) certain requests can be channeled to a laboratory group working on that particular problem, and (b) the laboratory can collaborate with such a center in its own investigative work.

4. He should also have a direct association with the health department's hospital for communicable diseases, with facilities for hospitalizing and observing patients with epidemic diseases of either known or unknown viral or rickettsial etiology.

Thus far, there are still few cities in this country which possess a laboratory devoted to the service of diagnosing viral and rickettsial infections. Naturally, the various research laboratories throughout this country, interested in viruses and rickettsiae, will accept a few specimens as a courtesy, but as far as has been ascertained, less than ten virus diagnostic laboratories are in existence, organized by federal or state health departments or by the Army.²

TABLE I
TESTS FOR DIRECT EVIDENCE OF INFECTION

<i>Disease</i>	<i>Experimental Animal</i>	<i>Optimal Route of Inoculation</i>	<i>Criterion of Infection</i>
Influenza	Chick embryo	Intra-amniotic	Agglutination of red cells
Mumps	Chick embryo	Intra-amniotic	Agglutination of red cells
LCM*	Mouse	Intracerebral	Spastic convulsions
Herpes simplex	Chick embryo	Chorio-allantoic membrane	Plaques
Herpes simplex	Rabbit	Corneal scarification	Keratoconjunctivitis
Vaccinia	Chick embryo	Chorio-allantoic membrane	Plaques
Vaccinia	Rabbit	Corneal scarification	Keratoconjunctivitis

* Lymphocytic choriomeningitis.

Isolated viruses are identified by means of neutralization and complement fixation tests with known positive sera.

Experience Gained in the Operation of a Virus Diagnostic Laboratory

The Virus Diagnostic Research Laboratory at the Children's Hospital of Philadelphia was set up according to the considerations outlined above, as a part of the research laboratories functioning at that institution. In this position it is able to apply newly developed procedures as they emerge from the investigative projects in these and other laboratories, and it can channel to them specimens of especial interest for more exhaustive study. This laboratory has been in operation for about two years. Although much time had to be spent on the development of the facilities, the preparation of test materials, the standardization of tests, and so forth, it may be of value to analyze at this time the experience gained during this initial period.

Diagnostic Procedures.—The types of tests thus far employed for direct evidence of infection (virus isolation), or indirect evidence (development of specific antibodies), are listed in Tables I and II. See also Florman.³ It is obvious that diagnostic tests for many viral diseases are still missing from the list. These include poliomyelitis, measles, and hepatitis. This, in part, is due to the fact that the etiologic agent for some of the diseases has not as yet been isolated in experimental animals, or in animals easily available to the laboratory. Others cannot as yet be handled conveniently because of the dangers involved in their cultivation, unless extensive safety measures are taken which are, at present, not available to this laboratory.

Specimens for virus isolation require special precautions in the preparation and shipment to the laboratory. Such specimens should consist of secretions, body fluids, or tissues most likely to harbor virus, i.e., the selection of specimen should be based on the type and location of the infection.

In order to insure optimal conditions for virus isolation, specimens should be taken early in the acute stage of illness, under aseptic conditions. Most specimens should be frozen immediately and shipped to the laboratory in frozen condition. Serum specimens should be taken at the time of onset, and again in two to three and sometimes in four to eight weeks after onset.

A concise but complete case history is *necessary* for the selection of the appropriate tests. Such history containing the date of onset of the patient's illness is especially important in the evaluation and interpretation of results based on antibody levels and changes in these levels.

Analysis of Requests for Diagnostic Studies.—Serologic studies accounted for about 80 per cent of the diagnostic activities. Virus isolation procedures constituted the remaining portion of the diagnostic work. This was the result of several factors: (1) the relative ease of securing serum specimens; (2) the greater value for diagnostic purposes of serum specimens than of materials for virus isolation, when taken late in the disease or in convalescence; (3) the relative ease of handling serum before submission to the laboratory—in contrast to handling material for virus isolation; and (4) the relative simplicity and economy of serologic tests. The obvious drawback to the serologic studies is that they are limited to the available antigens and should, therefore, be supplemented by techniques of virus isolation whenever feasible.

An analysis of requests for laboratory studies in individual cases can best be made by considering the purpose of these requests. Frequently the purposes are not clearly defined, and thus the classification is not too rigid: (1) Specimens were received for confirmation of clinical diagnoses, as in cases of Rocky Mountain spotted fever, herpes simplex, and mumps. (2) Many specimens were from patients with the undiffer-

entiated clinical diagnosis of "encephalitis," "respiratory infection," or "skin lesions." In these cases a differentiation between several possible etiologic agents was required. (3) Some specimens were submitted for exclusion of certain specific viral infections; thus, a number of serum specimens were submitted from patients who, during outbreaks of infantile paralysis, had symptoms suggestive of "abortive" or "atypical" poliomyelitis. These were tested for antibodies to the viruses of mumps and lymphocytic choriomeningitis, in order to exclude these agents from further consideration in the differential diagnosis. (4) Specimens for virus isolation from cases of disease of unknown etiology were accepted on a limited scale; these included diarrhea of the newborn, diffuse myelitis, and others. (5) Finally, a number of serum specimens were received on which no clinical diagnosis was given and no specific request for tests was made, save for "virus studies." Some of these were tested with antigens made from viruses believed to be most likely to cause the symptoms mentioned in the case history.

There were many difficulties in obtaining specimens at the proper time. Often no serum was available from the acute phase of the disease; in other cases, the late (second) serum was not submitted, thus making it impossible to determine a rise in antibody titer. In order to eliminate these difficulties and to insure proper handling and submitting of specimens, an educational program was carried out. This consisted of sending out instruction forms and delivery of lectures at a number of hospitals in Philadelphia and vicinity.

An analysis of the results of the diagnostic tests showed that in certain groups of infections an accurate answer may be obtained with relative frequency. It also showed that in many instances no definite diagnosis could be made, indicating the urgent need of research on the improvement and the development of further diagnostic tests. Results obtained in cases of meningo-encephalitis are summarized in Table III. Of 155 cases whose specimens were tested, a diagnosis of lymphocytic choriomeningitis and mumps meningo-encephalitis was made in 7 and 27, respectively. Such diagnoses were based on positive or suggestive serologic results. Only a few specimens were checked for the presence of virus. Two strains of lymphocytic choriomeningitis and two strains of mumps virus were isolated from the spinal fluid of 4 patients listed under "positive serologic tests." There were 121 cases whose sera gave negative results with the lymphocytic choriomeningitis, Eastern equine encephalomyelitis, or mumps antigens. Among them were 21 cases of possible poliomyelitis and 28 which were subsequently proven diseases of various etiologies, such as tuberculosis meningitis, multiple sclerosis, brain tumor, infectious mononucleosis, etc. The diagnosis of the remaining 72 cases remained obscure.

In attempts to identify the source of infection in the cases of lymphocytic choriomeningitis wherever possible, mice were trapped in the surroundings of the patients, and, in one instance, were proven to be carriers of the virus. As a result, an extensive campaign against rodents was suggested.

The mumps complement fixation tests, which

TABLE II
TESTS FOR INDIRECT EVIDENCE OF INFECTION

<i>Disease</i>	<i>Test</i>	<i>Antigen</i>
Influenza	Hemagglutination-inhibition	Influenza virus, types A and B
Influenza	Complement-fixation	Influenza virus, types A and B
Mumps	Complement-fixation	Mumps virus and soluble antigens
Meningo-encephalitis	Complement-fixation	Lymphocytic choriomeningitis, mumps, Eastern equine encephalomyelitis, Western equine encephalomyelitis, St. Louis encephalitis
Meningo-encephalitis	Neutralization	Lymphocytic choriomeningitis, herpes
Pneumonia	Cold agglutination	Type "O" cells
Pneumonia	Complement-fixation	"Lygranum-Squibb,"* Q fever rickettsiae
Herpetiform eruption	Neutralization	Herpes simplex, vaccinia
Spotted fevers	Complement-fixation	Rocky Mountain spotted fever-rickettsial pox
Typhus	Complement-fixation	Epidemic typhus rickettsiae Murine typhus rickettsiae

* Test for antibodies to viruses of the psittacosis-lymphogranuloma group.

TABLE III
RESULTS OF TESTS ON INDIVIDUAL CASES

Type of Disease	Number of Cases	No. of Positive Serologic Results		No. of Virus Isolations	Not Tested
		Possible Polio	Other Etiology		
Neurologic	194	7 LCM* 27 Mumps 21	28	2 LCM* 2 Mumps 1 Poliomyelitis	39
Upper respiratory (not part of localized outbreaks)	34	4 Influenza A			9
Pneumonia	83	21 Cold agglutinins 5 Lygranum antigen† 2 Influenza 2 Q fever			13
Rocky Mountain spotted fever	6	3 Rocky Mountain spotted fever			0

* Lymphocytic choriomeningitis.

† This antigen is prepared from an agent of the psittacosis-lymphogranuloma group.

make possible the diagnosis of mumps meningo-encephalitis in the absence of glandular involvement, deserve special mention. By the separate use of the mumps soluble or S antigen and of the virus or V antigen, as developed at the Children's Hospital of Philadelphia,⁴ a diagnosis can frequently be made in the first few days of illness, thus excluding other more serious causes of the clinical picture such as tuberculosis, brain tumor, post-measles encephalitis, and others. Cases of mumps meningo-encephalitis without involvement of the salivary glands have been noted with surprising frequency all through the year, without being linked particularly to epidemic outbreaks of mumps, and in many no known contact with a case of mumps could be ascertained.

It is needless to say that the mumps complement fixation test was of value also in other atypical forms of infection with the mumps virus, such as primary orchitis, or submaxillary or sublingual swellings. The test, in addition, has been applied to determinations of immunity to mumps either alone or in conjunction with skin tests.

Data concerning respiratory infections are also included in Table III. Diagnosis of influenza A was made in 4 cases of respiratory illness. An outbreak of respiratory disease was also shown

to be caused by the virus of influenza type A. This experience will be discussed further below.

Of 70 cases of pneumonia and pneumonitis, there was positive or suggestive evidence of primary atypical pneumonia in 21, as determined by cold agglutination tests. Sera from 2 cases showed a rise in titer to the influenza A virus. Sera from 5 patients yielded positive complement-fixation results with the Lygranum antigen.* Not all of these cases resembled, clinically, the type of infection caused by the psittacosis-lymphogranuloma viruses. The specificity of this test is still an uncertain factor, and additional research is indicated in order to make the test a tool for routine testing of sera from patients suspected of having pneumonia caused by the members of the psittacosis group.

Evidence of Q fever was obtained in two instances by means of the complement fixation test. In one, the significance of the result was obscured by the presence of antibodies reacting with Lygranum antigen; the other was quite definite, and showed a marked rise in antibodies over a period of weeks. This patient was employed in a factory processing wool. An investigation revealed that several fellow workers were ill with an influenza-like disease at the time of the patient's illness. The sera of some of these reacted, likewise, with Q fever antigens. These observations will be published separately.

Three of suspected cases of Rocky Mountain

* Lygranum C. F. (Squibb) antigen prepared from an agent of the psittacosis-lymphogranuloma group.

spotted fever gave positive results with the specific rickettsial antigen. One of the patients whose serum failed to react with this antigen was later found to have meningococcemia.

In addition to these tests and results, diagnostic tests were performed with the rickettsial pox antigen. The results have been negative thus far. Recently a diagnosis of epidemic typhus was made on one patient. This case may be one of Brill's disease, although the possibility of its being a primary infection has not yet been ruled out. Attempts were made to demonstrate or isolate an agent from diseases of unknown etiology, or in which a viral or rickettsial etiology is suspected, such as diarrhea of the newborn, Guillain-Barré syndrome, multiple sclerosis, Harada's disease, etc. As yet, no viral or rickettsial agents have been isolated from these diseases.

A number of specimens were submitted from patients suffering from diseases of the skin and mucous membranes. Attempts to isolate virus were made by personnel of the Skin Virus Laboratory, who will publish their results in greater detail elsewhere. A partial analysis follows:

Herpes simplex virus was isolated from 26 of 30 patients with acute stomatitis, from 1 out of 11 cases of recurrent stomatitis, and from 6 of 7 patients with eczema herpeticum. No virus was isolated from 5 persons with aphthous ulcers. Vaccinia virus was isolated from 2 cases of eczema vaccinatum and from two children with vesicular lesions, one of lip and one of penis, which represented unusual sites of accidental vaccination.

Analysis of Outbreaks.—A number of institutions in and near Philadelphia requested the cooperation of this laboratory in studies on the etiology of outbreaks and epidemics. In addition, specimens from epidemics in Toronto, Canada, and Stockholm, Sweden, were submitted for tests.

TABLE IV
NUMBER OF POSITIVE AND SUGGESTIVE RESULTS
(Specimens from Outbreaks)

Disease	Location of Outbreak	Virus Isolation	Positive Serologic Results	High Titers in Single Specimens
Influenza A	School L	5/19	25/25	12/33
Influenza A	School H			6/12
Influenza A	School P		7/7	3/4
Mumps	Sweden		55/63	
Poliomyelitis*	Canada		3/39†	

* Tests for mumps encephalitis.

† Mumps encephalitis.

An epidemic of influenza occurred in a school for boys in New Jersey. This epidemic of influenza type A, among a group of students vaccinated three months previously with a standard influenza vaccine, was caused by a strain or strains of virus antigenically different from those used in the vaccine.⁵ This finding fully accounted for the lack of protection by the vaccine. Influenza outbreaks in two other schools were studied.

A mumps epidemic in Sweden was studied, particularly in relation to encephalitis and other complications. In the majority of cases the serologic results confirmed the clinical diagnosis. However, in a few cases in which the clinical picture was considered as an atypical manifestation of infection with mumps virus, the serologic data failed to support this view.

During an epidemic of poliomyelitis in Toronto, a number of specimens were received in order to exclude a diagnosis of mumps meningo-encephalitis. Three of these patients in whom the possibility of mumps was considered gave definite evidence that their disease was indeed caused by mumps virus.

Table IV shows the results of studies on specimens collected during five outbreaks of viral diseases. The results have been discussed in reports published elsewhere.

Conclusion

It is concluded that the experiences gained and the results obtained during the twenty months of operation of a virus diagnostic laboratory clearly show the desirability of establishing and maintaining such a laboratory as an integral part of the total medical activity in a large community and, especially, as a reference point and listening-post in the community's public health program. From this point of view, the functions of a virus diagnostic laboratory may be considered at three distinct, yet correlated levels: (1) aid in the diagnosis of disease in individual patients; (2) aid in determining sources of infection involving single, family, or neighborhood cases; (3) aid in the diagnosis of larger outbreaks and epidemics. The last function makes it possible for laboratories scattered throughout a country or throughout the world to report on the etiology of localized outbreaks—before the appearance of extensive epidemics—so that all available methods of prophylaxis and control may be brought into action to prevent the spread of the disease and forestall a widespread epidemic.

Acknowledgment

The antigens of Eastern equine encephalitis, Western equine encephalitis, St. Louis encephalitis, and the sev-

eral species of Rickettsia were furnished through the kindness of Dr. H. R. Cox of Lederle Laboratories.

Research studies on poliomyelitis were carried out by Dr. H. Koprowski of Lederle Laboratories.

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FALSE DIAGNOSES CAN DO GREAT HARM

The most important thing in the recognition of acute rheumatic fever is evidence of active carditis. Whether recognized or not, carditis always occurs with rheumatic fever. Many patients with rheumatic fever have no involvement of the joints. Joint involvement is not essential to the diagnosis of rheumatic fever.

Persistent fever alone of 99 to 100 F, continuing for weeks or months, is rarely due to rheumatic fever. The correct diagnosis in these cases is often "inattentive solicitude." A false diagnosis of rheumatic fever is a frequent cause of great harm.

Of a thousand cases of rheumatic fever studied for a ten-year period, 470 had rheumatic heart disease and 203 were dead after ten years. Six hundred and forty-eight of the thousand cases, however, were leading normal lives, that is, if they had no symptoms, no fever, and no cardiac enlargement, their activities were not restricted.

Don't make a cardiac cripple out of a child with a murmur. Cardiac enlargement and dyspnea are the only reasons for restriction of activity.—W. B. G. in *Pittsburgh Medical Bulletin*.

Let us, above all, not be misled by the few faint-hearts, divisionists, and defeatists within our own ranks.

Never was the need more urgent for unity of purpose, for determination, and for confidence in our national leadership.

We know beyond question that when the American people understand the issues and learn the facts about compulsory sickness insurance, they will reject it. But our primary job is not so much to prove our case against socialized medicine, as to make our voluntary program work so well that all our fellow-citizens will join us in defending it.

Your state society will take every step within its power and resources to help you put our case before the people. But, essentially this is *your* fight, and we can't win it without *your* help and that of every member of the society.

Let us close ranks and join the struggle to preserve the great traditions of our profession, and to keep the road open for a constantly better service to the public.—J. HOWARD HORNBERGER, M.D., *President*, The Medical Society of New Jersey.

A NEW YEAR'S MESSAGE

We face what seems certain to be the most gravely critical year for the future of our profession within the lifetime of any of us.

For 183 years, your state society—The Medical Society of New Jersey—has grown and waxed strong in public service, in an atmosphere of professional freedom and scientific integrity.

Now—abruptly—we face the imminent danger that a proposal for federally operated medical care may become the law of the land. Every instinct of our professional lives tells us that the imposition of this plan would be a tragedy for the people we serve and for the profession we love.

Unfortunately, the proposal of our national organization, the American Medical Association, to equip itself with the necessary funds to counter this threat, has been widely misrepresented to the public—partly at least because of our own ineptitude in explaining our motives and purposes.

Let us hope that no member of our profession has been deluded by this propaganda, nor by the sly tactics of division that are being practiced upon us by those who stand to gain by dividing and discrediting us.

MSAP's SUBSCRIBERS OVER 300,000 AS ENROLLMENT GAINS 152.9 PER CENT

With the enrollment of the Medical Service Association of Pennsylvania passing the 300,000 mark in October, the amount of annual subscription fees in force neared \$3,000,000 during the same month.

The gain in MSAP's Blue Shield subscribers during the twelve-month period ended October 31 was 152.9 per cent. Total subscribers enrolled were 308,163 on the last day of October, as compared to 121,850 on the same day in 1947, an increase of 186,313.

Annual subscription fees in force on last October 31 totaled \$2,836,350.60 as compared to \$1,007,783.40 on the corresponding day one year previously. The gain of \$1,828,567.20 amounted to 181.4 per cent.

During the first ten months of 1948 the number of physicians' services paid was 17,515 as compared to 7433 for the same period in 1947, an increase of 10,082, or 135.6 per cent.

From January 1 to October 31, 1948, the cost of physicians' services incurred amounted to \$1,140,984.50, an increase of 135 per cent over the same ten months of 1947. This item totaled \$485,619 for the same period in 1947.

Improper Use of Estrogens in Gynecology

JOSEPH A. HEPP, M.D.

Pittsburgh, Pa.

OUR purpose in this presentation is to direct attention to a practice that is still prevalent, i.e., improper use of estrogens in gynecology. The presence of estrogenic bleeding as the result of endocrine therapy has been mentioned recently by Scheffey,¹ who said "the current popularity and ease of administration of glandular preparations has resulted in their indiscriminate and injudicious use in an attempt to control abnormal uterine bleeding. Rapid advances have been made in the preparation of potent endocrine products. The use of such products should be based on a sound knowledge of their respective physiologic properties."

Every gynecologist of experience has encountered patients with estrogenic bleeding. There is still widespread abuse of estrogens, especially those of the non-hormonal group represented most frequently by stilbestrol. Stoddard² has reported 8 patients who received endocrine therapy, but there was no indication for therapy in any one patient. Two of his patients showed genital malignancy. He wisely stated that the ease of administration has led to overzealousness on the part of some physicians with the result that almost any abnormality of the female generative tract may be interpreted as being due to endocrine imbalance. Briscoe³ makes a plea for pelvic examination, including a speculum examination, before hormone therapy is instituted. He mentioned 6 patients in whom organic pathology was the cause of the trouble and in whom therapy was not required. The diagnoses of some of his patients were: adenocarcinoma of the fundus, stenosis of the cervix with hydrometra, and tuberculosis of the endometrium.

Novak⁴ has called attention to postmenopausal bleeding as a hazard following stilbestrol therapy. He said that the hormonal equilibrium tends to adjust itself spontaneously after a variable time, with disappearance of the symptoms. He also said there is reason to believe that prolonged treatment may postpone the desired

re-establishment of equilibrium; in other words, the duration of the menopause may be prolonged. In addition to bleeding, Novak said, stilbestrol given over a long period of time with excessive dosage will cause a high degree of nerve tension not unlike that characterizing so-called premenstrual tension. He concludes by saying that hormone therapy should be given only when the symptoms are clearly menopausal and if they are troublesome to the patient. Furthermore, he warns against prophylactic estrogenic therapy and against any routine fixed dosage for indefinite periods.

Heckel,⁵ Finkler,⁶ Coleman,⁷ Johnson,⁸ and others have written on the improper use of estrogens, especially in the menopausal and postmenopausal patient. Their writings embody such good advice as the avoidance of estrogenic therapy, unless clearly indicated by the severity of vasomotor symptoms, and the undesirability and possible hazard of excessive or too prolonged estrogenic therapy. They all agree that the majority of menopausal women require no estrogen therapy at all, but in the comparatively small number who do, it is of definite value in tiding them over the rough spots, when used conservatively and intermittently.

Our personal experience covers a group of 52 patients whose ages are between 22 and 70 years. In reviewing these histories we found that the most frequent indication for hormone therapy was the menopause; 38 patients (73 per cent) were in the menopausal group, and 14 patients (26 per cent) were in the non-menopausal group. Here we call attention to the uterine bleeding which results from excessive and prolonged therapy with estrogenic substances primarily prescribed to combat the vasomotor disturbances of the menopause. As is well known, this type of bleeding always confuses the picture because it is difficult to determine whether the bleeding is due to estrogens or whether it is due to cancer of the corpus. Only a pelvic examination and a diagnostic curettage can answer the question definitely.

The shortest duration of time during which a patient received either "shots" or little "red hot

Read before the Section on Obstetrics and Gynecology at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 7, 1948.

From the Department of Gynecology, University of Pittsburgh.

TABLE I
MENOPAUSAL PATIENTS

<i>Age</i>	<i>Chief Presenting Symptom</i>	<i>Duration of Treatment</i>	<i>Time Since Last Period</i>	<i>Diagnosis</i>
55	Brown vaginal discharge for 2 years	3 years	5 years	Estrogenic bleeding
50	Intermittent bleeding for 2 years	2 years	4 years	Estrogenic bleeding
53	Bleeding	2 years	1½ years	Estrogenic bleeding
46	Bleeding	3 months	None	Estrogenic bleeding
46	Bleeding post-radium	4 months	2 years	Estrogenic bleeding; uterine myoma
39	Bleeding post-radium	12 years	2 years	Estrogenic bleeding; arteriosclerotic metritis
49	Bleeding post-radium	1 year	1 year	Estrogenic bleeding
53	Bleeding	35 days	7 years	Estrogenic bleeding
30	Bleeding post-surgical castration	28 months	5 years	Estrogenic bleeding
50	Bleeding	2 years	2 years	Estrogenic bleeding
46	Bleeding	1½ years	3 years	Estrogenic bleeding
47	Bleeding	4 weeks	None	Estrogenic bleeding
37	Nervous, excitable, apprehensive	8 years	9 years	Prolonged climacteric
50	Bleeding	3 years	2 years	Estrogenic bleeding
31	Bleeding post-surgical castration	4 months	4 months	Estrogenic bleeding
43	Bleeding post-surgical castration	5 years	5 years	Estrogenic bleeding
51	Bleeding	3 years	6½ years	Estrogenic bleeding
55	Bleeding 3 months	9 months	5 years	Estrogenic bleeding
53	Bleeding and enlarged breasts	2 years	4 years	Estrogenic bleeding
45	Sore breasts	Unknown	Unknown	Chronic cystic mastitis
50	Bleeding	5 months	1 year	Estrogenic bleeding
60	Bleeding	2 years	4 years	Estrogenic bleeding
57	Bleeding	3 years	3 years	Estrogenic bleeding
32	Bleeding, enlarged breasts post-surgical castration	15 months	4 years	Estrogenic bleeding; pigmentation of areolae of breasts
50	Bleeding	11 months	1½ years	Estrogenic bleeding
41	Bleeding post-radium	3 years	3 years	Estrogenic bleeding
44	Bleeding post-radium	3 months	3 months	Estrogenic bleeding
55	Bleeding	7 months	None	Estrogenic bleeding
63	Bleeding	5 weeks	Unknown	Estrogenic bleeding
33	Bleeding post-surgical castration	9 months	4 years	Estrogenic bleeding
52	Bleeding	2½ years	6 years	Estrogenic bleeding
40	Bleeding	Unknown	1 year	Estrogenic bleeding
47	Bleeding	Unknown	Unknown	Estrogenic bleeding
63	Bleeding	Unknown	11 years	Estrogenic bleeding

flash pills" was one week. The longest period of treatment was twelve years.

In no sense do we wish to discourage the possible benefits of carefully controlled endocrine therapy. In citing the following case histories, I wish to emphasize that these observations are not peculiar to our group. They have been noted by others and they are being recorded in current gynecologic literature.

Uterine Cancer

F. B., age 46, a nullipara, was seen because of menometrorrhagia. There was a history of bleeding for five months and the loss of 20 pounds in weight in the last six months. The physician was to operate, but after examining the patient he changed his mind and decided to give two hormone injections weekly for five months because of the bleeding. The first pelvic examination was done after the patient had been bleeding for five months. No biopsy was taken. Examination revealed carcinoma of the cervix, stage III (L. N.). The histologic diagnosis was squamous cell cancer of the cervix. The patient was treated with radium and deep x-ray therapy. It is now four years since treatment was given and there is no evidence of recurrence.

V. M. B., age 49, a multipara, had received endocrine injections twice a week over a period of four months because of the menopause. Two weeks before admission the physician made a pelvic examination and as a result of this she was sent to the hospital. Examination revealed cancer of the cervix, stage II (L. N.). Histologic report was squamous cell cancer of the cervix. Treatment with radium and deep x-ray was given. Failure to do a pelvic examination before instituting hormone therapy caused a delay in the diagnosis and treatment for this patient. At the end of three and one-half years there is no evidence of residual malignancy.

S. C., age 51, a nullipara, was seen because of bleeding. The menopause occurred four years ago. The patient had vaginal bleeding for the last six months; this was the first bleeding since the menopause. She had received hormone pills for hot flashes every day for four years. Examination revealed cancer of the cervix, stage III (L. N.). Histologic diagnosis was squamous cell cancer of the cervix. Six months after treatment by irradiation the patient died. Autopsy showed extensive cancer of the cervix and metastases to both kidneys. This patient had no pelvic examination before therapy was started.

J. M., age 45, a multipara, was seen because of vaginal bleeding. The menopause occurred nineteen months ago, and the patient took pills for hot flashes continuously for two years. Pelvic examination revealed a polyp extending out through the cervix. The polyp bled readily when touched with a sponge. The pathologic report was: marked hyperplasia of endometrium, adenomatous polyp of endometrium with beginning adenocarcinoma. The polyp was removed and radium treatment was given. When seen four months later, there was no evidence of recurrence.

Menopausal Group

The following case histories are interesting in this group:

M. C., age 39, multipara, was first seen in 1944 because of uterine bleeding and hot flashes. There was a

history of having received natural estrogens for about ten years. On June 24, 1944, following a diagnostic dilatation and curettage, she received 1800 mg. hours of radium. Following the radium treatment the patient again had menometrorrhagia and it was learned that she again had received estrone for two years. On June 10, 1946, a total abdominal hysterectomy and bilateral salpingo-oophorectomy was done. The pathologic diagnosis was: endometrium—atypical follicular phase, arteriosclerotic metritis; senile type fallopian tubes and cystic follicles of ovary. In all, this patient received endocrine therapy for a period of twelve years. She was the wife of a pharmacist and had access to any drugs in the store. Almost all the endocrine drugs in this case were self-administered. Needless to say, a hysterectomy was done to prevent further insults to the endometrium.

D. B., age 30, nullipara, gave a history of a bilateral oophorectomy and a retained uterus. She had been on endocrine therapy for twenty-eight months. Endocrines were taken on the advice of her friend, a nurse. This is another example of self-medication. Uterine bleeding ceased after endocrine therapy was stopped.

D. M., age 50, complained of a few hot flashes, bleeding, and felt very nervous and apprehensive. She took two stilbestrol tablets daily for two years. Her physician died six months after treatment was started, but the patient continued therapy for the next one and one-half years without the advice of a physician. She was advised to stop all hormone therapy and when seen two months later she felt much better.

S. M., age 46, multipara, complained of vaginal bleeding. The menopause had occurred three years ago. She took "hot flash pills" twice daily for one and one-half years. There had been no pelvic examination before therapy was started. Pelvic examination at this time was negative. A diagnosis of estrogenic bleeding was made and the patient was told to stop all endocrine therapy. When examined at the end of a month, the pelvic organs were normal and there was no further bleeding after therapy was discontinued.

M. C., age 47, had irregular bleeding and spotting following the administration of two hormone tablets twice daily for four months. There was no pelvic examination before therapy was started. After phenobarbital was substituted for endocrine therapy, the bleeding stopped and there has been none since that time.

L. R., age 52, had been on endocrine therapy for two and one-half years. The menopause occurred six years ago. The patient was seen because of vaginal bleeding and soreness and enlargement of the breasts. Examination of the breasts revealed dark brown pigmentation of the areolae and the nipples. This was similar to the color of the areolae often seen during pregnancy. Microscopic section of curettings showed cyst-like glands in the endometrium.

H. W., age 43, had taken "hot flash pills" for five years, during which time there was intermittent bleeding. The menopause occurred one year ago. She was advised to report if there was further bleeding. After all endocrine therapy was stopped, there was no further bleeding.

E. S., age 57, stated that the menopause occurred three years ago, during which time she took hormone injections. She complained of irregular bleeding for the last seven weeks. A diagnostic dilatation and curettage was negative for cancer. Hysterectomy was done. Histologic diagnosis was adenomyosis of the uterus.

TABLE II
RÉSUMÉ OF NON-MENOPAUSAL PATIENTS

Age	Reason for Therapy	Duration of Treatment	Diagnosis
57	Nervous breakdown Menopause 15 years ago	5 months	Estrogenic bleeding
52	"Feels tired" Menopause 5 years ago	Unknown	Estrogenic bleeding
39	Glandular disturbance, headache, malaise	Daily for 3½ years	Multiple myomata of uterus
28	Secondary amenorrhea	3 months	Pregnancy
33	Obesity Secondary amenorrhea	3 months	Pregnancy
22	Primary amenorrhea	2 months	Congenital absence of vagina
34	Glandular disturbance	3 years	Myomata of the uterus
64	Cystitis	1 week	Estrogenic bleeding
63	Cystitis Menopause 15 years ago	2 months	Estrogenic bleeding
30	Tiredness, general malaise, lack of appetite	1 month	Estrogenic bleeding
35	Functional bleeding	5 months	Myoma of the uterus
61	"Run down condition" Menopause 10 years ago	Unknown	Hypoplasia of endometrium and myomata of the uterus
37	Tiredness, "lack of estrogen in system"	3 months	Estrogenic bleeding
70	Tiredness; 22 years since last period	3 months	Estrogenic bleeding

Non-menopausal Group

L. V. V., age 39, was given endocrine therapy for three and one-half years for a "glandular disturbance." The symptoms for which patient received treatment were headache, malaise, premenstrual tension, edema of ankles, fingers and eyelids, pelvic pain, and nausea. Pelvic examination revealed multiple myomata of the uterus. Hysterectomy was performed. Histologic report of tissue was hyperplasia of endometrium and uterine myomata.

M. S., age 28. The menses had been regular until three months ago and there has been amenorrhea since that time. The patient did not have a pelvic examination, but was given stilbestrol in order to "make her

menstruate." Pelvic examination revealed a three months' pregnancy.

F. V., age 22, was seen because of primary amenorrhea. No pelvic examination had been done, but the patient received a course of endocrine therapy. Pelvic examination revealed a congenital absence of the vagina and rectal examination revealed a small rudimentary uterus.

E. K., age 34, was given endocrine therapy for three years for a "glandular condition." She was seen because of a history of bleeding and spotting for four months. Pelvic examination revealed an irregularly enlarged uterus due to myomata. Hysterectomy was done and microscopic study of the uterus revealed multiple fibromyomata.

M. D., age 66, single, developed bleeding after she was on estrogenic therapy. The indication for therapy was pruritus vulvae. Menopause occurred at age 50. Bleeding stopped after therapy was discontinued. The diagnosis was lichen planus.

A. B., age 64, took "red pills" for one week, following which she had a period of bleeding for two weeks. This was the first bleeding since the menopause twenty years ago. The indication for therapy was cystitis. A study of curettings showed the atypical follicular phase of endometrium (stilbestrol).

G. W., age 61, had a radium menopause induced ten years ago. She received estrogens by injection because she was in a "run down condition" and was nervous. Pelvic examination revealed an irregularly enlarged uterus due to myomata. Hysterectomy and bilateral oophorectomy was performed. The pathologic report was hypoplasia of endometrium and multiple fibromyomata of the uterus.

M. S., age 30, had received therapy by mouth every day for thirty days. Her chief complaints were tiredness, malaise, inability to do her daily work, and lack of appetite. Because the physician's examination did not disclose any cause for the above symptoms, he thought it best to prescribe endocrine therapy. Vaginal bleeding developed. Pelvic examination revealed no lesion in the uterus and adnexae. The diagnosis was disturbance of menstrual cycle due to endocrine therapy. The menstrual cycle became regular after endocrine therapy was stopped.

R. C., age 35, had received endocrine therapy for several months for functional bleeding. Pelvic examination revealed the uterus to be symmetrically enlarged due to a myoma in the fundus. Hysterectomy was performed.

Breast Symptoms

There were several patients who developed breast symptoms after receiving endocrine therapy. It is a well-known fact that the breast is a receptor for endogenous estrogen from the ovary. It is also known that the breasts respond to exogenous estrogenic stimulation. The following case histories are interesting:

A patient, age 33, surgical castrate, was given stilbestrol for nine months. During this time she developed enlarged tender breasts. Examination revealed tenderness of breasts, but no masses or lumps were found. Breast symptoms subsided after therapy was discontinued.

L. R., age 52, developed breast symptoms after she had been on stilbestrol therapy for two and one-half

years. There was also bleeding. Examination of both breasts revealed a dark brown pigmentation in the areola and on the nipple. The patient was a nullipara, and after all hormone therapy was stopped, the areola region became pink in color.

Two other patients, one age 34 and the other age 32, showed the same dark brown pigmentation on the skin of the breasts. In each instance there was desquamation of the pigmented area after hormone therapy was stopped.

Another patient, age 45, was the sister of a physician. She had received endocrine therapy for the menopause. Her breasts became heavy and felt sore to touch. These symptoms subsided after endocrine therapy was stopped.

P. S., age 53, developed enlarged, swollen, and tender breasts after she was treated with endocrines for the menopause. There was also uterine bleeding, although the last period had occurred four years ago. There was no evidence of tumor in the breasts and symptoms subsided with discontinuance of therapy.

Diagnoses on patients who received endocrine therapy were: cancer of the cervix (3 patients), malignant polyp of endometrium, uterine myoma (5 patients), adenomyosis of the uterus, chronic mastitis, extensive pelvic endometriosis (2 patients), arteriosclerotic metritis, pregnancy (2 patients), and congenital absence of vagina. There were 5 patients who were radium castrates.

Symptoms for which therapy was given were: the menopause, bleeding, nervousness and tiredness, cystitis, glandular disturbance, secondary amenorrhea, primary amenorrhea, and functional bleeding.

Let me repeat that we do not wish to disparage the possible benefits of carefully controlled endocrine medication. Stilbestrol itself is a good drug when given properly, and even then the possibility that therapy may disturb the delicate endocrine balance of a patient should always be kept in mind.

The writer called attention to "rest periods" between courses of endocrine therapy for menopausal patients, four years ago before this Society.⁹ As you all know, the vast majority of women passing through the climacteric (which is in itself physiologic) do not require treatment. An explanation of the temporary nature of the symptoms, together with a prescription for mild sedatives, may be all that is required. However, when the symptoms are marked, there is no more

specific therapy than estrogens or stilbestrol. It is best to give the smallest amount of stilbestrol (0.1 mg. t.i.d.) necessary to control vasomotor symptoms. The medication should be prescribed for only a limited period of time and it should be withdrawn gradually. When writing a prescription for endocrine therapy, it is wise to write "Do not refill." This procedure would have prevented three patients in this series from being victims of self-medication, not to mention excessive bleeding.

Conclusions

Every woman who is to be given estrogenic therapy should have a comprehensive general physical examination and a thorough pelvic examination. The cervix should be visualized through a speculum.

Estrogens should not be given prophylactically before the menopause.

Hysterectomy, per se, without removal of ovarian tissue, is not an indication for hormone therapy. This is true especially in the pre-menopausal group.

There should be a definite indication for endocrine therapy before it is administered.

When ordering estrogens, write on the prescription "Do not refill."

Estrogenic therapy in the climacteric should always be interrupted to prevent stimulating effects upon the tissues susceptible to their action.

Estrogens should not be given to women with a family history of cancer or to a patient who herself has cancer. Estrogens should be avoided in endometriosis, radium castrates, and patients with fibromyomata of the uterus.

Finally, it should be remembered that although these substances have been known for about twenty years and have been available for therapeutic use about ten years, they are still relatively new and we still have much to learn about their potentialities.

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Malignancy not suspected—75 per cent of rectal cancers can be felt with the index finger. See page 418, this issue.

The Management of Excessive Weight Gain in Pregnancy

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THE ancient belief that the pregnant patient must "eat for two" has no basis in fact since the additional dietary needs during pregnancy are only slightly greater than for the non-pregnant woman. All ingredients necessary to maintain maternal health and to provide for the growth of the fetus can be supplied in a diet which will limit the pregnancy weight gain to a maximum from which a return to normal occurs spontaneously as involution progresses. There is no necessity for the weight to have increased after each pregnancy is completed, but it happens all too frequently and accounts for many overweight women, each of whom is increasing her chance of succumbing to the serious sequelae of obesity. Prevention of excessive weight gain in pregnancy and its subsequent obesity is one of the most fruitful fields in preventive medicine.

Weight gain in the normal woman should be limited to an amount which can be accounted for by the physiologic changes associated with pregnancy. These, which include the weight of the fetus, the placenta, the amniotic fluid, the increased size of the uterus and breasts, and the normal fluid increase, both in the blood stream (increased plasma volume) and in the extravascular tissues, total about 15 to 18 pounds. Thus the individual who begins pregnancy at her normal weight need gain no more than the amount she will eventually lose following delivery and the completion of lactation.

Excessive gains in weight may be attributed to two causes: (1) an actual increase in body fat, and (2) abnormal retention of fluid in the extravascular spaces.

It is important to differentiate between these because the prognosis and treatment are different.

The individual who is simply enlarging her fat stores as a result of overeating usually gains weight steadily but in excessive amounts. A diet history will reveal an increased intake of foods high in fat and carbohydrate and a voracious ap-

petite. Gains resulting from abnormal fluid retention are characterized by sudden rises in weight which may or may not be associated with visible edema. Weight gains in excess of one pound weekly are usually a result of fluid retention and should be viewed with alarm. In even the normal woman during pregnancy there is a positive fluid balance and about half will show some evidence of edema, but a complacent attitude toward such problems is not justified since *the first detectable evidence of pre-eclampsia is an abnormal gain in weight.*

The results of abnormal weight gains are dependent upon the underlying cause. If it is simply a matter of excessive caloric intake, the ill effects are more apt to appear remotely than during the pregnancy, but the patient undoubtedly will weigh more following delivery than at the time of conception. Should this happen with each of several pregnancies, the normally slender primigravida develops into the grossly obese multipara and is a candidate for the serious complications of obesity (cardiovascular disease, arthritis, backache, etc.), which in such instances might have been prevented by the control of weight at its onset.

Gains resulting from fluid retention are potentially much more serious. One of the characteristic findings in pre-eclampsia, in most instances preceding the rise in blood pressure and the appearance of proteinuria, is an abnormal increase in weight due to the accumulation of extravascular fluid. An accurate diagnosis of pre-eclampsia at this stage is impossible, but all patients who are suspected of fluid retention should be considered to be potentially toxemic and treated as such. It is possible that the development of classical pre-eclampsia may sometimes be prevented by such an attitude; at least the course of toxemia, should it be present, can be altered by early and intelligent intervention.

Management of the Obese Patient

It is to be emphasized that the fundamental factor in weight reduction during pregnancy is exactly the same as in the non-pregnant individ-

Read before the Section on Obstetrics and Gynecology at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 6, 1948.

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ual—reduction in caloric intake, but the problem differs in that the dietary requirements for pregnancy must be met. These requirements consist primarily of (1) adequate amounts of protein (1.5 Gm. per kilogram of body weight), (2) adequate amounts of minerals, particularly calcium (1.5 Gm. daily) and iron (15 mg. daily), and (3) adequate amounts of vitamins. It is evident therefore that in order to provide these needs too drastic a reduction in food intake cannot be prescribed. It is impossible to supply the requirements for pregnancy with a diet containing less than 1200 to 1400 calories daily; however, these levels can be reached without sacrifice by reducing the amounts of fat and carbohydrate in the basic pregnancy diet. A multivitamin preparation must be prescribed for all patients on a restricted diet during pregnancy. The low caloric diet for pregnancy used in the Temple University Hospital is as follows:

- ¼ lb. lean meat, poultry, or fish—boil, broil or roast (liver or kidney at least once a week)
- 1 egg or a serving of cheese or additional meat
- 1 quart milk—skimmed
- 1 of the following:
 - ½ cup of cottage cheese
 - 1 oz. cheese (¼ inch slice)
 - 1½ tbsp. peanut butter
- Additional serving of lean meat or egg
- 4 or more servings of vegetables, preferably colored (omit peas, corn, lima beans, sweet potatoes)
- 3 servings of unsweetened fruit (2 citrus and 1 other)
- 3 slices of 100 per cent whole wheat or dark rye bread (½ cup cereal equals 1 slice bread)
- 3 tsp. butter or enriched margarine
- Iodized salt is preferable

Avoid the following foods because they contain large amounts of sugar, fat, or starch and their use may lead to excessive weight gain:

Rich desserts: ice cream	cake	cookies
ices	sherbet	puddings
jello	doughnuts	pie

Sugar, candy, jam, jelly, honey syrup
 Canned sweetened fruits
 Sweet rolls or other sweet breads
 Soft drinks, milk shakes, alcoholic drinks
 Gravy, sauces, fried foods, and fat meats such as bacon and sausage
 Salad dressings and oils*
 Olives, avocado
 Cream, sour cream, half and half mixtures of milk and cream
 Nuts, popcorn, potato chips
 Canned soups and rich stews
 Rice, macaroni, spaghetti, noodles, crackers, pretzels
 Any food rich in fat and sugar

It is important that all aspects of the diet be discussed with the patient and that the need for the caloric reduction be carefully explained.

* Vinegar, lemon juice, salt and other seasonings may be used on salad if desired.

Each restricted food should be designated and a definite dietary outline be prepared according to individual needs. A more strict reduction in intake is necessary in those patients who are grossly overweight than in those who are less obese. At each subsequent visit the food intake should be checked and necessary alterations in the regimen suggested in the light of how much weight has been lost or gained.

Most patients will be concerned as to the effect of such a diet on the baby. If the basic requirements for pregnancy are met and the caloric reduction is accomplished by limiting the fat and carbohydrate intake, there should be no adverse effect on either the weight or health of the infant.

The aim of weight control is to discharge the patient at the completion of involution as near her normal weight as is possible. The total allowable gain for the entire pregnancy is calculated at the first visit on the basis of what the normal non-pregnant weight should be and what the present weight is.

The ideal of what is to be expected of such a program may be outlined as follows for the individual whose normal weight is 120 pounds:

Pre-pregnancy Weight	+ Gain in Pregnancy	= Weight at Delivery	— Expected Loss	= Post-partum Weight
120	16	136	16	120
136	0	136	16	120
146	—10	136	16	120

It is not to be expected that all patients will respond equally well to a regimen of weight reduction. The increased metabolism and increased appetite in pregnancy tend to defeat the process except in those who have a sincere desire to cooperate. Constant supervision and encouragement are necessary and the percentage of failures is high.

An additional aid, which should be used only after diet alone has failed, is the administration of dexadrine sulfate. This drug decreases the appetite, thereby reducing the food intake. The initial dosage is 5 mg. one-half to one hour before each meal; should this be insufficient, the amount may be increased to 10 mg. To date no ill effects on the pregnancy have been noted.

Excessive Gain from Fluid Retention

Retention of fluid in the tissues appears to be related to the metabolism of the electrolytes, particularly sodium and chloride, and within limits is normal in pregnancy.

All solids in the tissues are maintained at a normal physiologic dilution by rapid shifts in fluid to and from the blood stream according to the needs at that moment. If the utilization or

excretion of electrolytes is altered and increased amounts are stored in the tissue, additional water is retained to provide for the necessary dilution. Should the requirement for fluid be markedly increased, visible edema develops when the tissues become overloaded. A decrease in tissue electrolytes automatically releases water which will then return to the blood stream and from there be excreted by the kidneys. Since this holds true in benign fluid retention during pregnancy as well as in that associated with pre-eclampsia, the principles of treatment for both are identical.

If at any prenatal visit the weight increment is greater than can be accounted for by normal gain, fluid retention should be suspected and treatment inaugurated to reverse the process. Since the underlying cause is thought to be an abnormal electrolyte metabolism, these substances rather than the fluids should be eliminated from the diet. If the amount ingested is insufficient to meet the daily needs of the body, the chemicals retained in the tissues must be metabolized; this in turn releases fluid which is excreted. The most effective method by which this may be accomplished is the removal of salt from the diet. It is insufficient simply to tell the patient to "stop using salt" because this is interpreted as meaning "add no extra salt to the food." All food is prepared without salt and none is added at the table and, in addition, foods containing large quantities of this substance are forbidden. These include all prepared meats (bacon, ham, luncheon meats, sausage, etc.), butter, all canned soups and vegetables, salted peanuts, pretzels, bread, crackers, beer, and other foods with a high sodium chloride content. Baking soda or other antacid preparations which many patients take for heartburn contain the sodium ion and should be specifically eliminated.

Further diuresis may be obtained if necessary by the use of ammonium chloride in dosages of 6 to 9 grams daily. The ingestion of this drug is followed by an increase in urine output and, in addition, a high level of urine sodium chloride, thus accomplishing the double purpose of eliminating fluid and the electrolyte which aids in holding it in the body. If administered continuously, the diuretic effect of ammonium chloride soon is reduced, hence three-day rest periods after each five days of treatment are necessary.

If adequately instructed and impressed with the necessity for adhering to the regimen, most patients will respond by losing weight. Should the rapid gain continue, it is likely that the patient is not adhering to the diet or that a toxemia is developing and admittance to the hospital for

at least a short period of control may be indicated. Frequently hospitalization and rigid dietary control will produce the desired response in a patient who will not or cannot carry out the program at home.

Comparison of the results of this program for the elimination of fluid with those of classical dehydration techniques indicates that it is at least equally effective in mobilizing the fluid and much more acceptable to the patient, as she is not made uncomfortable by reduction of her fluid intake.

Summary

One of the most fertile fields for increasing the scope of prenatal care is in the evaluation and control of excessive weight gain during pregnancy. The effective results of such a program are both immediate and long-range depending upon the cause. If the gain is associated with pre-eclampsia, it is possible at least to alter the course of the disease by early active intervention directed toward reversal of the abnormal physiologic process responsible for fluid retention. Weight reduction in the obese patient and limitation of gain during pregnancy will aid in preventing remote complications, such as cardiovascular disease, which develop so commonly in the overweight individual.

It is important to differentiate gains in weight which are on the basis of excessive caloric intake from those due to fluid retention since the dietary alterations for each are different. In the former a diet low in calories but containing all the ingredients necessary for pregnancy is indicated.

In the latter instance the attack is directed toward eliminating the factors thought to be responsible for the fluid imbalance, the abnormal tissue metabolism of electrolytes. Reversal of the fluid flow can usually be accomplished by reducing the salt intake without altering the amount of fluid ingested. The efficacy of the diet may be enhanced by the simultaneous administration of adequate amounts of ammonium chloride.

ABSTRACT OF DISCUSSION

CLIFFORD B. LULL (Philadelphia): This subject is so broad and incomplete at the present time that anything I may say in this discussion should not be considered as critical of anything that Dr. Willson has said, in spite of the fact that there may be some divergence of opinion; it should simply be recorded as another opinion which eventually may help to give us the correct answer. I don't believe any of us know, and we certainly are not ready to come forward with any specific detailed report on our work; therefore, I believe the only way we are going to arrive at conclusions is to express our opinions freely, one to another, as to what we think are the better points.

In Dr. Willson's paper he talks about an increased blood plasma volume. It has been shown that an actual increased plasma volume does occur, but this is compensated for by the increased placental bed; therefore, there is no relative increase in plasma volume. Thus, any evidence which would suggest an increased plasma volume is an indication of abnormal metabolism and physiology. Retention of fluids in the extravascular tissue is not normal and it does not occur in women who are in positive nutritional balance and whose metabolism is adequate.

Dr. Willson mentions that increase in body fat and fluid retention are the result of the same mechanism, namely, hypoproteinemia. This mechanism works as follows: With a decrease in protein intake, there must be an increase in carbohydrate and fat intake in order to satisfy the caloric needs of the individual.

If this caloric satisfaction is not obtained in this manner, a breakdown of tissue proteins or a conversion of protein ingested by mouth will occur in order to supply the necessary energy requirements. This disruption of tissue integrity and/or the breakdown of incoming protein initiates the beginning of physiologic and metabolic dysfunctions which we recognize in pregnancy as minor or major catastrophes.

This produces fluid retention through a breakdown in tissue metabolism which is one of the keys of "Krebs' cycle" in which metabolism of proteins and carbohydrates is dependent upon the key members of the B complex vitamins and which, in deficiency levels, results in a failure of metabolism of carbohydrates and proteins and the establishment of a positive fluid balance, or fluid retention.

It further follows that in any given amount of protein intake a sufficient amount of carbohydrates must be present in order to buffer or protect these proteins to avoid the above metabolic disturbances; therefore, acute deficiency states with a breakdown in metabolism and physiology can occur from insufficient food intake just as well as from an excessive caloric intake.

Further, the biologic adequacy of the proteins ingested must be maintained at all times. An example of this is the individual who may have a total protein intake for twenty-four hours which is adequate, but who takes these proteins in such a way that they are incomplete, and spaced at such intervals that they are not usable in their entirety. This mechanism can produce from 30 to 50 per cent net deficiency in available proteins to the individual organism.

Weight gains in excess of one pound weekly are not necessarily the result of fluid retention alone, and our study proves this. We see edema in less than 3 per cent of our patients; certainly never reaching 50 per cent as Dr. Willson states.

We believe that the nutritional needs of a woman during pregnancy approximate 2100 calories, but should be computed on her daily needs and on her pregravidic weight. This 2100 calories is the usual requirement for the average woman during pregnancy.

In the reduction of weight in a pregnant woman who supposedly starts out overweight, we believe it to be rather a dangerous procedure, and would rather limit our endeavors to keeping her weight at approximately the same level than try to reduce her during pregnancy by the use of a very low caloric diet and the use of dexadrine sulfate, as we feel this drug produces a deficiency state in the simple mechanism of not eating.

I will not go into a discussion of the electrolytes, as I feel that I do not know very much about them; in

fact, I doubt that anybody knows much about them.

The use of ammonium chloride is simply beating a tired horse. It is a last way of overcoming a positive fluid balance. It will be effective for only a brief period of time and does not do anything to correct the causative factor of the fluid retention which we believe to be the result of a hypoproteinuria with an attendant B complex deficiency. We do not use ammonium chloride in our Nutritional Research Clinic, but resort to positive nutritional control, which means simply establishing the patient on an adequate nutritional intake commensurate with her specific needs for the stage of pregnancy under consideration. This results usually in loss of edema and the reduction of any hypertension. As a matter of fact, if magnesium sulfate is used, it is a faster diuretic than ammonium chloride.

Dr. Willson refers to an adequate nutrition, and by that I take it he means adequate protein intake and vitamin intake. This should certainly be emphasized.

The metabolic and physiologic status of the patient should be evaluated as early as possible, and any nutritional deficiencies present should be corrected as quickly as possible; therefore, nutritional therapy to be effective must be intensive; it must also be started as early as possible.

In 275 patients whom we have delivered at this special clinic so far, there has been only one case labeled a mild pre-eclampsia. I do not believe that the last word has by any means been written concerning the problem of nutrition in pregnancy, and there will probably be for some time to come a difference of opinion as to the various physiologic and metabolic changes which have to do with pregnancy as affected by nutritional deficiencies. It is only by the expression of opinion by various individuals that we may arrive at a conclusion in the not too distant future.

DELMAR R. PALMER (Erie): This subject has been rather a pet peeve of mine since I have been in practice, and just recently I gave a report on it to the obstetric section of the Erie County Medical Society.

I will quote rather rapidly some of my figures on a report of 846 cases from my own private practice. I had 21 patients who lost weight during pregnancy, 7 who gained up to 5 pounds, 34 who gained up to 10 pounds, 129 who gained from 10 to 15 pounds, 160 who gained from 20 to 25 pounds, 158 who gained up to 30 pounds, 119 who gained up to 35 pounds, 69 who gained up to 40 pounds, 35 who gained between 40 and 50 pounds, 24 who gained between 50 and 60 pounds, and 2 patients who gained over 60 pounds.

In none of these cases did I feel that there was any danger of pre-eclamptic toxemia.

I mentioned two patients who gained over 60 pounds. One of these two gained 69 pounds. She was a young primipara, 20 years old. Her pre-pregnant weight was 102 pounds, and she gained up to 171. At no time did she show any signs of rising blood pressure or any urinary findings indicative of pre-eclampsia. For the information of Dr. Willson, this girl, six weeks after delivery, had a postpartum checkup and had dropped down to 120 pounds.

I should like to ask Dr. Willson for his opinion of these underweight primiparas who gain up to their normal weight and then gain probably 20 or 30 pounds in addition.

I should also like to cite a parallel of two cases. I don't know that many doctors have as patients two sisters who marry two brothers. This one girl, a 25-year-old gravida IV, went from 185 to 204 pounds. She was

thirteen hours in labor and was delivered of a baby weighing 8 pounds 4 ounces. Her older sister, 31 years old, was a primipara; her weight increased from 165 pounds to 205 pounds, a gain of 40 pounds as compared with the 19 pounds her younger sister gained. Both of them had babies just about a fourth of an ounce difference in weight. The primipara who had gained 40 pounds went back to 170 pounds at the end of six weeks; in other words, a gain of 5 pounds. The multipara who had gained 19 pounds went back to 180 pounds, or a loss of 5 pounds as a result of her pregnancy.

In my opinion, control of the weight or of the diet in most of these patients creates somewhat of a mental upset.

I should like to cite the case of a patient whom I delivered of her second baby. She gained 34 pounds during her pregnancy and had a 6 pound 4 ounce baby. While I was in the service, she consulted another one of my colleagues, who immediately told her that I had let her gain too much weight, and he made the statement to her that if she would gain less, she would have a smaller baby and therefore an easier time. He put her on a rather strict diet, to the extent that she gained 12 pounds during pregnancy, and she told me she practically starved herself. She was mentally upset all the way through because every time she overstepped her diet she felt that she was committing a crime. At the end of her pregnancy she said that she had a harder time than when I had taken care of her, and she had a 7½ pound baby.

So, I say, why control weight by limiting a patient's diet and then supplement it with vitamins, minerals, and other things that detail men pass around to us? There are several of them, my friends, in the audience. I hope they do not take offense.

I had another primipara, 18 years old, who weighed 220 pounds when she came in to see me. She gained 50 pounds during pregnancy. Her blood pressure all the way through pregnancy was in the neighborhood of 160 to 168 systolic; the diastolic remained around 70 or 80. At no time during her pregnancy did she show any eclamptic signs, and I delivered her of a 7 pound baby last January.

I should like to ask Dr. Willson what he would do in the case of a patient who weighs over 200 pounds, because I have two on my hands at the present time.

OWEN J. TOLAND (Philadelphia): I should like to commend Dr. Palmer for his truthful and accurate summary of his experience. I think it is a common mistake of all of us to try to standardize our work to too great a degree and not allow for individual variations in our patients which often are of no clinical significance.

I am afraid that all of us have a tendency to emphasize anything that makes us important, and at present I feel that a great deal of undue emphasis is attached to the subject of weight gain during pregnancy. I suspect that a fair number of our patients are made quite miserable throughout their pregnancy by our zeal in stressing this phase of prenatal care. As our colleague from Erie has pointed out, there can be a good deal of latitude in this matter. It has been my own experience that it is very common for women between their fourth and fifth months of pregnancy to put on a great deal of weight. This I interpret simply as a natural reaction to the escape from feeling nauseated during the first three and a half to four months of their pregnancy. I attach very little importance to it and find that an

appeal to feminine vanity is usually sufficient to prevent a repetition.

I should like to point out that a great deal of emphasis need not be placed upon the existence of ankle edema when unassociated with albuminuria or a significant rise in blood pressure. In my own experience, practically all of my patients have some edema of the ankles in hot weather, a state which I do not view with alarm.

To sum up, I should like to encourage this section to be guided, as far as possible, by the basic principle that we are treating individuals rather than conditions in our maternity practice and wide fluctuations from so-called normal patterns can often be observed with complacency.

The other point of view, carried to an extreme, will unquestionably make pregnancy a miserable state for a large number of patients.

DR. WILLSON (in closing): I am very happy to learn that Dr. Lull did not bring the last word, because we are using a diet very much like the one used at Lying-In Hospital, and we are not by any manner of means able to duplicate his results.

As far as weight is concerned though, Dr. Lull, you deny the fact that an increased plasma volume is of importance although it is weight added during pregnancy. The additional vascular space added as the uterus enlarges must be filled, and when the uterus returns to its normal size after delivery, the added blood volume must be diminished as the vessels disappear.

It has been quite definitely shown that the patient who is pregnant is not in normal fluid balance. She definitely does retain fluid, and this is part and parcel of a normal pregnancy which may in some instances overshoot the mark and go to extremes. Because a patient develops edema during pregnancy does not mean that she has pre-eclampsia; it simply means that there is some upset in the physiology. Whether fluid is retained on the basis of some normal change in pregnancy, or whether it is eclampsia, pre-eclampsia, or kidney disease, doesn't make much difference; it still is there. The important point which I hope to impress upon you is the fact that the initial sign of pre-eclampsia is fluid retention. Every patient who has a little excess weight gain and fluid retention is not of necessity going to convulse; but we must recognize the early stage and we must begin treatment before the patient has demonstrable signs of eclampsia, convulsions, anuria, and so on.

As for ammonium chloride and a salt-free diet, we have some studies under way now comparing this method of dehydration with the classical method. It is dehydration exactly as is the classical method, but accomplishes the same thing in a manner that is easier for the patient and more physiologic.

We allow the underweight patient to gain a little more during pregnancy than the patient with normal weight but, unfortunately, weight and diet are the result of habits which have developed, for the most part, over many years. The patient who is underweight has an increased appetite during pregnancy, she eats more, gains a little more, and loses it immediately afterward in the vast majority of cases. She is let down after the baby comes, works hard, misses meals, and goes back to her old habits of not eating properly.

The patient who weighs over 200 pounds we put on a reduction diet and attempt to reduce her weight even during pregnancy, and we have noticed no bad results on either the patient or the baby.

UNITY IN THOUGHT AND PRACTICE

JOHN ROBBINS HART, Ph.D., Rector
Washington Memorial Chapel, Valley Forge, Pa.

THIS centennial is of universal significance and I was greatly pleased and highly honored to receive an invitation to take part.

We are all associated with the medical profession, and my subject is "Unity in Thought and Practice" as we endeavor to give health and healing to all people.

We live in a world that seems too much inclined to destroy unity. Various schools of thought in all sciences, religious denominations, political parties, caste systems—ancient and modern—numberless centers of prejudice and intolerance, are forever stressing our differences. Let us not put the emphasis on difference but on unity. The things which unite us are of first importance while the things which separate us are relatively unimportant.

LIFE is the keyword. Fall in love with life and be true to that love. In the center of the study of life and the devotion to life we find the medical profession. Many times, in my work, I have wished for a medical education. The body and mind, the ethical and spiritual life, are all included in the thought and practice of this profession. Every good doctor, since the days of Hippocrates, has combined with his knowledge of the human organism the best in psychiatry and religion which his age afforded. The more we combine the best in human knowledge, the more we put it in practice, by just so much do we add to the abundance of life. The totality of life is our first concern, not just a part of it. This fullness of life becomes our greatest desire and purpose. Life is defined as the irritability of tissue, the contractility of the muscles, but above all, life is the sum total of forces that resist death. We should endeavor to keep that resistance as nearly perfect as possible.

We unite with the natural scientists of bygone days in their efforts to be in correspondence with and in conformity to our total environment. It goes without saying that we recognize the ultimate victory of material death but not death on

the higher levels. This reminds me of Dr. John C. Heisler, who formerly held the chair of anatomy here at the University of Pennsylvania. I once accompanied a professor of mathematics into his dissecting room in the Hare Laboratory, and after surveying the grim scene before him, this professor turned to Dr. Heisler and said: "I should think in this place a man would be concerned with merely the mortal." "Not at all," replied Dr. Heisler, "quite the contrary, I am concerned here with the immortal studying the mortal." What a motto for every medical student!

The unity under consideration may be illustrated strikingly by a word that has a central place in both science and religion. The word in the Latin tongue, as you know, is SALUS, the name of the Goddess of Health, and identical with the Greek Hygeia, translated in our science to mean health and in our religion to mean salvation. It seems proper and fitting that these two English words should spring from the same root. We say a person is healthy when fully adjusted to his total environment, and likewise he is in a state of salvation when he is rightly adjusted to his total environment, both human and divine.

Our unity in thought and practice never necessitates uniformity. Always in man's search for truth and in his practice there will be a diversity of interpretation. Different convictions and practices will always be a part of individuality and independence, in both of which we believe. These differences, however, need have no period after them—no need to stop there—but there should be a plus sign, a signal for the awaiting of more truth and for more searching. In other words, a conviction followed by a plus sign spells progress, while a conviction followed by a period spells prejudice. Further pursuance of any subject, my own point of view or that of those who disagree with me, should lead to new and better discoveries. As a rule, one person is not right and the other wrong; both are partly wrong. The truth stands out in front of us and we must step forward to meet it. Here is no place for strife, discord, or emotional upsets, but for sound

Delivered at the "Religious Hour" of the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Sunday afternoon, Oct. 3, 1948.

thought and reasoning—a friendly cooperation.

According to a recent lecturer, the lack of coordination is the chief weakness of science. That, with a lack of cooperation, I have associated with the story of a poll parrot. When the Germans occupied Paris during the dread days of World War II, some of the German officers went to a restaurant every day where there was a parrot trained to make fun of them. "Down with the Bosche—kill the Bosche," the parrot would scream; finally, one irritated Prussian went to the restaurateur and said: "If you don't get rid of that bird, we'll kill him." In great dismay the owner took his parrot to the parish priest and said: "Father, what can we do about this?" The good priest replied: "Oh, that is easy. Leave your parrot and take my bird to your restaurant." So it was done, and the next day, to the amazement of the officers, not a word came from the parrot. Finally, the same Prussian went up to the cage and said: "Go ahead, polly, speak your piece, say 'Down with the Bosche—kill the Bosche,'" and the parrot bowed his head and meekly replied: "May the Lord answer your prayer, my child." It showed not only that the parrot had been well trained by the priest but also the best cooperation between any two birds, human or otherwise, that I have ever seen.

Teaching in the field of psychology, I have encountered seven theories of how the mind and body are related. It is not too significant which theory is right or how much right there is in any one of the seven, but the significance lies in the fine adjustment which exists between the mind and the body—the delicate relationship between the two—whereby they mutually affect each other. Here is a natural unity of life which calls for our best unity in thought and practice.

Professor John McFarlane, the renowned botanist, was especially interested in the sensitive correspondence between the mental and moral activities and he eventually coined the word "mento-moral," believing that the two were in some way inseparable. In this field the doctor stands in a unique position. As he treats the pa-

tient for bodily ills, he becomes the great confidant, acquainted with the most intimate facts relating to the patient's life and that of his family. Hearing these confidences, day after day, the doctor has the opportunity to teach and establish the highest and best standards of living and to transfer his own knowledge and integrity to the lives of his patients. The ultra-development of specialization may be losing some of this good effect and, if so, our unity of thought and practice must be considered from that angle. I should suggest, also, that a quickened and alert conscience is needed in the medical profession for those men who become famous as they grow older and become busier. They face the temptation to slip over small things that may seem relatively trivial to themselves but are still vital to those who depend upon them and have placed their confidence in them.

From recent scientific conferences has come the report that we *can* work together, and increasingly we hear the imperative warning that we must work together. "United we stand, divided we fall" is just as true on the battle front of disease and mental disorder as it is in a war of arms. As Mr. John Foster Dulles recently said, "We must go on working daily to mobilize Christian power to break down the walls of division."

In conclusion, we are determined to do all things necessary to maintain health—total health—of body, mind, and spirit. "Man," said Victor Hugo, "is an infinite little copy of God. I am a man, an invisible atom, a grain of sand on the seashore, a drop of water in the mighty ocean, but as little as I am, I feel the divine within me, because I too can create out of my chaos." Out of every chaos we are called upon to create law and order—the law and order of health, the abundance and wholeness of the good life. "If thou wilt thou canst be made whole," said the Great Physician. These words are needed by many, many people today, and the true unity of science and religion is needed by the entire world.



VENEREAL DISEASE NOTES

Published Through the Cooperation of the Pennsylvania Department of Health
and The Medical Society of the State of Pennsylvania

The *Pittsburgh Medical Bulletin* of Dec. 18, 1948, contained the following:

Treatment Is Defeated

It is a well-known fact that many cases of infectious syphilis disappear before adequate treatment has been administered. Many syphilologists are of the opinion that inadequate treatment is as bad or worse than no treatment.

It is realized that busy physicians cannot take the time to locate and educate an irresponsible patient.

Cooperation in bringing your patient back to you for treatment is offered by the Pittsburgh Syphilis and Venereal Disease Control Program through its epidemiologic section. A phone call to the administrative office, Atlantic 3900, Extension 259 or 375, will set in operation quiet but efficient methods of bringing the patient back to you for treatment.

We are gratified to see this announcement since it indicates that the second largest medical organization in the State advises, at least by inference, its membership to report patients who neglect to receive treatment for syphilis while they are infectious or liable to become infectious.

On Oct. 7, 1936, in a paper presented at a general meeting of The Medical Society of the State of Pennsylvania in Pittsburgh, the following was stated:

"Private medicine, so to speak, is 'on the spot.' There are well-defined forces which would make medicine subversive of government to a degree that is obnoxious to a free people. I believe that private medicine, as it is now constituted, will demonstrate its ability to protect the public if it is given the opportunity." By "opportunity" was meant the following: "The Pennsylvania Department of Health . . . proposes the development of a system that has for its purpose the 'follow-through' of all syphilitic infections no matter what may be the economic condition of the subjects. The success of such a plan rests primarily upon the private practitioner of medicine. Without his help the plan will not be possible of execution."

In addition, it was stated that free drugs would be furnished to physicians for the treatment of patients who were not able to pay the standard fee. The paper referred to called attention to the system of free clinics operated by the State Department of Health for the treatment of indigent patients. Private physicians were requested to provide sufficient treatment to their private patients in order that syphilis would be stopped at its source. An offer to furnish trained investigators whose duty was to follow up neglectful patients and bring them back to treatment was stated in this article. This type of service has been at the disposal of private physicians since 1937. It is gratifying to state that some physicians have taken advantage of the service. But, on the other hand, it is disappointing to note that such physicians have been in the minority. It would appear that there could be no stronger argument to present to legislators than the support that private medicine has given to public health agencies in their effort to control syphilis. I believe that it is not too late for the private physician to demonstrate his interest in this vital matter.

The regulation provides that patients who have syphilis of less than four years' duration and who neglect treatment shall be reported to the City or State Health Department in accordance with the residence of the patient. Private physicians should observe this regulation.

It is gratifying to report a diminution of patients entering clinics with recent syphilis. What is the reason? Are they going to private physicians? Or are there, in fact, less syphilitic infections? Both questions might be answered in the affirmative. Is it possible that the armed services have been mainly responsible for this condition with their facilities for segregation and rapid cures? (The experts say that one full course of penicillin cures 80 per cent of early infections.)

The State and the City Departments of Health are anxious to receive information on patients who, because of neglect of treatment, endanger the public. It is believed that private physicians will augment the public clinics in their endeavor to stop infection at its source. There should be a thorough "follow-through" of treatment. One full course of penicillin, no matter whether it be administered in doses of 40,000 units every two hours around the clock for seven and one-half days or whether in doses of 600,000 units in a retarding agent every twenty-four hours for eight days, will stop infection at its source.

The physician's duty does not end with one course of treatment. The infection may not have been eliminated. An appraisal of the treatment should be made every two months with *quantitative* serologic testing. If the titer drops to zero and remains so, further treatment need not be given. If the titer rises and continues to rise, a second course of treatment must be given if the infection is to be eliminated. The duty that surrounds the private physician and the public clinics is plain. No case of early syphilis should ever be permitted to go its way until the patient has been observed for a period of at least twelve months.

Congenital syphilis can be stopped at its source by means of antenatal treatment with penicillin. There is a law that requires a serologic test in the case of the pregnant woman. The State gives free serologic service to pregnant women regardless of economic status. The Department of Health furnishes penicillin for the treatment of pregnant women who are unable to meet the cost of the drug. Information on this point may be obtained by a simple post card request.

EDGAR S. EVERHART, M.D., Chief, Venereal Disease Division.

Deaths from Selected Causes in Pennsylvania, July, 1948

County	All Causes, Excluding Stillbirths	Still- births	Infant Deaths	Maternal Deaths	Cancer	Heart Disease	Intra- cranial Lesions of Vascular Origin	Nephritis	Pneu- monia	Tuber- culosis
Adams	27	2	5	0	2	9	6	1	0	0
Allegheny*	1105	75	74	3	175	347	98	53	27	29
Armstrong	44	4	2	0	6	15	5	2	0	0
Beaver	87	5	4	0	12	32	8	6	1	0
Bedford	22	3	0	0	2	6	3	2	0	0
Berks*	217	11	13	0	29	79	27	8	2	3
Blair*	125	6	8	3	13	52	12	4	4	0
Bradford	53	1	4	0	7	21	0	4	2	2
Bucks	94	0	4	0	13	28	9	8	0	5
Butler*	62	3	7	0	2	21	12	3	1	0
Cambria*	135	15	10	0	25	41	10	9	2	1
Cameron	2	0	0	0	0	2	0	0	0	0
Carbon	51	2	2	0	7	16	2	7	0	2
Centre*	51	3	8	0	5	19	1	5	0	0
Chester*	120	3	10	0	14	40	9	11	3	0
Clarion	25	0	0	0	6	8	4	1	0	1
Clearfield	69	1	7	0	9	23	6	2	3	3
Clinton	38	0	6	0	5	11	5	0	0	1
Columbia	46	3	1	0	2	22	5	3	1	0
Crawford	66	4	1	0	10	20	5	1	4	0
Cumberland	72	0	2	0	6	20	11	8	0	1
Dauphin*	167	16	10	1	25	63	12	11	2	4
Delaware	220	6	15	0	31	77	30	16	4	2
Elk	8	0	0	0	0	6	0	0	0	1
Erie*	143	4	4	0	26	52	15	6	3	5
Fayette	135	7	17	1	19	48	10	8	2	4
Forest	3	0	0	0	1	0	2	0	0	0
Franklin*	58	0	5	0	4	20	6	8	1	1
Fulton	9	0	0	0	3	2	2	0	0	0
Greene	31	1	2	0	3	12	2	1	1	0
Huntingdon	27	0	2	0	2	11	3	0	0	1
Indiana	46	4	3	1	8	18	3	2	0	2
Jefferson	40	0	3	0	7	16	2	2	0	0
Juniata	13	0	1	0	1	7	0	0	0	0
Lackawanna	227	14	11	2	44	74	17	10	7	5
Lancaster*	188	6	9	0	25	70	14	8	3	4
Lawrence	75	3	4	1	9	23	10	2	0	2
Lebanon*	51	1	2	0	7	15	5	6	0	0
Lehigh*	142	8	9	1	19	50	11	6	3	4
Luzerne	305	17	17	1	48	101	20	24	7	7
Lyeoming	104	7	7	0	6	41	9	6	3	2
McKean	38	2	2	0	6	13	8	2	1	0
Mercer	79	7	10	0	11	21	7	5	2	0
Mifflin	33	5	2	0	2	12	2	5	0	1
Monroe	34	2	3	0	6	13	3	1	0	0
Montgomery*	230	11	21	1	39	80	14	14	5	3
Montour*	28	4	4	0	5	3	3	2	0	1
Northampton	118	4	6	0	16	56	11	2	2	2
Northumberland	89	2	4	0	14	26	8	9	2	2
Perry	15	0	0	0	3	3	2	3	0	0
Philadelphia*	1844	79	104	3	306	646	116	92	48	86
Pike	9	0	0	0	1	5	0	0	0	0
Potter	12	2	0	0	0	6	0	1	0	1
Schuylkill	176	10	9	0	27	66	12	8	5	5
Snyder*	8	1	0	0	2	3	1	0	0	0
Somerset*	66	3	6	0	10	19	10	5	2	0
Sullivan	8	0	0	0	0	4	0	0	0	0
Susquehanna	20	0	1	0	1	4	1	3	0	0
Tioga	26	1	0	0	5	11	1	0	0	0
Union*	23	1	1	0	4	5	1	4	0	2
Venango*	26	0	3	0	2	9	2	1	1	0
Warren*	22	2	2	0	1	7	3	0	0	0
Washington*	142	4	10	0	21	41	18	8	3	2
Wayne*	27	0	0	0	3	13	4	0	0	0
Westmoreland*	183	11	13	0	29	73	16	5	1	6
Wyoming	19	1	2	0	3	7	1	2	0	0
York	112	3	2	0	18	45	12	8	1	1
State and Federal Institutions	254	1	1	0	17	61	13	15	12	61
State totals	8144	391	495	18	1190	2790	680	449	171	265

* Exclusive of deaths in State and Federal institutions except general hospitals.

CENTENNIAL CELEBRATION PHOTOGRAPHS



BENJAMIN RUSH AWARDS—Martin Keener, representing the Lancaster Rotary Club, lay organization winner, Past President Hess, Alan Magee Scaife, Pittsburgh, individual winner, and President Engel discuss the awards.



STATE DINNER—Many distinguished guests, seated directly in front of the speakers' table, honored the society by their presence at the dinner commemorating the founding of the Society.

TECHNICAL EXHIBIT—Over one hundred technical exhibitors displayed their latest products.



CENTENARIAN PUBLICITY—John G. Wilson, M.D., 80, Factoryville, views the news releases and photographs of the 74 hundred-year-old state citizens who were given plaques in honor of their long life span.



TELEVISION—This innovation of medical teaching to large groups was enthusiastically received. The result was "standing room only."

REGISTRATION—A busy place all week. Previous records were broken with a registered attendance of 6228.





RELIGIOUS HOUR—The Centennial Celebration Session opened with a program of praise to the Great Physician. Three outstanding clergymen spoke and music was presented by a vested choir under the direction of Alexander McCurdy, D.Mus.



CONGRATULATIONS—President-elect E. Roger Samuel, left, Mt. Carmel, receives the congratulations of President Engel following his election by the House of Delegates.



OUTSTANDING SERVICE—Secretary-Treasurer-Editor Walter F. Donaldson, right, received a television set from the Society at the Installation Meeting in appreciation of the distinguished services he has rendered to organized medicine during his thirty years in office.

(Below) **SCIENTIFIC MEETINGS**—The scientific sessions in Convention Hall were well attended. Thirty-two separate programs were held in which 133 speakers participated.



(Below) **OPERATION FOR TELEVISION**—An operation is performed before the television camera at University Hospital and shown to hundreds at Convention Hall. The black wire running up the operator's back is connected to a microphone concealed in his mask so that he can describe the technique of the operation.

SUPERB MUSIC—The Bach Festival Chorus and the Baltimore and Ohio Glee Club provided music at its best for the Installation Meeting.





THE AUXILIARY—Prominent in the planning of the Woman's Auxiliary sessions were, *left to right*, Mrs. M. Fraser Percival and Mrs. Charles J. Swalm, Philadelphia; Mrs. Rufus M. Bierly, West Pittston; Mrs. Paul C. Craig, Reading; Mrs. Drury Hinton, Drexel Hill; and Mrs. Jay G. Linn, Pittsburgh.



BIRTHDAY PRESENT—One hundred roses were presented to the Society by the Auxiliary at the Installation Meeting in honor of the Society's birthday. Mrs. Rufus M. Bierly made the presentation to Past President Hester while Edgar S. Buyers, chairman of the Society Advisory Committee to the Auxiliary, looks on.

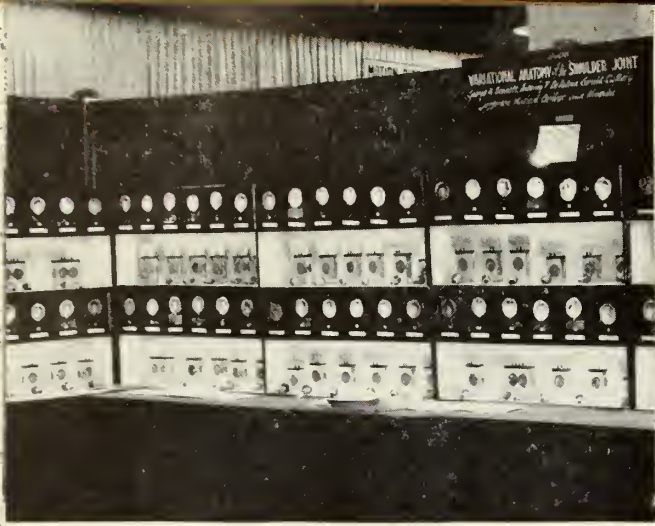


HONORARY MEMBER—Mrs. Edgar S. Buyers, Norristown, who helped organize the Woman's Auxiliary in 1924, was made the first honorary member of the group. Following the presentation of an engraved silver tray, Mrs. Buyers was guest of honor at a "Gay Nineties Tea." *Below:* Outgoing president of the Auxiliary, Mrs. Rufus M. Bierly, congratulates president, Mrs. Paul C. Craig, as she takes office.



UNIQUE GIFT—During the State Dinner Mrs. Edgar H. Green, wife of the president-elect of the Medical Association of Georgia, presented to the Society a beautiful gavel made from dogwood grown at the birthplace of Crawford Williamson Long, M.D., the Georgia physician who in 1842, first used ether as an anesthetic. *Below:* View of the Academy of Music as Gilson Colby Engel delivers his presidential address.





RIZE-WINNER—This exhibit, presented by George A. Bennett, Anthony F. DePalma, and Gerald Callery of Jefferson Medical College, won the second prize award in the Scientific Exhibit.

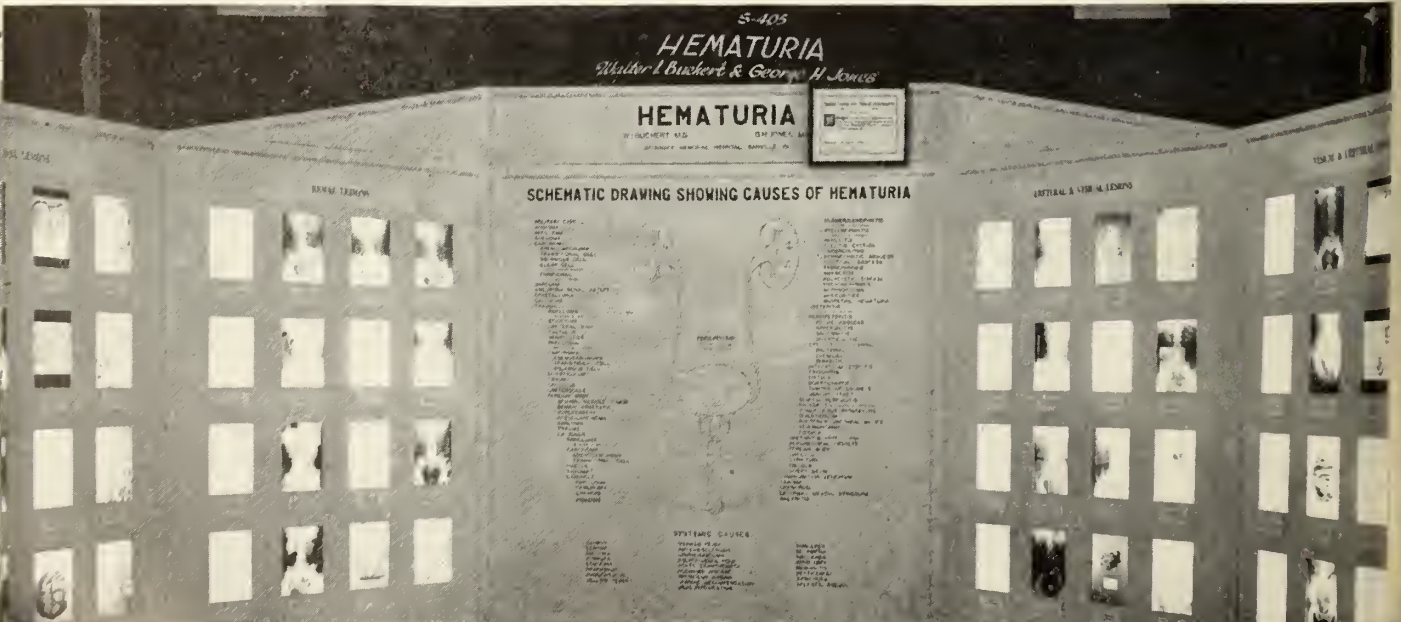


TRADITION—Retiring president Elmer Hess receives the traditional past president's gavel from President Gilson Colby Engel.



Above) **DIABETES THEN AND NOW**—The Commission on Diabetes exhibited a painting showing the important historical contributions to the longevity of the diabetic from 3000 B.C. to the present.

(Below) **FIRST PRIZE**—The first place Award of Merit in the Scientific Exhibit was presented to Walter I. Buchert and George H. Jones, Jr., Danville, for their exhibit on "Hematuria."



THE PENNSYLVANIA MEDICAL JOURNAL

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EDITORIALS

HOSPITAL COSTS

Currently one of the most serious problems facing society in its fight with disease is the rising cost of hospital care. Blue Cross organizations are confronted with the embarrassing necessity of frequently increasing their premiums and are in danger of "pricing themselves out of the market." In spite of this they face continuing red figures on their balance sheets. A situation is rapidly arising which challenges the growth of the Blue Cross movement and even threatens the continuation of the voluntary hospital plans. At the same time requests are going forth from individual hospitals for increasing local, state, and federal subsidies to prevent a breakdown in hospital finances, and the cost of hospital care for the individual is approaching prohibitive levels.

In a developing society, institutions take on new functions and responsibilities, but seldom does their philosophy of operation keep step with these changes. There is a real need for sound constructive thinking regarding the equitable and proper distribution of the costs of hospital operation.

The hospital originally came into being as the place where seriously ill people could be cared for in such a manner as to conserve man power by communal care and to make essential expansive treatment equipment available to the sick. Under such an organization the costs of hospital operation were properly assessed against the patients or in the case of indigents paid from gov-

ernment funds allocated for the support of the poor.

The last quarter century has seen a gradual but progressive trend away from this philosophy of function. The hospital has steadily and sometimes rapidly evolved into a communal center where teaching and training of doctors, nurses, and technicians is conducted on a large scale; where clinics for the care of the medically indigent are operated in increasing number; and where ambulance service and diagnostic and research facilities for the community are provided. The cost, however, has continued to be carried primarily by the in-patient, either from his private funds or through his voluntary insurance arrangements. In effect the clinical and diagnostic facilities of the hospital used in community service have been underwritten and paid for by the sick in-patients, and in part by government subsidy of in-patient free care. Nursing training costs have expanded to such an extent that in many of our larger hospitals they approach \$100,000 per annum. All these costs are lumped together as the cost of hospital operation and divided as a per capita cost of caring for patients. Expansion of these extra services—and they have in most hospitals expanded much more rapidly than the services rendered the patients—has been a major factor in pushing hospital charges to a point where the average citizen can no longer bear the load, where Blue Cross organizations face disaster, and where social unrest is

being fomented. To charge to the sick man the cost of operating these educational facilities and community clinics is both improper and unfair; to require Blue Cross subscribers to underwrite these services for the entire body politic, subscriber and non-subscriber alike, is economically unsound.

The financing of the educational activities of the hospitals is as reasonably the responsibility of the state as is the maintenance of teachers' colleges and industrial training schools. The communal clinic and its diagnostic facilities should be paid for by tax funds and not by an exorbitant levy on the small but unfortunate group of the community currently requiring hospital care. Only by logical thinking and proper relating of services can these costs of hospital care be reasonably distributed and can fair fees for hospitalizing the sick man be maintained.

Unfortunately, the costs of medical service per se and of hospital care are associated together all too frequently in the public mind. The controlled cost of hospital care is therefore increasingly important to the medical profession. Should we not urge a more realistic approach to hospital accounting in which government shall pay its rightful bills and not cover the waterfront "ineffectively and incompletely," in which the community chest and community taxes shall support their proper facilities, and only the actual costs of illness shall be charged to the patient? If we do, we will ease the burden of illness; we will help to preserve our voluntary insurance plans and voluntary hospitals; and we will point the way to the proper functioning of government in the field of health.

H. K. P.

MULTUM IN PARVO

The editor recently received the appended letter from the president of one of our smaller county medical societies. It illustrates so well a great accomplishment in a small compass that he feels like shouting it in the faces of many county medical society officers.

1200 Families Enlisted for MSAP

Walter F. Donaldson, M.D., Editor,
Pennsylvania Medical Journal.

After reading the editorial "America! Why Not an Alternative Plan?" on page 145 of the November issue of THE PENNSYLVANIA MEDICAL JOURNAL, I thought the following action taken by the Greene County Medical Society would be of interest to you.

At a meeting of the society on Oct. 8, 1948, Messrs. Irwin, Pete, and Lawry of the Blue Shield-Blue Cross

organization, Pittsburgh, presented the complete plans of Blue Shield to the county medical society members and suggested that a drive in Greene County be undertaken to enlist subscribers in the Blue Shield service program.

Following their presentation the entire subject was taken up for discussion by the members of the county medical society. This discussion lasted almost three hours, during which time most phases of the Blue Shield program were thoroughly discussed. A decision was eventually reached and was unanimously adopted by the society in which it was urged that Blue Shield proceed in Greene County in an attempt to enlist subscribers. Furthermore, the Greene County Medical Society went so far as to give full cooperation and to state publicly that they believe Blue Shield to be one of the good programs being offered to the public as a means of prepaying surgical and medical care.

An announcement came out in the newspaper stating the above, and the drive was undertaken. *This enrollment was held on a community-wide group basis under which individuals and individual families, regardless of where they worked, were permitted to join.* The number enlisted in the ten-day period in which the drive was undertaken was 1200 families. Blue Shield thought this most successful.

The society's membership felt that in taking this step they were definitely making headway against socialized medicine; that a good service was being promoted; and that it was a definite step forward and in the right direction; also that it was our duty as a society to come out publicly and announce to the general public that such voluntary insured plans were readily available.

There has been some comment in the county, all of which has been favorable, and others are now asking how they may obtain such insurance. I thought this would be of interest to you and I can see no reason why it could not be carried out by other county medical societies in the State of Pennsylvania.

(signed) BRUCE R. AUSTIN, M.D., *President*,
Greene County Medical Society (25 members),
Waynesburg, Pa.

There it is, ladies and gentlemen of all the county medical societies in Pennsylvania. Similar activities on your part, with proportionate results throughout the State, would quickly bring 500,000 new subscribers to Blue Shield to be followed soon, through good will engendered, by another million or more.

Which component society in Pennsylvania will be the first to do as did Greene County—invite a soliciting crew from Blue Shield to attend a society meeting prior to combing the county, with the society's well-publicized blessing, for family subscribers? It is by such methods that funds are raised to build or enlarge hospitals and other projects of little if any more value to the community than the thorough coverage by good non-profit voluntary insured medical service skillfully rendered by the great majority of the doctors of medicine of each community.

Why not, indeed? Why not?

Multum in Parvo

HELP CONTROL RHEUMATIC FEVER

The Commission to Study the Control of Rheumatic Fever of The Medical Society of the State of Pennsylvania is inaugurating a state-wide registration of rheumatic fever patients.

For several years it has been recognized that some type of survey is necessary as a basis for understanding the rheumatic fever problem, not only as applied to the State as a whole but also to its various communities. In the past the reporting of rheumatic fever as one of the infectious diseases has been grossly neglected. At present the only statistics available are those of the new State Department of Health rheumatic fever clinics and of a few large city hospitals. These will of necessity be inadequate and inaccurate for research purposes. When such available data are correlated with the more or less random statistics of school physicians, additional confusion results.

The type of survey now planned by the commission was selected because it can be economical in operation and relatively convenient for the reporting physicians. Its accuracy will depend upon the interest and cooperation of all physicians who see such cases.

Letters explaining the survey, together with a small initial supply of report cards, have been mailed to every physician in the State. The cards are of the prepaid postage type and are addressed to the Medical Society Offices in Harrisburg. Additional cards will be mailed to those physicians who begin reporting and to hospitals or clinics treating rheumatic fever patients.

The card as now designed will furnish basic information on patients under 21 years of age who have active rheumatic fever, or are convalescent from a known rheumatic infection. The number of actual attacks and the presence or absence of demonstrable cardiac complications are to be noted. As the survey develops from year to year, changes in the forms will be made as experience indicates the need for revision.

In addition to the accumulation of data on rheumatic fever, this survey will serve to stimulate awareness of the rheumatic fever problem. It is one of the most important features of the rheumatic fever control program affecting both professional and lay groups. In carrying out this program, the commission of nine members will be assisted by the chairman of the rheumatic fever committee of each county medical society.

In recent years considerable confusion and overlapping of interest in rheumatic fever have arisen with the appearance of various organizations concerned with cardiology, pediatrics, and

arthritis at national, state, county, and city levels. It is hoped that a survey controlled by our State Medical Society members can assist these various organizations in clarifying this most difficult problem.

ANDREW B. FULLER, M.D., *Chairman,*
Commission to Study Control of
Rheumatic Fever.

BUREAUS AND MONEY ONLY SUPPLIED BY COMPULSORY INSURANCE

Much has been written recently for readers of medical publications concerning voluntary sickness service insurance as an alternative for nationalized compulsory sickness insurance.

It remained for a lay woman of Washington, D. C. (Mrs. Agnes E. Meyer) to best express, in the editor's opinion, the serious import of this to the people of the United States, as their future is involved in the current discussions regarding compulsory or voluntary methods in the solution of the problem.

Medical Annals of the District of Columbia describes Mrs. Meyer as "an earnest, dynamic, public-spirited citizen whose thorough understanding of health and welfare problems is generally recognized."

Mrs. Meyer is then quoted as stating that "the battle over the organization of a nation-wide health program has been so violent because its solution will go to the roots of our existence as a nation of free men," and further because "the national health program is a question on which every responsible citizen must take a stand, since the answer to it all will affect the whole destiny of our nation."

She also makes it clear that "it is essential that the public should be informed on the actual progress toward sound public health planning that already exists in many of our states, and on a nation-wide scale.

"Many people who advocate a revolutionary, overcentralized, Federally dominated organization for health protection do so only because they see no other alternatives.

"The utopian promises of compulsory national health insurance have led some of our people to think that all we need is Federal legislation to implement it and, presto, every medical need will be met.

"Advocates of the Wagner-Murray-Dingell bill should never lose sight of the hard truth that

a national compulsory insurance program supplies merely organization and money but does not supply hospitals, doctors, nurses, dentists, and other essential personnel.

“If our citizens learn by direct participation in planning for their own health that the problem is closely enmeshed with their daily lives and with the availability of local facilities, they will be sure to reject authoritarian overcentralized plans that might destroy the very aims they seek.”

Mrs. Meyer further states: “We shall be forced to accept compulsory national health insurance before very long unless we make a greater success of voluntary health insurance without delay, especially for the low-income groups.

“To achieve this, the medical profession must throw itself wholeheartedly behind all cooperative insurance plans, whether for medical service or hospitalization.

“The various independent insurance systems in industry, labor unions, and other groups have come into being only because the Blue Shield has not improved the range and quality of its medical care.

“With the wholehearted cooperation of the American Medical Association, the Blue Cross, and especially the weaker Blue Shield the standard of medical care all over the country could be raised.”

The foregoing comments are of value because they come from a lay woman who is said to “frequently be caustic in her criticism of the A.M.A.” They are excerpted from an address made by Mrs. Meyer on Nov. 9, 1948, at the seventy-third annual meeting of the American Public Health Association before an audience doubtless comprised very largely of persons favorably disposed toward Mr. Oscar Ewing’s compulsory sickness insurance plan for the people of the United States of America.

STATE MEDICINE HASN'T WORKED ANY MIRACLES

In a recent Meet the Press program Lawrence Spivak quoted Oscar Ewing, head of the Federal Security Administration, as having said this: “Which is more important? The personal, selfish business and professional values of 180,000 practicing physicians in this country, or the health and well-being of some 68,000,000 of our population?”

Administrator Ewing might better have asked,

“Which is more important: the opinions and professional standards of 180,000 doctors who have been trained to practice medicine and who have raised American medical care to a level achieved nowhere else, or the supposed notions of some millions of laymen that if medicine became a Federal bureaucracy, better medical care would follow immediately?” Mr. Ewing implies that the objections of the doctors to socialized medicine are purely selfish and that better health would result from the bureaucratic scheme now contemplated.

None of these contentions is impressive, but that does not mean we shall not get socialized medicine. Indeed, the bloc of professional social workers, whose benefits from such a scheme are obvious, has sold the idea to millions. Already the private physician has been successfully smeared to the satisfaction of millions as a profiteer whose interest in medicine is that it pays better than selling vacuum cleaners.

However, it might not be a bad idea to take up at least a few of the extravagant claims made for public medicine. Dr. Melchior Palyi, economist at the University of Chicago, spent last summer in Europe studying the effects of “planning” in various fields. Medicine interested him particularly because its socialization gets defenders who would not favor the socialization of anything else. He found that there are two ways to socialize medicine: the Bismarck method, which was to make public functionaries of doctors; and the French method, which was to leave the practice of medicine alone, but send the patient’s bill to the state. (This latter appears to be the way Mr. Ewing wants it.)

The corruption in the Bismarck system resulted in such backbreaking costs and such bad medicine that the Germans had to change it. The French scheme works out about as badly. The patient sends his bill to the government, but the kickbacks became so scandalous that a huge army of functionaries has arisen to check the doctors’ bills. Inevitably the deficit of the health-insurance program mounts steadily and has to be replenished from other revenues. Inevitably also, the state, to postpone bankruptcy, must interfere more and more with medical practice.

Britain, which has taken a modified form of the German system, has already run into the pattern of rapidly rising costs. Doctors’ waiting rooms are packed as, according to Dr. Palyi, human nature asserts itself, “diluted by utopian ideas of the individual’s alleged right to costless service provided by the state, which is presumed to have unlimited resources.” The catch in so-

cialized medicine is, of course, that the insured can always take out more than he pays in. Unfortunately, the decline of medical standards, which always accompanies the encroachments of bureaucrats into professional matters, means that the medical care which can be guaranteed becomes less and less worth getting.

It seems to us that Congress, instead of swallowing whole hog what the social worker bloc

and the CIO-PAC and louder irresponsibles in politics think about the practice of medicine, might consult the doctors. They might at least enlighten us on just how 180,000 medical men are going to do the work of the 500,000 medical men who will be needed when pills and poultices are free, merely by taking their orders from social workers and Federal jobholders.—*The Saturday Evening Post*, Jan. 22, 1949.

THE VALUE OF A DOCTOR

In a recent schedule of United States Civil Service examinations, announcement is made of an examination for a medical officer at a salary of \$4,479 to \$6,235 per year. In the same announcement there is offered for an agricultural research scientist up to \$8,509, for a geographer up to \$10,305, chemist \$7,432, and astronomers, clinical psychologists, and geologists the same. An oceanographer can get up to \$10,305. Oh, for a life on the ocean wave!—*Journal of A.M.A.*, Jan. 8, 1949.

1948 HANDBOOK AVAILABLE

Copies of the 1948 Handbook of the American Medical Association are still available to physicians upon request. This 60-page booklet gives a brief description of the various councils and bureaus of the A.M.A. and contains a complete index to sources of information at the Association headquarters. Address requests to the Council on Medical Service, 539 North Dearborn St., Chicago 10, Ill.

TUMOR DIAGNOSTIC SERVICE FOR CHILDREN

St. Christopher's Hospital for Children, in conjunction with the Pediatric Department of Temple University Hospital, announces the establishment of a Tumor Diagnostic Service and Registry for Children. This service, which consists of tissue diagnosis, is available to any hospital in the State and is made possible by assistance from the State Department of Health through its Cancer Fund.

Material for diagnosis may be sent as mounted slides, tissue in paraffin blocks, or the gross specimen. The last is preferred; the specimen should be placed in 10 per cent formalin as soon as possible after removal. Ideally, the specimen should be placed in ten times its weight of formalin.

A brief synopsis of the clinical data should accompany the specimen.

Specimens should be sent through the pathology department of the hospital. When there is no pathologist, they may be sent by the surgeon or the medical director. This service is not designed to take work away from other pathology departments, but rather to offer

additional consultative diagnostic facilities. No fee will be charged by St. Christopher Hospital. Whatever charge is made to a patient will be by the pathologist or hospital sending the specimen.

In addition to the diagnostic service, another obvious benefit will be the collection of a large amount of material for the classification of tumors in infants and children. This is badly needed so that diagnostic accuracy can be improved and so that adequately catalogued data will be available for the determination of prognosis in relation to various forms of therapy which may be employed.

Owing to the decreasing death rate among infants and children from other causes, tumors are becoming of increasing importance and at some ages now rank as a major cause of death.

In some instances there will be an urgent need for prompt reporting of the results of the examination, and under such circumstances this will be provided by wire or telephone.

COMPULSORY DISABILITY INSURANCE

For medical men, the question of disability insurance has broad implications. It is obviously a short step from paying for loss of wages caused by sickness to paying the sickness costs themselves. Then, too, disability insurance sometimes puts the doctor on the spot. He must certify eligibility for benefits. If he says to a laggard patient, "Get up and go to work," the backfire in ill-will is hard to avoid.

Rhode Island and California already have statewide, compulsory programs. The Rhode Island plan is a state monopoly. The California plan is a combination of government and private enterprise; the state covers workers who don't have better protection through private plans. This year, New Jersey became the third state on the list. Its program will be patterned after California's.

Uncle Sam's Version: The Federal government is also in the business, but only for railroad workers. Though less than two years old, the Federal plan may not last much longer. Committees of both houses of Congress reported out bills that would kill the program. Though no further action was taken, there was strong feeling that the government was no longer justified in making a special case out of railroad workers.—*Insurance Economics Survey*.

THE JOB AHEAD

"Applications for appliances may be prescribed by general practitioners on Form E.C. 10 for National Health Service patients. Regulations, 1948 (S.I. No. 506) Third Schedule." (These appliances include everything from animal wool, breast relievers, corn plasters, eye shades, finger stalls, ice bags to trusses, tampons, and douches.)

—*British Medical Journal*.

"Dr. C. (rural single practice), area, 150 square miles; N.H.S. patients 1450; private patients, nil, dispensing; no hospital. N.H.S. cheque first quarter \$1,052; expenses per quarter \$500. He is therefore left with \$56 weekly salary to maintain his practice and live."

—DR. L. R. ROUTLEDGE, Herham Division.

This bird's-eye view of England's National Health Service should be adequate to stimulate each and every physician in America to respond to Oscar Ewing's challenge that a national health service in America is the panacea for all our ills.

The Medical Society of the State of Pennsylvania's Committee on Public Relations has accepted this challenge and recognizes the threat of government-controlled sickness insurance as its most immediate problem. Many times we will hear the accusation that our only interest in maintaining the present system of medical care is for selfish reasons. If that were true, we would have no right to organize a campaign under the banner of Public Relations. If we are fighting this battle in the interest of the American people and the American way of life—if we are striving to improve the quality and quantity of medical care and to promote voluntary sickness insurance to meet the catastrophic costs of unexpected illnesses, then our program is definitely in the interest of the public and rightfully is a part of our public relations program.

We can render no greater public service to the American people than to educate them to the inadequacy, the tremendous cost, and the socialistic tendencies of government-controlled medical care.

One of our chief handicaps is the fact that in many cases the spirit is willing but the flesh is weak. The time has come when we must respond to the dictates of our spirit and resolve to actively participate in this educational campaign.

Every county medical society must organize a campaign to reach every citizen in the county. A liaison committee should be established to contact the professional organizations in each county, such as the bar, engineering, pharmacists, dental and ministerial associations, and enlist their cooperation in preserving our free enterprise system of medical care. Such organized groups realize that the medical profession is just the first to be regimented. They envision their own groups being attacked and subjugated should medicine succumb.

Our educational program must be planned to reach all segments of the public. Everyone would be affected; therefore, all groups, classes, races, and creeds should be informed. A committee should be established to discuss the over-all problem of medical care with the civic and union leaders in each county.

The "spoken word" will no doubt be our most effective approach; therefore, each physician should become thoroughly acquainted with the shortcomings of compulsory government sickness insurance as compared to the more practical alternative—the voluntary sickness insurance plans. Each should be prepared and willing to accept speaking engagements before community organizations. A few minutes' conversation with each patient can be used to advantage to influence his or her thinking.

Some physicians are keeping a scrapbook on their waiting room tables in which they have mounted news clippings, editorials, and columnists' opinions such as Dorothy Thompson's column on December 20, 1948, George Sokolsky's on December 21, or the editorial which appeared in the *New York Daily News* entitled "Why Smear the Doctors?" Such reading will give you an entree to discuss the subject of compulsory sickness insurance with your patients.

High schools and colleges should be encouraged to discuss or debate this subject. The department heads of economic or social studies should be contacted and furnished with subject material. They should also be informed of the willingness of your county medical society to provide physicians to address their classes should they so desire.

The Medical Society of the State of Pennsylvania's Committee on Public Relations is prepared to furnish you with adequate material to thoroughly familiarize you with this subject. Material such as the "Brookings Institution Report," "The Case Against Socialized Medicine," "Check and Double Check," "Uncle Sam, M.D.," and other current material will be sent to you on request in the form of a library package. Just drop a line to us at 230 State St., Harrisburg, Pa.

This fight is not going to be an easy one. We have a formidable foe who will not be easily discredited nor readily discouraged. The cooperation of the entire profession is demanded if we are to be successful. We can no longer afford to say, "Let Harry or Joe do it"; that's too dangerous a practice when the stakes are as high as they are at the present time. Too many times Harry and Joe say, "Let Dick and Tom do it." Consequently, it never gets done! Each individual physician must assume the role of a crusader and preach this gospel of the free enterprise system of medical care, in contrast to the inherent dangers of a compulsory government-controlled system of medical care, to the far corners of his practice and his community.

He who resigns himself to the apparently inevitable, without first making a stand for what he believes to be right and just, is not worthy to display the crest of his profession.

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*

8104 Jenkins Arcade

Pittsburgh 22, Pa.

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State From What It Is to What It Ought to Be.

THIRTY-SEVENTH ANNUAL SECRETARIES-EDITORS CONFERENCE

(None held 1940-44)

To Component County Medical Society Secretaries, Editors, Presidents, and Presidents-elect and their respective 1949 Chairmen of Committees on Public Health Legislation, Public Relations, and Medical Economics.

DEAR DOCTOR:

The thirty-seventh annual *Secretaries-Editors Conference* will be held in the Penn-Harris Hotel, Harrisburg, on Thursday afternoon and evening, March 3, and continued on Friday morning, March 4, 1949.

The Board of Trustees and Councilors of The Medical Society of the State of Pennsylvania, as always, recognizing the great potentialities of these winter meetings have provided sufficient funds to pay the reasonable travel and hotel expense of the above-mentioned four to seven designated representatives of each of our 61 county medical societies.

Post cards are enclosed for the purpose of making early hotel reservation for Thursday night, March 3, and for the Thursday evening dinner. Because of the anticipated large attendance of county and state medical society representatives (in 1948 registered attendance was 170), it will be smart to return post cards promptly and wise to anticipate two from the same county society occupying a double room.

We enclose also an epitome of the program as now arranged by the committee chosen at last year's conference: Drs. James Z. Appel, Joseph C. Bolton, Wilbur E. Flannery, and George R. Good, chairman.

Cordially yours,

WALTER F. DONALDSON,
Secretary-Treasurer.

PROGRAM

Thursday, March 3, 1949

Registration 12:30 to 1:30 p.m.

(p.m.)

1:45 Welcome.

Introduction of new county society secretaries and editors—Walter F. Donaldson, M.D., Secretary-Treasurer, The Medical Society of the State of Pennsylvania.

2:00 What Does the Woman's Auxiliary Expect from the County Medical Society?—Mrs. Paul C. Craig, Reading, President, Woman's Auxiliary to The Medical Society of the State of Pennsylvania.

2:30 Highlights of the Recent Public Health Survey

in Pennsylvania—Roscoe P. Kandle, M.D., American Public Health Association.

3:00 Responsibility of the Local Society in Disciplining Members—Charles V. Hogan, M.D., Pottsville, Trustee and Councilor, Fourth Councilor District, The Medical Society of the State of Pennsylvania.

3:30 Medical Publicity and Radio-Press Relations (symposium).

Moderator—Joseph C. Bolton, M.D., Harrisburg. Press—Mr. George Grey, Editor, *Uniontown Evening Standard*.

Radio—Mr. David Bennett, Harrisburg.

Mr. Leo E. Brown, Executive Assistant, Committee on Public Relations, The Medical Society of the State of Pennsylvania.

4:45 Adjournment.

6:00 Reception.

6:30 Dinner.

After-dinner program:

Propaganda and Political Medicine—Forest A. Harness, Chairman of House of Representatives Committee on Publicity and Propaganda, 80th U. S. Congress.

Friday, March 4, 1949

(a.m.)

9:30 The Hospital and the Private Physician—Elmer Hess, M.D., Erie, Past President of The Medical Society of the State of Pennsylvania.

10:00 Orientation of New Members—George S. Klump, M.D., Williamsport, Trustee and Councilor, Seventh Councilor District, The Medical Society of the State of Pennsylvania.

10:30 Rheumatic Fever—Andrew B. Fuller, M.D., Pittsburgh, Chairman, Commission to Study Control of Rheumatic Fever, MSSP.

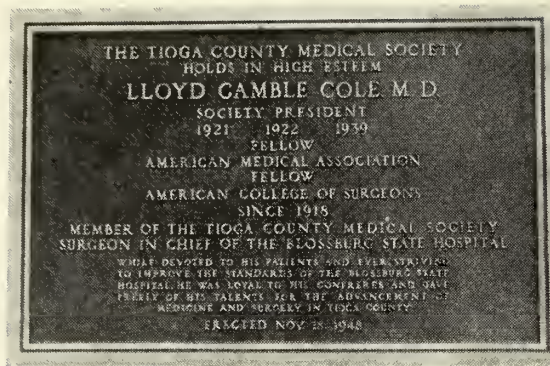
11:00 Medical Society Influence on MSAP Enrollment—Bruce R. Austin, M.D., Waynesburg, 1948 President of Greene County Medical Society of the MSSP.

12:00 Adjournment.

HOSPITAL COSTS

Do you think it is fair to make private patients pay for hospital prestige activities? Do you believe that many hospitals might be operated more economically and could profitably employ an efficiency expert to point out wastage?

If such thoughts have not occurred to you, the editor recommends reading the editorial "Hospital Costs" in this issue.



SURGEON HONORED BY HIS COUNTY MEDICAL SOCIETY

Appended are remarks made at the unveiling of the Lloyd G. Cole, M.D., bronze memorial tablet, Nov. 18, 1948, at the Blossburg State Hospital, by Archibald Laird, M.D., editor of the *Bulletin* of the Tioga County Medical Society.

This occasion marks the sesquicentennial of medical service in Tioga County. The committee is deeply grateful to the physicians who have provided the day's excellent scientific program and to the hospital superintendent, Charles F. Bowers, and his staff for the delightful reception accorded the Tioga County Medical Society and guests. What has taken place thus far today is a fitting tribute to the pioneers in medicine and we are happy that so many representatives of all fields of endeavor are with us on this historic occasion.

William Willard, M.D., became the first resident physician in Tioga County when he settled in Willardsburg, now Tioga, in 1798. His humanitarian service has been carried on by hundreds of medical practitioners since that date and we take special pride in the record of the Darling family who supplied the county with one physician in each generation since 1829.

Medical society organization had its original supporters in the persons of Drs. Nelson Packer and Wellington W. Webb in 1860.

Arthur L. Bottum, of Westfield, established the first hospital in the county in 1880.

Augustus Niles devoted his time and energy to the elevation of medical standards by serving on the first board of medical education and licensure in the State of Pennsylvania in 1894.

Solomon P. Hakes served the Tioga County Medical Society as an officer for forty years and was the first physician in the county to receive the fifty-year certificate of The Medical Society of the State of Pennsylvania. During his long tenure as secretary of the society he was considered the champion of medical ethics in the county.

In recent years, one of our number has combined all of the outstanding attributes of those pioneers and has added more honors to an honorable profession. Unselfishly devoted to the cause of alleviating human suffering, endowed with the rare quality of inspiring leadership, sustained by an abundant supply of tireless energy, a patron of all that is good in medicine, his contributions are without parallel. Avoiding the privilege of limiting his time and talents to a narrow portion of his chosen profession, his influence is felt in many

fields. As a surgeon, teacher, humanitarian, and administrator, he has made the ideal of "Service Above Self" spread health and happiness in his community, his county, and his commonwealth. Through the years he has carried the good-will of those who labor with him.

By virtue of his dynamic and influential leadership he built a modest hospital into a great institution. His breadth of vision made it impossible for him to circumvent local medical organizations or compromise the rules of professional conduct. Time and again he has left the ceaseless activity of his own institution to participate in local, state, and national medical gatherings to further the cause of medical education and a united profession.

Distinction was added to his recognized skill as a surgeon when he became a founder-member of the American Board of Surgery.

Numerous organizations have made use of his wise counsel: the Mansfield State Teachers College, the Blossburg State Hospital, the American Medical Association, The Medical Society of the State of Pennsylvania, the American College of Surgeons, the American Board of Surgery, the Tioga County Medical Society, the Blossburg Rotary Club, the Northwestern Pennsylvania Military District, the Veterans Administration, and many insurance companies.

During the past thirty years he has lived up to the lofty ideals and traditions of the medical profession and his associates in the Tioga County Medical Society hold in high esteem

LLOYD GAMBLE COLE, M.D.

Society president 1921, 1922, and 1939; Fellow of the American Medical Association and Fellow of the American College of Surgeons; since 1918 a member of the Tioga County Medical Society and surgeon-in-chief of the Blossburg State Hospital. While devoted to his patients and ever striving to improve the standards of the Blossburg State Hospital, he was loyal to his confreres and gave freely of his talents for the advancement of medicine and surgery in Tioga County.

The day's program included morning and afternoon scientific sessions given by the hospital staff and by visiting physicians from Pittsburgh and Sayre, and from Binghamton and Elmira, N. Y.

The evening program devoted to the observance of the sesquicentennial of the Tioga County Medical Society included the following:

Presiding Officer—Eleanor Larson, M.D., president of Tioga County Medical Society.

Invocation—Rt. Rev. Joseph Nallin.

Address of Welcome—Eleanor Larson, M.D.

One Hundred and Fifty Years of Medical Service in Tioga County—Archibald Laird, M.D., editor of Tioga County Medical Society *Bulletin*.

Anniversary Recognition.

I. PROFESSIONAL TRAINING AND CONDUCT.

American Medical Association—Arthur W. Booth, M.D., F.A.C.S., past trustee.

American College of Surgeons—Donald Guthrie, M.D., F.A.C.S., governor.

American Board of Surgery—George W. Hawk, M.D., F.A.C.S.

The Medical Society of the State of Pennsylvania—Howard K. Petry, M.D., F.A.C.P.

AMA SPECIAL ASSESSMENT NOTICE

To the Members of The Medical Society of the State of Pennsylvania.

DEAR DOCTOR:

Doubtless you have previously both read and heard of the \$25 assessment by the American Medical Association against each of its members, including you, and the undersigned, and all of the 10,460 other Pennsylvania doctors who are active members of their own county and state societies and of the AMA.

Continuing the progressively enthusiastic and unanimous approval of this evidence that the AMA has, in behalf of the best health interests of the American people, *become thoroughly realistic*, the Board of Trustees of The Medical Society of the State of Pennsylvania at a meeting on Dec. 17, 1948, unanimously approved the AMA request (see Secretary Lull's recent letter to you) that each state medical society "collect this assessment through county units or in any other way desired."

To that end a statement and a stamped addressed envelope are enclosed, by means of which the statement accompanied by your check may be returned.

Sincerely yours,

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*.

Jan. 3, 1949

NOTICE OF ASSESSMENT

The American Medical Association has requested your state medical society to collect this year a \$25 assessment. Please make check in favor of *American Medical Association—Assessment* and mail to The Medical Society of the State of Pennsylvania, 8104 Jenkins Arcade, Pittsburgh 22, Pa. Stamped addressed envelope enclosed.

If your county medical society has combined this AMA assessment with its own dues for 1949, the bookkeeping of your county, state, and national medical societies will be greatly simplified if these two obligations are paid by *separate* checks.

AMA assessment check sent via
state medical society ☐

AMA assessment paid through
county medical society ☐

_____, M.D.
Name

County (Pa.)

To The American Medical Association, *Debtor*
Special Assessment \$25.00

The above communications were sent to active members by counties alphabetically, the first being mailed out January 7 (Adams County).

The receipt of the first few hundred checks covering the \$25 AMA assessment was of exciting interest to those in the office of the Secretary-Treasurer. Doubtless this will subside with the growing task involved in the necessary bookkeeping and correspondence arising from the increased flow of remittances totaling 1919 from 49 counties at the end of the third week with 4000 statements not yet mailed out.

II. PROFESSIONAL SERVICE.

- Guthrie Clinic and Robert Packer Hospital—Stanley Conklin, M.D.
 Williamsport Hospital—Albert F. Hardt, M.D., F.A.C.S., and John B. Nutt, M.D.
 Potter County Memorial Hospital—Herman C. Mosch, M.D.
 Soldiers and Sailors Memorial Hospital—Sterling C. Basney, M.D., and B. Clifford Woolsey, superintendent.

III. PROFESSIONAL ORGANIZATION.

- Bradford County Medical Society—Orlo G. McCoy, M.D., president.
 Chemung County Medical Society—Philip J. Riley, M.D.
 Lycoming County Medical Society—Reynolds M. Grieco, M.D., president.
 Potter County Medical Society—Clarence E. Baxter, M.D., president.
 Steuben County Medical Society.
 Woman's Auxiliary to Tioga County Medical Society—Mrs. Archibald Laird, president.

IV. CIVIC SERVICE.

- Mansfield State Teachers College—Dr. James G. Morgan.
 Pennsylvania Department of Welfare—Bruce Dunlap.
 Blossburg State Hospital Board.
 Blossburg Rotary Club—Richard H. O'Donnell.
 Veterans Administration—John H. Doane, M.D., chief medical officer.

V. ALLIED PROFESSIONS RELATIONSHIPS.

- Tioga County Dental Society—Emerson Evans, D.D.S., president.
 Tioga County Nurses Association.
 Tioga County Court—Hon. Thomas A. Crichton.
 Tioga County Bar Association—Charles G. Webb.
 Tioga County pharmacists—Edward Donley.
 Tioga County clergy—Orrin G. Cocks, D.D.
 Tioga County public schools—Walter G. Clark.

ARMED FORCES MEDICAL ADVISORY COMMITTEE

"Early this week—possibly over the weekend—Secretary of Defense Forrestal is expected to announce appointment of his long-awaited armed forces medical advisory committee. Its chairman will be Charles Cooper, board president of Presbyterian Hospital, New York City, and former American Telephone and Telegraph official. The committee will be composed of the following: Drs. Maurice Pincoffs, University of Maryland; Edward D. Churchill, Harvard University; Howard A. Rusk, New York University; Paul R. Hawley, Blue Shield; Richard L. Meiling, of AMA's Council on National Emergency Medical Service; Raymond Allen, Seattle, Wash.; Michael DeBakey, Baylor University; Paul Titus, Pittsburgh; Walter H. Scherer, Houston, Tex., and the medical heads of the Army, Navy, and Air Force. All are doctors of medicine except the chairman and Dr. Scherer, who is a former president of the American Dental Association.

"It will be seen that most of the appointees are not only widely known professionally but have taken prominent parts in medical affairs nationally, serving on government committees or in other capacities. While they

constitute an advisory group, their potential influence will be considerable in framing military medical policies—manpower (including doctor-deferment practices), logistics, hospital utilization, postgraduate education of medical department personnel and adjustment of their salaries. The committee will take the place of Secretary Forrestal's present medical advisory unit, the so-called Hawley Board, and inherit more than a dozen reports made by that board in the last several months but which have not been acted upon. Organization meeting of the new committee isn't likely to be held before early 1949."—"Washington Report on the Medical Sciences," Dec. 13, 1948.

CONTRIBUTIONS TO MEDICAL BENEVOLENCE FUND

The Committee on Medical Benevolence makes grateful acknowledgment of the following contributions to the fund. These have also been previously acknowledged individually.

A member, Philadelphia County	\$10.00
Woman's Auxiliary, Potter County	11.00
Previously reported	200.68

Total contributions since 1948 report \$221.68

CHANGES IN MEMBERSHIP OF COUNTY SOCIETIES

New (47) and Reinstated (10) Members

ALLEGHENY COUNTY: Alfred A. Conti, George M. Dulabon, Louis Goodman, John S. Liggett, and Edward L. Waisbrot, Pittsburgh.

BEAVER COUNTY: (Reinstated) Franklin A. Bontempo, Rochester.

BRADFORD COUNTY: Willard E. Dotter, Sayre.

BUCKS COUNTY: Howard P. Thomas, Jr., Telford. (R) Charles W. Weber, Langhorne.

CAMBRIA COUNTY: Donald E. Burkett, Portage; Charles F. Reeder, Geistown.

CARBON COUNTY: (R) James F. Forrest, Summit Hill.

CLINTON COUNTY: Arnold M. Stevens, Lemar.

COLUMBIA COUNTY: Thomas S. Cretella and Ferdinand F. Szabo, Berwick.

DAUPHIN COUNTY: Robert L. Harding, Harrisburg.

DELAWARE COUNTY: Walter H. Beadling, Jr., Prospect Park; Joseph M. Brill and Peter H. Lebischak, Chester.

FAYETTE COUNTY: William F. Colvin, Vanderbilt. (R) Gerald M. DeWoody, Belle Vernon.

GREENE COUNTY: (R) Horatio B. Miller, Crucible.

INDIANA COUNTY: Herbert C. Long, Jr., Indiana; Kenneth H. Sayers, Clymer.

LACKAWANNA COUNTY: Robert P. Bfundage, Peckville; Anthony J. Cummings, Scranton. (R) William H. Conway, Clarks Summit.

LANCASTER COUNTY: Eugene V. Johnston, Christiana; Charles J. Kilduff, Jr., and Einar A. Palmgren, Jr., Lancaster.

LEBANON COUNTY: Harry R. Wilson, Jr., Lebanon.

LEHIGH COUNTY: William R. DeWar, Catasauqua; John A. Griffin, Kermit Kistler, Raymond J. Lutz, and George W. Thoma, Allentown.

MERCER COUNTY: Wayne D. Daugherty, Grove City.

MONTGOMERY COUNTY: Theodore J. Berry, Wynne-wood.

MONTOUR COUNTY: Harry W. McCurdy, Danville.

NORTHAMPTON COUNTY: James G. Whildin, Bethlehem.

PHILADELPHIA COUNTY: Nathaniel H. Copeland, Howard Z. Fretz, Mario E. Fornasier, Selma Kramer, Leonard I. Lapisohn, Thomas Scarlett, and Louis A. Soloff, Philadelphia.

SUSQUEHANNA COUNTY: (R) Selton S. Stevens, Wyoming.

WASHINGTON COUNTY: John K. Hootman and Harry J. Thompson, Washington; Gale Richardson, Fredericktown; William R. Rongaus, Donora; E. J. Saltsman, Houston.

WESTMORELAND COUNTY: Theodore T. Bronk, Irwin. (R) Harold J. Kinney and Mary Kinney, Ligonier; Carl E. Wasmuth, Scottsdale.

Resignations (8), Transfers (13), Deaths (15)

ALLEGHENY: *Transfer*—Howard C. MacMillan, Pittsburgh, from Beaver County Society. *Resignations*—Harry M. Geyer, Washington, D. C.; James A. Heckman, Pittsburgh; Robert Karpas, Long Island, N. Y.; Wm. H. Oetting, Jr., New Rochelle, N. Y. *Deaths*—Walter G. Aughenbaugh, Pittsburgh (Univ. Pgh. '13), November 23, aged 59; John S. Mackrell, Pittsburgh (Univ. Pgh. '09), November 21, aged 64; Adelbert E. Torrens, West View (Univ. Pgh. '02), November 13, aged 74.

BEAVER: *Transfer*—Robert M. McKee, Beaver, from Allegheny County Society.

BERKS: *Deaths*—Ernest R. Scholten, Reading (Albert Univ., Prussia '93), October, aged 81; Clarence W. Schwalm, Shoemakersville (Temple Univ. '23), October, aged 64.

BLAIR: *Resignation*—Wolfgang F. Vogel, Paterson, N. J.

CAMBRIA: *Death*—William E. Matthews, Cramer (Jeff. Med. Coll. '87), October 30, aged 88.

DAUPHIN: *Resignation*—George J. Coloviras, Jr., Lafayette, Ind. *Death*—John T. Burnite, Harrisburg (Hahn. Med. Coll. '04), October 19, aged 69. *Transfers*—Fred B. Hooper, Harrisburg, from Perry County Society; John E. Kurtz, Harrisburg, from Allegheny County Society.

DELAWARE: *Transfer*—C. Stephen Stahlneck, Media, from Philadelphia County Society.

ELK: *Death*—Leo T. McKee, St. Marys (Georgetown Univ. '28), October 26, aged 45.

ERIE: *Death*—Francis P. McCarthy, Erie (Jeff. Med. Coll. '01), October 28, aged 69.

LACKAWANNA: *Death*—Lloyd J. Rossiter, Olyphant (Balt. Med. Coll. '97), October 28, aged 70.

LANCASTER: *Death*—Michael G. Chadman, Lancaster (Univ. Pa. '21), November 15, aged 52.

LEHIGH: *Transfer*—Harry L. Cunin, Allentown, from Northampton County Society.

McKEAN: *Death*—William C. Hogan, Bradford (Univ. Pgh. '02), November 20, aged 74.

MERCER: *Transfer*—Donald H. Walker, Sharon, from Montour County Society.

NORTHAMPTON: *Transfer*—Thomas A. Cope, Bethlehem, from Philadelphia County Society.

NORTHUMBERLAND: *Transfers*—Louis P. Baylor and Benjamin Schneider, Danville, from Montour County Society.

PHILADELPHIA: *Transfer*—John W. Carnwath, Philadelphia, from Montgomery County Society. *Resignations*—Victor S. Hirsch, Cleveland, Ohio; Henry V. Ratke, Rochester, Minn. *Deaths*—Ella Buchanan Custer, Philadelphia (Woman's Med. Coll. '83), November 8, aged 87; Horace C. Bare, Philadelphia (Univ. Pa. '01), November 18, aged 70.

WASHINGTON: *Transfer*—M. H. Applbaum, Charleroi, from Allegheny County Society.

WESTMORELAND: *Death*—Joseph M. Steim, New Kensington (Med.-Chi. Coll. '98), November 13, aged 71.

WYOMING: *Transfer*—John J. Foote, Meshoppen, from Luzerne County Society.

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since October 31. Figures in first column indicate county society numbers; second column, State Society numbers.

Nov.	1	Philadelphia	3153-3170	10446-10463	\$135.00
		Armstrong	47	10464	7.50
	3	Bucks	96	10465	7.50
	5	Westmoreland	203	10466	7.50
		Montour	40	10467	7.50
	8	Clinton	29	10468	7.50
		Columbia	1-2	3-4	30.00
		Montgomery	331	10469	7.50
		Bucks	97	10470	15.00
		Bradford	48	10471	7.50
		Dauphin	252	10472	7.50
	12	Greene	28	10473	15.00
		Greene (1947 dues)			15.00
		Montgomery	1-17	5-21	255.00
		Washington	143-147	10474-10478	37.50
	15	Susquehanna	18	10479	15.00
		Delaware	287-289	10480-10482	45.00
	22	Indiana	43-44	10483-10484	30.00
		Northampton	2	22	15.00
	23	Cambria	1-2	23-24	30.00
	24	Beaver	139	10485	15.00
		Lehigh	121-216	10486-10490	52.50
	27	Carbon	31	10491	15.00
		Carbon (1947 dues)			15.00
		Westmoreland	1-2	25-26	30.00
		Westmoreland	204-206	10492-10494	45.00
		Fayette	118-119	10495-10496	30.00

HAVE YOU USED THE PACKAGE LIBRARY SERVICE?

Have you taken advantage of the facilities offered by the package library of The Medical Society of the State of Pennsylvania? Over 97,000 reprints are now filed in the library for your use.

Prior to 1944 the average yearly number of requests was approximately 350. However, from 1944 to 1948 inclusive, there has been a continuous increase in usage. There were 899 requests filed during 1947, an increase of 196 requests over the total for 1946. During the first eleven months of 1948 there were 1098 requests.

A package of reprints will be sent immediately for a loan period of two weeks to any member of the State Society. There is a charge of 25 cents for each subject requested to cover postage and part of the expense of collecting the material. Send requests to the Librarian, 230 State St., Harrisburg, Pa.

Subjects requested between November 1 and November 30 were:

Peptic ulcer	Leukemia	Cutaneous sarcoid	Blood chemistry
Thymol turbidity tests	Blood deficiencies	Autopsies	Burns
Tinea capitis	Tattooing	Pancreatitis	Silicosis
Lupus erythematosus	Pneumonia in children	Venereal disease	Toxicity of cold wave
Polycystic kidney	Erythema multiforme	Gonorrhea	Allergy in children
Multiple sclerosis (2)	Periarteritis nodosa	Poliomyelitis	Facial paralysis
Contract practice	Diabetes	Sulfa drugs	Radial paralysis
Geriatrics	Physiology of eye	Vivisection	Peroneal paralysis
Anesthesia	Intra-ocular fluid	Ménière's disease	Halitosis
Modern drugs	Scarlet fever	Duodeno-colic fistula	Perineal field block
Effects of mustard gas	Cancer therapy	Duodenal diverticulum	Psychiatry
Glycuronic acid	Cancer of breast	Aplastic anemia	Gout
Drug addiction	Feeding of infants	Osteomyelitis	
Fat embolism	Undulant fever	Use of radioactive iodine	
Rutin	Adaptation syndrome	Treatment of colonic fistulas	
Alzheimer's disease	Hexokinase	Effect of electrical shock	
Medicine in Virginia	Post-spinal headache	Cardiovascular diseases	
Gastric polyposis	Bile duct calculi	Use of penicillin in therapy of pneumonia	
Acute head injuries	Cholangiography	Complications following cholecystectomy	
		Tuberculous peritonitis	
		Roentgen therapy of cancer of larynx	
		Causes of bronchial asthma	
		Congenital dislocation of the hip	
		Psychosomatic medicine (2)	
		Foster-Kennedy syndrome	
		Hospital administration	
		Socialized medicine (2)	
		Medical treatment of hypertension	
		Rice diet in hypertension	
		Intercostal nerve block	
		Wounds and injuries of the face	
		Physiology of vocal cords and larynx	
		Herniation of intervertebral disk	
		Malaria and typhoid therapy for paresis	
		Use of propyl-thiouracil in hyperthyroidism	
		Gas gangrene infections of the uterus	
		Fatty metamorphosis of liver	
		Drug treatment of alcoholism	
		Blood and blood derivatives	
		Pregnancy complicated by diabetes	
		Dermatitis herpetiformis	
		Preservation of eyesight	
		Cancer of uterus and cervix	
		Carbohydrate metabolism	
		Use of vasopressors in spinal anesthesia	
		Vitamin E in heart disease	
		Ultraviolet air sterilization	
		Mortality in the United States in 1945	
		Clinical pathology in a hospital	



Bowel Management of the Irritable Colon . . .

"As an aid in reestablishing a normal rhythm, the temporary use of a bland bulk-producer . . . may be beneficial. . . . Patients having irritable colon who believe they are suffering from constipation commonly use high-residue diets, . . . They may not realize that this practice is similar to using irritating cathartics or large enemas and often increases the tendency to constipation by increasing spasm of the colon."*



Metamucil is "a bland bulk-producer" which gently initiates reflex peristalsis and movement of the intestinal contents. The "smoothage" therapy of Metamucil encourages a return of the normal function of the colon without irritating the mucosa.

METAMUCIL®

is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.



SEARLE RESEARCH IN THE SERVICE OF MEDICINE

*Collins, E. N.: The Diagnosis and Treatment of Irritable Colon: Physiologic, Local, Irritative and Psychosomatic Factors, *M. Clin. North America* 32:398 (March) 1948.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the co-operation of the Pennsylvania Tuberculosis Society
and The Medical Society of the State of Pennsylvania

“**D**OCTOR, should I do any flying?” Many patients with tuberculosis of the lungs want an answer to this sometimes difficult question. Whether or not it is wise for them to fly depends on a number of things. Some can do it safely. The rest are facing danger.

HAZARDS OF FLYING FOR TUBERCULOUS PATIENTS

Air on the ground is much heavier than it is a mile or two up. At sea level it exerts a pressure of 15 pounds on each square inch of the body surface, which is not felt because it presses equally on all sides. This pressure diminishes rapidly as one rises from sea level. In other words, the higher one goes, the lower the pressure.

Inside Air Expands

A toy balloon has rubber walls that stretch. Take this balloon up in the sky and it will get bigger because the air inside expands as the pressure of the air surrounding the balloon decreases.

Many patients with pulmonary tuberculosis have abnormal collections of air in their bodies. A cavity in the lung represents such a collection—so do pneumothorax and pneumoperitoneum. They are major hazards in flying since they behave like the balloon.

The size of these abnormal collections of air will vary with the height above sea level. They will become 7 per cent larger at 2000 feet, about 50 per cent larger at 10,000 feet, and nearly 100 per cent larger at 16,000 feet.

Commercial planes usually fly below 10,000 feet. They may have to fly higher when crossing mountains or encountering storms. At any height, changes can be expected in all collections of air.

Breathing Hazards

A refill for pneumothorax or pneumoperitoneum is calculated to produce the right pressure on the lung. A bigger refill might do harm. Going up in an airplane is just like getting a bigger refill.

Flying is definitely hazardous for those who have pneumothorax complicated by adhesions, as they may break or they may pull hard enough to rip the surface of the lung. Air will then leak into the pneumothorax air pocket and dangerously increase its size. Massive increase will push the heart toward the opposite side of the chest and compress the opposite lung. If respiration is embarrassed, the patient may become alarmingly short of breath, have palpitation, sudden weakness, even shock.

Some patients have pneumothorax compressing both lungs. Their capacity to breathe is much diminished. Flying for them is contraindicated, as it can well bring on severe shortness of breath and other frightening symptoms.

Pressure and Hernia

Beneath the breast bone one lung is separated from the other by a group of structures known as the mediastinum. This mediastinum has several weak spots. Through these a pneumothorax may bulge into the opposite side of the chest. This is called a hernia of the mediastinum and is not without danger even on the ground. In flight, such a situation can become exceedingly uncomfortable.

Those patients who notice discomfort after pneumothorax or pneumoperitoneum refills will certainly have greater discomfort when flying. Those who are short of breath on exertion will have more difficulty when flying. Patients who have recently bled from the lungs should postpone any thought of flying because of the danger of reopening the blood vessel.

Cavities produced by tuberculosis frequently contain air which expands in flight. When air



even after **40**, a woman's work is never done...

Dishes, dustpans, a thousand details...the three "d's" of household drudgery...are challenge enough at any age, but a stack of dinner dishes can look mountain high to the woman in the menopause. This is a disquieting aspect of the daily life of such patients that physicians can bring into proper perspective with "Premarin."

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can escape from a cavity, the danger is minimal. If an obstruction is present, the trapped air in expanding may tear the walls of the cavity or injure a blood vessel with subsequent bleeding which can threaten life.

To prevent serious discomfort or damage, some patients may have to breathe oxygen through a mask when flying. Other patients will fare better if air is removed from their pneumothorax or pneumoperitoneum before they fly. Airplanes that fly far above the earth, 20,000 or 30,000 feet, are pressurized. Pumping systems maintain an air pressure inside the cabins simulating conditions much closer to the ground. Otherwise, no one could remain alive at those heights. Nevertheless, a few patients face danger in a pressurized airplane because the pressure in the cabin cannot be kept at ground level values.

The tuberculous patient is wise who consults his doctor before he flies.

Hazards of Flying for Tuberculous Patients, Ezra Volk Bridge, M.D., The NTA Bulletin, May, 1948.

MATERNAL DEATHS BY COUNTIES

On page 392, this issue, will be found a listing of "Deaths from Selected Causes in Pennsylvania, July, 1948." The column "Maternal Deaths" totals 18, divided by counties as follows: Allegheny, Blair, and Philadelphia, 3 each; Lackawanna, 2; Dauphin, Fayette, Indiana, Lawrence, Lehigh, Luzerne, and Montgomery, 1 each. It is important that the causes for these deaths were determined and discussed by members of the medical societies in the counties where such deaths occurred.

Let us respect gray hairs, especially our own.—J. P. SENN.

KEEPING UP WITH MEDICINE

Recent advances in biochemistry have highlighted the importance of minerals in growth and development of the human organism.

* * *

A prominent northwest surgeon now recommends that no hysterectomy be performed until there has been consultation with another competent surgeon. He cites the 1946 experience of a large city hospital where 24 per cent of 187 hysterectomies were, upon review, considered as contraindicated.

* * *

For the routine treatment of infections of the urinary tract, mandelic acid and the sulfonamide compounds are still the drugs of choice.

* * *

The use of tetra-ethyl-ammonium chloride has been advised as the best means of securing successful post-operative results in the surgical treatment of hypertension.

* * *

Hippocrates said that, of all the professions, medicine is the most distinguished, since it aims not only to heal the body but also to calm the mind and spirit.

* * *

Be willing to take time to listen to a patient until he feels that he has a friend who is trying to understand his case and to help him.

* * *

Chronic brucellosis should always be considered in the differential diagnosis of any chronic, low-grade, remittent, or recurring illness with tiredness and exhaustion as a feature.

* * *

Bearing in mind the physiologic effects of the tocopherols (vitamin E), they may prove of value in cases of osteomyelitis and delayed wound healing.

* * *

Anal cystitis and perianal dermatitis, the latter frequently of fungus origin, are the two commonest causes of pruritus ani.

* * *

Henry Christian recently called attention to the fact that in these days of specialization the medical student is the only one now supposed to know medicine as a whole.—*The Ohio State Medical Journal*, October, 1948.

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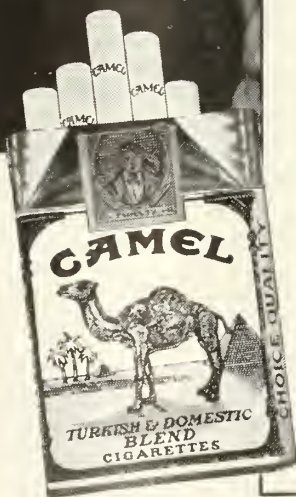


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THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

547 Water Street

Indiana, Pa.

OUR PART IN LEGISLATION

Legislation to be submitted to the Pennsylvania Legislature is traditionally prepared in the interim between the November election and the convening of the Legislature early in January. We read and hear daily the opinions of columnists, commentators, politicians, the man in the street, and the woman next door as to whether or not the President and his Congress will be able to carry out all that was promised previous to November 3.

We are aware, both from pre- and post-election declarations, that the President is committed to a Federal compulsory health insurance program, and that this measure will have a high priority on the Eighty-first Congress agenda. Many will interpret this to mean complete and absolute government control of the distribution of medical care to the majority of the people. Others may be optimistic enough to believe that, though the new Congress may include some application of health insurance principles, it will not go far toward approving the tremendous costs against which must be weighed the hoped for but doubtful benefits. In any event, we of the Auxiliary can no longer shun our definite responsibility to become thoroughly informed on the subject of *compulsory versus voluntary* medical insurance.

What with more doctors dying or retiring in proportion to the recently increased population than there are new ones entering practice, our husbands have time for little else than "extending to all people in all communities the best possible medical care." From what group then must come the answer to the question of the American public, "What shall we do about paying for medical care?" Certainly from no group can more information and interest be reasonably expected to come than from the Woman's Auxiliary.

We have been asked by our state president to devote a part of each of our meetings to the acquisition of authentic information on the subject. We have received a list of reference material, easily obtainable, readily understandable, and rich with information "based on facts, not emotions." How well have we availed ourselves of

this "at hand" knowledge? How often have we passed these facts on to members of other organizations, even to our bridge party companions?

Brookings Institution has gained a wide reputation of accuracy, fairness, and sound judgment in its research in economics, in social and government problems. We have done well if we have given wide publicity to its findings: (1) contrary to what the exponents of socialized medicine would have us believe, "no great nation in the world has among its white population better health than prevails in the United States"; (2) this country has made greater progress in applying medical science than has any other country in the world; (3) the so-called draft statistics are unreliable as a measure of the health of the nation; a "break down" of the draft statistics shows that actually less than a million and a half men were rejected for conditions that might have been prevented by more medical care and that many of these would have been doing front-line duty in spite of handicaps had they been citizens of any other country in the world.

We know that the morbidity and mortality rates of the United States are the lowest in the world. We know that the United States leads the world in medical education. But have we let other people know it? And beyond this, have we let them know how dissatisfied the medical profession always is with the status quo? Have we let them know how it is constantly organizing, nurturing, and launching methods to bring the farthest advances of science within the reach of all people? The cause of the profession currently stands greatly in need of understanding and outspoken support by lay persons and lay groups.

The average expenditure per year per family for medical service is only fifty dollars. Yet no one knows when he will have some really costly and serious medical catastrophe during which his earning power may be stopped. Therefore, it is wise to equalize the financial impact of illness. It is because of the medical profession's recognition of the merit of such equalization that the Medical Service Association of Pennsylvania was set up as "The Doctors' Plan." It is *splendid* for us to be thoroughly familiar with this Blue Shield

Plan. It is *imperative* for us to let others know of the superiority of this type of insurance to compulsory sickness insurance because of its lower cost, its preservation of the doctor-patient relationship, its elimination of political domination, and its preservation of our high medical standards. It is essential that we convince the public so thoroughly that the program of the American Medical Association is for the improvement of the general welfare that the people will join with us in accomplishing the realization of the program.

If we have followed this suggested program, then our next aim shall be easy to accomplish—we shall have no difficulty in promoting legislation with which the Medical Society may from time to time ask us to assist. Since, in a democracy, where majority rule is supposed to prevail, decisions are often made not by a majority of the people but by a majority of those who make themselves heard, we shall find many people *eager* to make themselves heard. We shall find them willing to use that most powerful and intimate means of communication known next to actual face-to-face conversation—the personal letter to Congressmen. We shall not be alone in our efforts to inform the members of Congress, and especially the new members, on the problems involved in changing our medical care program and on the progress the medical profession is making in the development of voluntary non-profit prepayment plans.

We feel that we cannot overestimate the importance of keeping Congressmen informed on what we believe to be best for the general welfare, and so we have received permission from the *Journal of the American Association of University Women* to reprint an article appearing in the January (1948) issue entitled "Concerning Letters to Congressmen," by Walter H. Judd, M.D., member of Congress from Minnesota. The article, in part, follows:

Things Your Congressman Likes

1. He likes to hear opinions from home and wants to be kept informed of conditions in the district. Base your letter on your own pertinent experiences and observations.
2. If writing about a specific bill, describe that bill by number or by its popular name. Your Congressman has thousands of bills before him in the course of a year and cannot always take time to figure out which one you are referring to.
3. He likes intelligent, well-thought-out letters which present a definite position, even if he does not agree with it.
4. Even more important and valuable to him

is a concise statement of the *reasons* for your position. This is particularly true if you are writing about a field in which you have specialized knowledge. He has to vote on many matters with which he has had little or no first-hand experience. Some of the most valuable help he gets in making up his own mind comes from facts and arguments presented in letters from persons who really know what they are talking about.

5. Short letters are almost always best. Members of Congress receive many, many letters each day and if a long one appears, it may not get as prompt a reading as a brief statement would.

6. Letters should be timed to arrive while the issue is "alive." If your Congressman is a committee member, he will appreciate having your views while the bill is before him for study and action.

7. A Congressman likes to know when he has done something of which you approve. He is quite as human as you.

Things Your Congressman Does Not Like

1. He does not like letters that merely "demand" or "insist" that he vote for or against a certain bill; or that tell him *what* you want him to vote for but not *why*. He has no way of knowing whether your reasons are good or bad, and he is not greatly influenced.
2. He does not like to be threatened with promises of defeat at the next election.
3. He does not like to be told how influential the writer is in her own locality.
4. He does not like to be asked to commit himself on a particular bill as the best means of achieving a desired end, until the committee in charge of the subject has had a chance to hear the evidence and dig out all the pros and cons.
5. He does not like form letters or letters which include excerpts from other letters on the same subject.
6. He does not like to hear from people from other districts, except when the letter deals with a matter which is before a committee of which he is a member. Congressional courtesy makes him refer letters from non-constituents on other subjects to the proper persons anyway.

WOMAN'S AUXILIARY CONFERENCE
FOR COUNTY PRESIDENTS AND
PRESIDENTS-ELECT

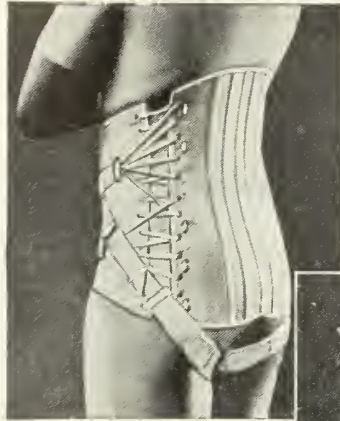
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**Hugh T. Jones, M.D.*

Low Back Pain from the Orthopedic Standpoint

California Medicine

Vol. 68, February, 1948

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7. He does not like to be deluged by letters from the same person on the same subject. Quality, not quantity, is what counts.

(MRS. ALBERT F.) ANN SWANSON DOYLE,
Legislative Chairman.

COUNTY NEWS

Many of the county auxiliaries started their new auxiliary year in September and are continuing with the inspiration and knowledge gained at the Philadelphia convention and from our president's visits.

First, the convention: Delegates returned to their counties and gave glowing reports. *Berks* had a large delegation present to see one of their members, Mrs. Paul C. Craig, installed as our president for 1948-49. Mrs. Charles J. Swalm and Mrs. M. Fraser Percival, chairman and co-chairman of the convention, reported in *Philadelphia*. They are to be congratulated on their wonderful work; the convention was really different this year and thoroughly enjoyed by everyone attending. *Montgomery* had fourteen members present and several of the sessions were discussed at their meeting. They were thrilled with the honor given to one of their members, Mrs. Edgar S. Buyers, when she was made the first honorary life member of the State Auxiliary. At this county meeting, a pleasant surprise was the arrival of Mrs. Drury Hinton, president-elect, Mrs. Edward H. Bedrossian, and Mrs. Walter A. Landry, all of *Delaware*. Other counties had reports by delegates, including: *Cambria*, Mrs. Albert F. Doyle; *Clinton*, Mrs. Frank P. Dwyer and Mrs. David W. Thomas; *Delaware*, Mrs. K. G. Taylor and Mrs. William R. Leute, Jr.; *Erie*, Mrs. Usher H. Meyers and Mrs. Delmar R. Palmer; *Fayette*, Mrs. Joseph E. Shelby, Mrs. George N. Riffle, and Mrs. L. Dale Johnson; *Indiana*, Mrs. Harry B. Neal, Mrs. Joseph C. Lee, and Mrs. Daniel H. Bee; and *Northampton*, Mrs. Walter S. Brenholtz.

Our president began her visiting throughout the State shortly after the convention. Those members who have heard her will undoubtedly strive to achieve higher levels in auxiliary endeavors. (For those she will visit later, you can be sure there is a wealth of information and inspiration.) First, she went to *Lehigh*, October 12, for the annual luncheon at the Lehigh Country Club. Miss Lucille Ronco, coloratura soprano, sang a group of selections. In the evening she visited *Northampton* at a dinner meeting at the Northampton Country Club, accompanied by Mrs. J. Frederick Dreyer, president, *Lehigh*, and Mrs. Elmer H. Bausch, Second District counselor. Miss Mary H. Stites, *Northampton*, was presented as the Third District counselor. *Delaware* held a luncheon meeting October 14 at the Llanerch Country Club, Manoa. One of their members, Mrs. Mary Tollen deProphetis, accompanied by Mrs. Evelyn Glenney McKay, entertained with a number of vocal selections. *Chester* met the next day at Westtown Farm House.

Mrs. Harry W. Buzzard, counselor, accompanied Mrs. Craig on a five hundred mile trip through the Seventh District: To Ridgway, where the group met at the home of Mrs. James W. Minter, in *Elk-Cameron* County. Then back to the *Clinton* meeting at the Fallon Hotel, Lock Haven. The same day to Wellsboro, where five *Potter* women drove fifty miles to meet with the *Tioga* group: Mrs. Clarence E. Baxter, Mrs. J. Irving Bentley, Mrs. Robert W. Gage, Mrs. Alfred F. Doma-

leski, and Mrs. Robert H. Kazmierski. *Lycoming* entertained on October 22.

The last of October the president went to Erie and spent the week-end as the guest of Dr. and Mrs. Elmer Hess, and met with the Eighth District auxiliaries. Mrs. Mary Harker Jones, councilor, joined her. Mrs. Maxwell Lick, a former state president of the Auxiliary, graciously opened her home for the *Erie* meeting. Then followed *Warren*, *Mercer*, and *Crawford*, in quick succession, so that the president could get to Chicago for the Conference of State Presidents.

In the Ninth District counties, Mrs. Craig and their councilor, Mrs. F. Earle Magee, met November 9 at a *Butler* dinner meeting at the Willard Hotel; November 10, at a luncheon meeting of *Armstrong* and *Indiana* at the Kittanning Country Club; that evening Mrs. Craig, Mrs. Magee, Mrs. Harry B. Neal, president, *Indiana*, and Mrs. Daniel H. Bee, state publicity chairman, traveled to Punxsutawney to the summer home of Dr. Frank A. Lorenzo for dinner. At that time *Jefferson* reorganized, electing Mrs. Hollister W. Lyon as their new president. Armistice Day Mrs. Craig and Mrs. Bee visited *Cambria*, along with Mrs. Albert F. Doyle, state legislation chairman, and Mrs. Robert S. Ideson, Eleventh District councilor, for a luncheon meeting at the Fort Stanwix Hotel, Johnstown.

On November 16 *Schuylkill* had a luncheon at the Necho Allen Hotel, Pottsville, for our president. Mrs. Charles E. Peach, third vice-president of the State Auxiliary, also attended. Mrs. Craig was the guest of the Fourth District councilor, Mrs. William J. Jacoby. There followed meetings in *Northumberland*, where Dr. E. Roger Samuel, president-elect of The Medical So-

ciety of the State of Pennsylvania, came to greet our president; at *Montour-Columbia*, a half-hour radio interview on Auxiliary program on Station WLTR was arranged.

November 13 found the Auxiliary joining in celebrating the one hundredth anniversary of the *Bucks* County Medical Society. Mrs. Craig, Mrs. Elmer H. Bausch, councilor, and county presidents from the Second District joined the distinguished list of doctors as honored guests.

Thanksgiving week found Mrs. Howard H. Hamman, councilor, escorting Mrs. Craig on a hectic two-day trip through the Tenth District; a Sunday buffet supper given by Mrs. Oscar B. Snyder for the *Westmoreland* executive board preceded. On Monday they drove to the *Lawrence* meeting for luncheon at the Castleton Hotel, New Castle. The same evening the *Beaver* group met at the home of Mrs. George M. Durschinger in Rochester. Tuesday, November 23, Mrs. Hamman and Mrs. Craig appeared on a fifteen-minute radio program in Greensburg and then attended the *Allegheny* meeting at the Hotel Schenley, Pittsburgh. A nice unexpected touch at that meeting—six Delta Gamma fraternity sisters of Mrs. Craig, members of the Pittsburgh Alumnae group, came to the luncheon to greet her. The *Westmoreland* meeting concluded the trip with a dinner. Mary Shine said in her write-up in the *Pittsburgh Sun-Telegraph*: "Mrs. Craig has learned that 'p' stands for 'peripatetic' as well as for 'president.' She'll have to run nearly as fast as a turkey to get home in time to spend Thanksgiving with her family." And so it was.

Berks welcomed one new member in September and four in October. Eight new members have been ad-

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mitted to *Erie* since September. *Fayette* had a tea November 4 in honor of seven new members. Mrs. Harry R. Wilson joined *Lebanon* September 13. New members welcomed in *Northampton*, October 12, were Mrs. Warren Kietrich and Mrs. George R. Greenwood, Bethlehem, and Mrs. Harry T. Hoffman, Easton.

Several counties have reported on their method of taking care of the raise in National and State Auxiliary dues: *Cambria* raised their dues; *Clinton* collected one dollar from each person present at their October meeting; *Indiana* assessed each member one dollar; and *Philadelphia* asked each member to make a one dollar donation.

Potter was the first county to contribute to the Medical Benevolence Fund this year; *Clinton* has pledged \$75. Other counties are raising money for their contributions to this fund and other organizations and projects. *Fayette* sponsored a Medical Ball; admittance was by invitation and all members of the County Medical Society were asked to be patrons; \$500 was cleared. *Indiana* held a rummage sale. *Lehigh* had a card party and white elephant sale in conjunction with their September business meeting and a country dance and buffet supper in October. An auction bake and dessert sale was held in *Northampton* following their November meeting, at which time \$51 was raised. A bazaar followed the November meeting of *Warren*; a collection of jams and jellies was brought to be presented to the Hoffman Children's Home for Thanksgiving.

Erie has set aside the sum of \$500 to be used for establishing a permanent health exhibit at the Erie Public Museum. Clothing was collected by *Huntingdon* for the needy widows and orphans of physicians in England. *Lancaster* discussed plans for the creation of a nursing scholarship for a girl from that area. This scholarship will be given through competition, each June, to a high school graduate of that county. She will be asked to write an essay on "Why I Am Choosing the Nursing Field." *Lebanon* is considering renting hospital beds or wheel chairs to families needing them; also of offering a nurse's scholarship to a deserving student. *Lycoming* contributed to the Community Chest and will purchase a proctology table; the nurse's scholarship fund will be dispersed at the discretion of the Nursing School Committee, with approval of the auxiliary.

Programs following business meetings are of a varied nature throughout the state. *Allegheny* had for their guest in September, Thomas McC. Mabon, M.D., president of the Allegheny County Medical Society, and saw the film, "Pennsylvania," depicting the Commonwealth's industry, scenery, and history, in observance of Pennsylvania Week. *Berks* was entertained by their president, Mrs. Frederick W. Knoll, at a bicentennial picnic in September. Miss Mabel Sayer gave an excellent talk on "The Sterling Qualities, Characteristics, and Customs of the Pennsylvania German People." Mrs. John C. Stolz, now state corresponding secretary, gave a concise review of the Brookings Institution Report. Their next speaker was Elwood R. Brubaker, M.D., a medical director of Reading's Fertility Clinic. A public relations program was held November 8, at which time home and medical care were discussed by J. Arthur Heck, D.D., School of Theology of Albright College, "Home and Family Life," and Howard K. Petry, M.D., "The Costs of Medical Care."

Butler heard Miss Frances Purdy, Director of Nursing at the Butler County Memorial Hospital. Members set up a Nurses' Fund to help Miss Purdy in acquiring books, records, and other items needed for the students in the School of Nursing. *Cambria* had Mr. George

Moreland, librarian of the Cambria Free Library of Johnstown, speak about the Freedom Train. At the September meeting of *Centre*, Mrs. B. O. Harvey, Bellefonte, gave an interesting account of her recent European tour and spoke of the present conditions in several of the countries; in October, David A. Campbell, professor of architecture at Pennsylvania State College, described the southwestern states and showed colored slides of his recent trip in that area.

Dauphin invited all auxiliaries in the Fifth District to their November meeting, when Mrs. Charles L. Shafer, legislative chairman of the Woman's Auxiliary to the American Medical Association, told what to expect in legislation. She emphasized the need for every member to keep her eyes open and to become articulate in letting the public know that the doctor's chief concern is that the best possible medical care be provided for the people of the nation; that the doctors' objection to politically dominated or compulsory prepayment medicine is based on a conviction that the health of the nation and the individual would suffer.

Fayette had Mrs. George N. Riffle give a talk on "Early American Apothecary Shops" centered around the display used at the Philadelphia convention. Mrs. George Tolstoi read several informative articles on socialized medicine. In November members of this auxiliary were invited by the medical society to hear a lecture on "Plastic Surgery" by S. Milton Dupertuis, M.D., of the University of Pittsburgh. Following the talk, Mrs. Rodney Mosier reviewed *National Road*, by Jordan, for the auxiliary members.

Guests of honor at *Lackawanna* in October were Frederic B. Davies, M.D., and Michael G. O'Brien, M.D., president and president-elect of the Lackawanna

County Medical Society. Dr. Davies' subject was "Pre-paid Medical Service Versus Government Medicine." At the first meeting of the *Lehigh* study group, Mrs. Donald W. Haff discussed "Private Enterprise or Government in Medicine," by Louis H. Bauer, and "The Issue of Compulsory Health Insurance," from the Brookings Institution Report. In *Northampton* members modeled old and present-day hats, the oldest of the vintage of 1843.

On October 12 in *Philadelphia*, Mrs. Donald Helferich gave "The Early History of the Pennsylvania Germans and Their Art." November was a busy month for this auxiliary; on the fifth, at the Talent and Hobby Show, about twenty-five interesting hobbies were exhibited by doctors; "movies" of England were shown by Frederick H. Allen, M.D.; a monologue was given by Mrs. Marston T. Woodruff; there were musical selections by Mr. Guy E. Suer, tenor, Mrs. Muriel H. Miller, harpist, Mrs. B. H. Nelson, pianist, Kenneth Scott, M.D., pianist, and Stanley P. Reimann, M.D., pianist; on the ninth, at the regular meeting, Mrs. Helen Stevenson West discussed "Dressing the Stars"; on the twenty-sixth the Junior Dance was held.

Mrs. Robert S. Ideson, Eleventh District councilor, has accepted the chairmanship of the advisory committee for the organization of "Baby Sitters" in Johnstown. This organization is sponsored by the Red Cross and the State Employment Agency.

Lebanon members called all the doctors in the county during the summer concerning the Postgraduate Institute.

Mrs. J. Treichler Butz, former Second District councilor, was honored by *Lehigh* when she was given honorary membership.



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UNNECESSARY RECTAL OPERATIONS PERFORMED IN THE PRESENCE OF CANCER OF THE LARGE BOWEL

RAYMOND W. McNEALY, M.D., and DURAND SMITH, M.D.

Chicago, Ill.

This paper is the result of a study made at Wesley Memorial Hospital. The stimulus for the analysis was the repeated history of rectal operations having been performed in the presence of undiscovered malignancy of the bowel. In order to obtain an accurate picture of the frequency of this regrettable error, we reviewed the records of all patients entering the hospital for the period from July, 1943, to January, 1947, with a diagnosis of carcinoma of the lower part of the gastro-intestinal tract. We restricted the survey to individuals in whom a tumor mass could be felt by digital examination of the rectum. The reason for limiting this series to subjects in whom the correct diagnosis could have been made by proper digital examination was to preclude the common excuse that a lack of diagnostic instruments was responsible for the failure to discover the malignant lesion. We considered as pertinent only that treatment which had been rendered immediately preceding admission to the hospital.

In making our study, we reviewed 95 cases of large bowel malignancy. Of this number, 56 came within the limitations mentioned above, i.e., carcinoma which could be felt by digital examination. Yet 42.8 per cent of this group were treated for bowel conditions other than carcinoma. The treatment given proved very interesting. Fifty per cent were managed surgically, the other half medically. The surgical regime is even more enlightening. Of the entire series, 17.85 per cent had actual operative intervention in and about the rectum; 10.7 per cent had hemorrhoidectomies; 5 per cent had anal fistulectomies. Moreover, 3.57 per cent had hemorrhoids injected with sclerosing material. One person had two hemorrhoidectomies. Many who were under medical care were given suppositories. In others, attention was directed towards the bleeding, diarrhea, and spastic colon.

Carcinoma of the rectum does not present the same picture in every patient. For this reason, one must be alerted constantly to the possibility of a malignant lesion by any one or several of a group of signs and symptoms which occur with large bowel pathology. Bleeding from the rectum is by far the most common complaint.

Bloody stools were noticed by 78.5 per cent. In the majority of cases the blood was discovered at the time of bowel movement. Others passed blood or bloody mucus. A change in bowel habit was described in 65.9 per cent either as diarrhea—32.1 per cent, constipation—26.7 per cent, or alternating diarrhea and constipation—7.1 per cent.

It is of little value to elaborate on the symptoms and their diagnostic importance. From our study it is evident that one should be exceedingly cautious in attributing findings in any individual case to a single cause until a thorough examination excludes other lesions, particularly carcinoma. In this series 42.8 per cent were treated for one condition when actually two possible sources of the symptoms were present. Many were treated for hemorrhoids, yet all had concomitant malignancies. Hemorrhoidal tissue is found in varying amounts in the routine examination of most adults beyond the age of fifty. Hence the

DATA

Number of cases	56
Average age	57.8 yrs.
Sex { Males	57.1%
Females	42.9%
Subjected to surgery	21.4%
Treated medically	21.4%
Total treated	42.8%
Average distance of tumor above anal verge	6.5 cm. (2.56 inches)
Average greatest diameter of tumor	5.53 cm. (2.17 inches)
Duration of symptoms in un- treated patients	7.5 mos.
Duration of symptoms in treated patients	9.0 mos.

Symptoms	Frequency	Duration in Months
Bleeding (rectal)	78.5%	8.26
Change in bowel habit	65.9%	
Diarrhea	32.1%	4.77
Constipation	26.7%	10.6
Alternating diarrhea and constipation	7.1%	6.5
Weight loss	26.7% (19.6 lbs.)	5.64
Pain in rectum	12.5%	8.4
Pain with bowel move- ments	8.9%	8.1
Decrease in caliber of stool	8.9%	8.0
Weakness	8.9%	8.0
Urgency	7.1%	2.66
Mucus in stool	3.5%	6.2
Tenesmus	3.5%	

This paper is reprinted from the *Illinois Medical Journal*, November, 1948.

From the Department of Surgery, Wesley Memorial Hospital, Chicago.

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References: 1. Dodd, K. and Minot, A. S.: *J. Pediat.*, 8:442, 1936.
2. Dodd, K. and Minot, A. S.: *J. Pediat.*, 8:452, 1936.
3. Sahyun, M.: *Am. J. Dig. Dis.*, 13:59, 1946.

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finding of hemorrhoids in the presence of bleeding or any other rectal complaint does not preclude the presence of other pathologic conditions.

A history of bleeding should definitely encourage one to investigate completely the status of the entire large bowel. Approximately 75 per cent of all rectal cancers can be felt with the index finger. In this series 100 per cent could have been diagnosed correctly and earlier, had the initial examiner been thorough. As a result of the failure to recognize the lesion early, there was a definite avoidable delay in the treatment of the malignancy. This is predicated on the assumption that the symptoms, of which the patient complained at the time that the correct diagnosis was made, were the continuation of the symptoms which he had earlier. We are also assuming that the symptoms, both early and late, were attributable to the malignant lesion. The average duration of symptoms in untreated patients was 7.5 months, while the average duration of symptoms in patients who had some type of rectal treatment not directed to the malignant lesion was nine months.

It is a concept of law that all men are considered innocent until proved guilty. In large bowel studies the converse should be true—that all symptoms are the result of a malignancy until proved otherwise.

Conclusions

1. All rectal symptoms demand a thorough and complete study.
2. Coexisting rectal lesions are present in many patients with carcinoma of the rectum.
3. Hemorrhoidectomy or other rectal surgery should not be performed until the presence of carcinoma is definitely ruled out.

Summary

In a series of 56 cases in which the carcinomatous lesion could be felt with the index finger, 42.8 per cent were subjected to unnecessary treatment.

A correct diagnosis was not made early because malignancy was not suspected.

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FIRST ORTHOPEDIC APPLIANCE SYMPOSIUM A SUCCESS

Climaxing a full week of lectures, clinical demonstrations, and laboratory experiments, Dr. E. R. Weidlein, director of Mellon Institute, assured the participants in the first annual Symposium on Orthopedic Appliances that the outstanding success of this first collaborative effort made it mandatory that additional symposia be organized by the Institute in the future. His remarks, following those in similar vein by Dr. William S. McEllroy, dean of the School of Medicine, University of Pittsburgh, at the formal luncheon which concluded the symposium held at Mellon Institute during the week of September 20, virtually insure that the Sarah Mellon Seafie Foundation will continue to underwrite this altruistic experiment in industry education for another year at least.

The symposium was organized as a cooperative undertaking between the Institute's Multiple Fellowship on Orthopedic Appliances, established in August, 1947, by the Sarah Mellon Seafie Foundation, and the Medical School's Department of Orthopedic Surgery. A detailed program of lectures, demonstrations, and plant visits was worked out by a committee consisting of Dr. John A. Heberling, associate professor of orthopedic surgery in the University of Pittsburgh's Medical School, Dr. E. F. Murphy, assistant director for Research, Prosthetic and Sensory Aids Service, Veterans Administration, and Dr. G. H. Young, assistant director, Mellon Institute, who served as chairman and presided at the technical sessions of the symposium. Invited to attend as formal "registrants" were 65 experienced and mature orthopedic technicians and brace makers, drawn from all over the country. Of these men, approximately 40 were owners of their own brace shops, 11 were officially designated by the Veterans Administration to attend from the major veterans' hospitals, and 14 were sent to the symposium by hospitals and institutions wherein they are in responsible charge of brace making and fitting. Present as observers were more than sixty orthopedic physicians, representatives of the Veterans Administration of both the United States and Canada, and representatives of other organizations interested in aid to the handicapped and in rehabilitation problems.

The symposium was formally convened Monday morning, September 20, in the auditorium of Mellon Institute. Dr. Weidlein and Dean McEllroy explained the impetus behind the undertaking and set the keynote for the entire week as "a dynamic example of cooperation among scientists, physicians, engineers, and orthopedic technicians." The next five days were crowded with the most intensive lecture and demonstration schedule ever attempted by the Institute. Technical sessions were held mornings, afternoons, and evenings, on a rigid time schedule, culminating in an open discussion session Saturday morning immediately preceding the concluding luncheon.

Broadly, the symposium covered those elements of anatomy important to an understanding of the function and accurate fitting of orthopedic appliances; clinical demonstration of the many conditions requiring appliances and detailed consideration of their design and construction; and the engineering principles involved in the selection of brace materials including definitive information on strengths of various steel and light metal alloys, heat treating, brazing and welding, corrosion prevention, and possible plastic adjuncts or replace-



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ments. The concluding lecture session was devoted to rehabilitation, the role of physical medicine and therapy, and "the patient." Although all of the sessions were uniformly praised by the participants, particularly outstanding were the lectures on anatomy presented by Dr. G. W. Cook, of the University of Pittsburgh's Medical School, and the very pertinent and instructive lecture demonstrations by Dr. Atha Thomas, of the University of Colorado's Medical School. A definite highlight of the symposium was the session on cerebral palsy conducted by Dr. W. M. Phelps, medical director of the Cockeysville, Md., Children's Rehabilitation Institute.

The Sarah Mellon Scaife Foundation Fellowship on Orthopedic Appliances at Mellon was established late in 1947, in response to an increasing need for unbiased and authoritative scientific information and data on new constructional materials, advanced principles of design, and the utilization of sound engineering concepts in orthopedic appliance fabrication. Although a basic role of the Fellowship is the broad dissemination of data and proven techniques applicable to brace making, in this field it is not possible to entirely separate laboratory research from clinical trial. Accordingly, the Fellowship, headed by Dr. J. L. Young and currently staffed with four trained research assistants, functions with the advisory assistance of a committee named by the director of the Institute. This committee is at present headed by Dr. Paul B. Steele, professor and head of the Department of Orthopedic Surgery, School of Medicine, University of Pittsburgh. Drs. John A. Heberling and Carl C. Yount, of the Department of Orthopedic Surgery, are also members. The Fellowship operates under the administrative supervision of Dr. G. H. Young, assistant director of Mellon Institute.—*Pittsburgh Medical Bulletin*.

THE RESPONSE OF THE QUADRICEPS FEMORIS TO PROGRESSIVE RESISTANCE EXERCISES IN POLIOMYELITIC PATIENTS

(By Thomas L. Delorme, M.D., Robert S. Schwab, M.D., and Arthur L. Watkins, M.D., Boston, Mass.)

The response of poliomyelitis-weakened muscles to progressive-resistance exercises has been studied in twenty-seven quadriceps femoris muscles. The effectiveness of these power exercises for increasing strength in normal muscles and in those atrophied as a result of immobilization prompted the study. The rationale for treatment was based upon the hypothesis that, in poliomyelitis, the remaining innervated muscle fibers are normal and, therefore, possess the same potentialities for hypertrophy and power as normal muscles. Thus the degree of the muscle's response to exercise should be directly proportional to the number of muscle fibers with intact nerve supply. Results clearly indicate that poliomyelitis-weakened muscles respond in much the same fashion as do normal muscles, but to a degree proportionate to the number of remaining innervated muscle fibers.

Subjects of the Investigation.—Nineteen subjects participated in this investigation, eight males and eleven females. Eight had bilateral involvement, and, therefore, comprised sixteen of the twenty-seven quadriceps studied. The interval between the end of the acute stage of the disease and the initiation of exercise ranged from one to forty-nine years; therefore, changes in muscle function observed during the exercise period were probably due to exercise and not to spontaneous

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*Beams, A. J., and Endicott, E. T., Histologic changes in the livers of patients with cirrhosis treated with methionine, *Gastroenterology* 9:718-735 (Dec.) 1947.



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recovery. The ages of the participants ranged from 18 to 50 years.

Originally, it was intended that all patients receive exercise for four months. However, in only fourteen of the twenty-seven quadriceps femoris muscles studied was the four-month period completed. Of the remaining thirteen, in which the full course of exercises was not completed, ten were accounted for because of financial, occupational, or transportation difficulties of the patients. In the other three, strength equal to that of the uninvolved extremity (as measured by strength tests) was attained before the end of the four-month period. All subjects in this investigation exercised once daily, four days a week. One-repetition maximum and ten-repetition maximum were determined once a week. Throughout the period of investigation, the patients received no other remedial exercises, and they were instructed to continue daily activities as usual.

Methods of Evaluation.—The progress resulting from exercise was evaluated at monthly intervals. Studies were made of (1) muscle strength (maximum single effort), (2) work capacity, (3) limb volume, (4) electric activity, and (5) functional ability. All tests on any one subject were scheduled at the same time of day, in an attempt to avoid diurnal variations.

The qualitative and quantitative evidence presented supports the hypothesis that, following acute anterior poliomyelitis, the remaining innervated muscles respond to progressive-resistance exercises by an increase in strength and work capacity in much the same manner as normal muscles.—Abstracted by ALBERT A. MAR-
TUCCHI, M.D., from *The Journal of Bone and Joint Surgery*, October, 1948.

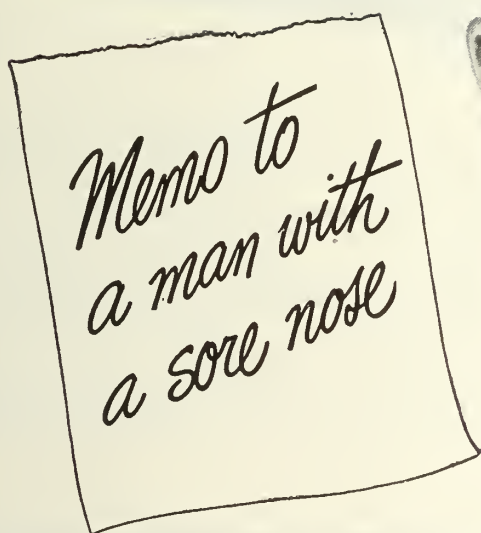
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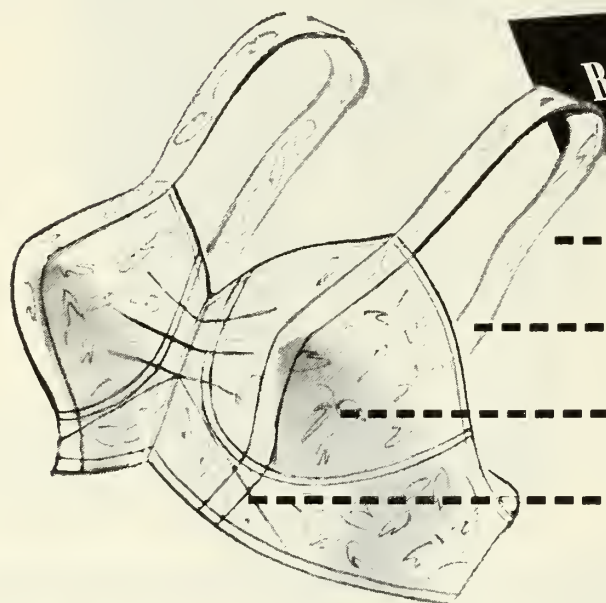


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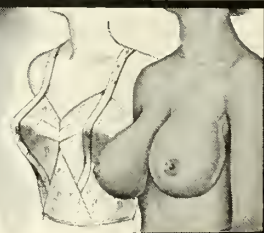
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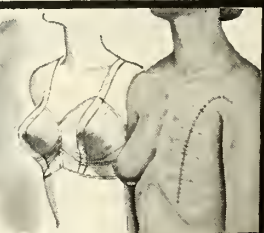
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MEDICAL NEWS

Future Meeting Calendar

SECRETARIES-EDITORS CONFERENCE—Penn-Harris Hotel, Harrisburg, March 3 and 4, 1949.

AMERICAN ACADEMY OF GENERAL PRACTICE—Cincinnati, March 7 to 9, 1949.

AMERICAN COLLEGE OF PHYSICIANS—New York, March 28 to April 1, 1949.

PHILADELPHIA COUNTY MEDICAL SOCIETY POSTGRADUATE INSTITUTE—Philadelphia, April 5-8, 1949.

Birth

TO DR. AND MRS. HARVEY F. ENYEART, of Grove City, a daughter, Judith Ann, March 11, 1948.

Engagements

MISS PATRICIA JELLETT, of Philadelphia, and Robert Delos Heath, M.D., of Allentown.

MISS CARMEN MILLICENT CAUTERUCCI, of Philadelphia, and Robert Ellsworth Gundel, M.D., of Columbia.

MISS VIRGINIA EVELYN BIGGERS and Mr. Richard Howell Witmer, son of Dr. and Mrs. C. Howard Witmer, all of Lancaster.

MISS FRANCES SCOTT, daughter of Dr. and Mrs. John P. Scott, of Merion, and Mr. John Henry Maylahn, of Milwaukee, Wis.

MISS ROSEMARY METCALF VARKER, of Berwyn, and Mr. Horace Pettit, Jr., son of Dr. and Mrs. Horace Pettit, of Gladwyne.

MISS KATHARINE CALVERT GILES, of Narberth, and Mr. Robert Davis Ezickson, son of Dr. and Mrs. William J. Ezickson, of Merion.

MISS DORIS ANN SEMISCH, of Jenkintown, and Robert E. Barto, Jr., M.D., son of Dr. and Mrs. Robert E. Barto, of Elizabethtown.

MISS AMY AUSTIN, daughter of Dr. and Mrs. J. Paul Austin, of Conshohocken, and Mr. William James Winship Lewis, of Baltimore, Md.

MISS ROSEANNE ELEANOR KLAPPER, of Narberth, and Mr. Thomas Mitchell Campbell, son of Dr. and Mrs. Edward H. Campbell, of Wynnewood.

MISS MARGARET JANE BLACKBURN, daughter of Dr. and Mrs. Walter J. Blackburn, and Mr. Robert Dunbar Darrach, all of Philadelphia.

MISS HENRIETTA UNDERWOOD LIZARS, of Bryn Mawr, and Mr. Jacob Hursh Vastine, 3d, son of Dr. and Mrs. Jacob H. Vastine, 2d, of Wynnewood.

MISS ELIZABETH MARY DONNELLY, daughter of Dr. and Mrs. John D. Donnelly, of Bala-Cynwyd, and Midshipman Elias Venning, Jr., U.S.N., of Charleston, S. C.

MARY MARGARET THISSELL, R.N., daughter of Dr. and Mrs. Henry N. Thissell, of Lock Haven, and Gerard F. McDonough, also of Lock Haven, formerly of Manchester, N. H.

Marriages

MISS MARY ELIZABETH MCCARTER, of Norristown, to Charles William Dunn, M.D., of Cheyney, December 23.

MISS SARAH MARGARET MOFFETT, of Ardmore, to Frank P. Dwyer, Jr., M.D., son of Dr. and Mrs. Frank P. Dwyer, of Renovo, December 31.

MISS JEAN E. GRIEST, daughter of Dr. and Mrs. Andrew J. Griest, of Steelton, to Mr. James R. W. Leiby, of Allentown, November 26.

MISS JANICE ROSALIND IGLER, of Philadelphia, to Mr. John Thomas Montgomery, son of Dr. and Mrs. Thaddeus L. Montgomery, of Cynwyd, December 18.

MISS ELIZABETH WOODRING SCHNABEL, daughter of Dr. and Mrs. Truman G. Schnabel, of Philadelphia, to Dr. William Dunstan Chamblin, Jr., of Blytheville, Ark., January 8.

MISS MARY JULIA GILL to Thomas W. Moran, 3d, M.D., son of Dr. and Mrs. Thomas W. Moran, all of Latrobe, December 27. Dr. Moran is teaching at the University of Pennsylvania.

MISS CAROL SHRODER, of Narberth, to Mr. Ralph E. Pilgram, Jr., son of Dr. Ralph E. Pilgram, of Harrisburg, December 25. Mrs. Shroder is a graduate nurse at the University Hospital, Philadelphia, and Mr. Pilgram is a junior at Temple University Medical School.

Deaths

○ Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

○ William E. Keller, Scranton; University of Pennsylvania School of Medicine, 1892; aged 76; died Dec. 29, 1948, after a brief illness. A native of Stroudsburg, Dr. Keller was said to have remarked at one time, "I'm of the fifth generation of doctors in my family. My mother was a Walton and for 125 years Stroudsburg was never without a Dr. Walton." Dr. Keller served as a major in the Spanish-American War and in the Mexican Border campaign, later being promoted to lieutenant colonel. During World War I he saw service on five fronts while commander of the 103d sanitary train of the 28th Division. Following the war he specialized in medical examinations for many life insurance companies. Dr. Keller had served as president and secretary of the Lackawanna County Medical Society, and at one time he headed the Scranton Bureau of Health. He also organized and directed the Scranton Public School Medical Inspection Bureau for twenty-two years and served as its chief medical inspector for some time. Surviving are his widow, a daughter, and two sons.

○ George J. Kastlin, Pittsburgh; University of Pennsylvania School of Medicine, 1924; aged 48; died Dec. 31, 1948, of gastric carcinoma. Dr. Kastlin was associate professor of medicine at the University of Pittsburgh School of Medicine, and was on the staff of Presbyterian and St. Margaret Hospitals. He was consultant hematologist at Montefiore and St. John's Hospitals, medical director of the Skin and Cancer Foundation, and consultant at the Veterans' Hospital, Aspinwall. During World War II he was a colonel in the Medical Corps and served as chief of the medical staff at Bruns General Hospital, Santa Fe, N. M. Dr. Kastlin was faculty representative at cyclotron activities at the University of Pittsburgh Medical School. He was a Fellow of the American College of Physicians, a member of the American Society of Clinical Pathologists, and a charter member of the International Congress of Hematology. He is survived by his mother.

○ Francis J. Madden, Duquesne; University of Pittsburgh School of Medicine, 1895; aged 78; died suddenly Dec. 15, 1948, the day he was scheduled to leave for Arizona and retirement. He and his wife had planned the trip for several years and had sold their home and furniture several months before. Active in

Duquesne Democratic politics for several years, Dr. Madden was defeated for mayor in 1944. A member of the Duquesne council from 1940 to 1944, he was in charge of public safety and the water and health departments. Besides his widow, he is survived by a son, a brother, and two sisters.

○ **Daniel E. Sable**, Pittsburgh; University of Pittsburgh School of Medicine, 1907; aged 64; died Dec. 11, 1948. Dr. Sable was chief surgeon of Pittsburgh's Department of Public Safety for thirty-four years until his retirement four years ago. Since that time he had practiced industrial surgery. During World War I he served in the Army and was mustered out with the rank of lieutenant colonel. He also served on the Mexican border. He was a member of the Society of Military Surgeons and the Industrial Surgeons Society. He is survived by his widow, a son, a daughter, and three sisters.

○ **Charles J. Swalm**, Philadelphia; University of Pennsylvania School of Medicine, 1906; aged 64; died Jan. 1, 1949, following a heart attack. He collapsed over the wheel of his car while waiting for a traffic light to change. Dr. Swalm was a member of the staff of Jewish Hospital and was appointed to the post of coroner's physician seven years ago. He was a Fellow of the American Academy of Ophthalmology and Otolaryngology. Surviving are his widow, a son, a sister, Edna Swalm Laird, M.D., and two brothers, one of whom is William A. Swalm, M.D., of Philadelphia.

○ **W. Burrill Odenatt**, Philadelphia; Medico-Chirurgical College of Philadelphia, 1897; aged 72; died suddenly Dec. 3, 1948. Dr. Odenatt was formerly chief of staff at the Stetson and Nazareth Hospitals and was medical director of the Stetson Hat Company since 1942. He was a past president of the Medical Club of Philadelphia, a Fellow of the College of Physicians of Philadelphia, and district censor of the State Medical Society since 1937. During World War II he was secretary of Local Draft Board 52 in his city. He is survived by his widow.

○ **Voigt Mooney**, Pittsburgh; University of Pittsburgh School of Medicine, 1920; aged 54; died of a heart attack Dec. 28, 1948. Dr. Mooney was attending surgeon at Allegheny General Hospital and consulting orthopedic surgeon at the United States Marine Hospital and for the Allegheny County Institutional District. He was a Fellow of the Pittsburgh Academy of Medicine, the American Academy of Orthopedic Surgeons, and the American College of Surgeons. Surviving are his widow, two sons, and two daughters.

Walter W. Seibert, Easton; Hahnemann Medical College and Hospital of Philadelphia, 1900; aged 72; died Dec. 15, 1948, at his winter home in St. Petersburg, Fla. He formerly served on the staff of Easton Hospital, and at the time of his death was president of the board of trustees of the Allentown State Hospital, a post that he held for seventeen years. His widow survives.

○ **John S. Mackrell**, Pittsburgh; University of Pittsburgh School of Medicine, 1909; aged 64; died Nov. 21, 1948, of a cerebral hemorrhage. Dr. Mackrell was a captain in World War I. He was president of the Pittsburgh city school medical examiners for thirty-one years. Surviving are his widow, three daughters, and four sons, two of whom are physicians.

David S. O'Donnell, Philadelphia; University of Pennsylvania School of Medicine, 1905; aged 68; died Dec. 23, 1948. Dr. O'Donnell was a member of the staff of St. Joseph's Hospital. During World War I he was a first lieutenant in the Medical Corps. He is survived by a son and a brother.

○ **Paul C. Walter**, Harrisburg; Johns Hopkins University School of Medicine, 1923; aged 51; died Nov. 26, 1948. Dr. Walter was on the surgical staff of

the Harrisburg Hospital. He is survived by his widow, one son, and three brothers, one of whom is Ralph S. Walter, M.D., of Harrisburg.

Mathias S. Mengel, Elverson; University of Pennsylvania School of Medicine, 1885; aged 86; died Dec. 3, 1948. A practicing physician for sixty years, Dr. Mengel also served in the Army Medical Corps during World War I. He is survived by his widow, two daughters, and three sons.

○ **Abel E. West**, Philadelphia; Leonard Medical School, Raleigh, N. C., 1908; aged 72; died Jan. 9, 1949. Dr. West was chief of the eye, ear, nose, and throat department at Mercy-Douglas Hospital. He is survived by his widow, two daughters, and two sons.

○ **Harvey O. Rohrbach**, Bethlehem; Illinois Medical College, Chicago, 1902; aged 78; died Dec. 10, 1948. Dr. Rohrbach was a member of the American Academy of Pediatrics and a Fellow of the American College of Physicians.

○ **George B. Miller**, Philadelphia; University of Pennsylvania School of Medicine, 1885; aged 84; died Dec. 6, 1948. Dr. Miller had practiced medicine for sixty-two years before retiring in 1947 because of illness.

○ **George N. Richmond**, Philadelphia; University of Pennsylvania School of Medicine, 1895; aged 79; died Jan. 9, 1949. He had practiced medicine for more than fifty-three years. His widow and a brother survive.

○ **Joseph L. Daugherty**, Mechanicsburg; Medico-Chirurgical College of Philadelphia, 1910; aged 63; died Dec. 31, 1948, as a result of a heart ailment. He is survived by his widow and a sister.

Charles J. Wivell, Scranton; Baltimore Medical College, Maryland, 1901; aged 72; died Nov. 26, 1948, after a long illness. He is survived by a daughter, two brothers, and two sisters.

○ **Elmer E. Onstott**, Saltsburg; University of Illinois College of Medicine, Chicago, 1889; aged 87; died Dec. 2, 1948. He is survived by his widow, one son, and one daughter.

○ **William C. Hogan**, Bradford; University of Pittsburgh School of Medicine, 1902; aged 74; died Nov. 20, 1948. Dr. Hogan was a Fellow of the American College of Surgeons.

○ **Ernest R. Scholten**, Reading; Christian-Albrechts-Universität Medizinische Fakultät, Kiel, Prussia, 1893; aged 81; died recently.

○ **Walter G. Aughenbaugh**, Pittsburgh; University of Pittsburgh School of Medicine, 1913; aged 59; died Nov. 23, 1948.

○ **Michael G. Chadman**, Lancaster; University of Pennsylvania School of Medicine, 1921; aged 52; died Nov. 15, 1948.

Miscellaneous

THE FRANKLIN COUNTY MEDICAL SOCIETY recently revised its by-laws, creating the office of president-elect.

THE CHEVALIER JACKSON POSTGRADUATE COURSE in broncho-esophagology at Temple University Medical School was conducted in December with students from South America and Canada as well as from numerous states of the Union.

DRS. EDWARD L. BORTZ AND EDWARD A. STRECKER, of Philadelphia, have been named honorary and reserve consultants to the Navy Bureau of Medicine and Surgery to assist in formulating policies for the Medical Department of the Navy.



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THE MCKEESPORT HOSPITAL has received a gift of \$300,000 from Mrs. E. R. Crawford, widow of the former president of the McKeesport Tin Plate Company. The money will be added to the building fund for constructing a new wing to the hospital.

W. EMORY BURNETT, M.D., professor and head of the Department of Surgery at Temple University School of Medicine, was the guest speaker at the recent post-graduate course in general surgery presented by the Dallas Southern Clinical Society and the Dallas Society of General Surgery.

UNITED STATES SENATOR ROBERT A. TAFT will be the speaker at an open meeting of the Pittsburgh Academy of Medicine to be held in the auditorium of Schenley High School, in Pittsburgh, Saturday, February 19. The Senator will speak on "National Sickness Service Insurance."

WILBUR CLYDE THOMAS, M.D., has been appointed associate professor of pathology at Temple University School of Medicine, Philadelphia. Previous to accepting this appointment Dr. Thomas was assistant professor of pathology at the Bowman Gray School of Medicine at Wake Forest College.

THE WOMAN'S MEDICAL COLLEGE, Philadelphia, has received \$37,302 as a grant under the National Mental Health Act for developing psychiatric training for undergraduate medical students. The funds will be made available for the school year 1949-50, and will be paid in annual allotments over a three-year period.

A GIFT OF \$100,000 FROM THE PENNSYLVANIA RAILROAD COMPANY toward construction of the planned new Philadelphia Medical Center of the University of Pennsylvania was announced in December by President Harold E. Stassen. The contribution was made specifically toward the Thomas Sovereign Gates Memorial pavilion, an integral part of the proposed \$10,000,000 new medical center.

W. EDWARD CHAMBERLAIN, M.D., professor and head of the Department of Radiology, George P. Rosemond, M.D., clinical professor of surgery, and George C. Henny, M.D., professor and head of the Department of Medical Physics, Temple University Medical School, presented papers at the thirty-fourth annual meeting of the Radiologic Society of North America held in San Francisco, December 5 to 10.

THE MARCH, 1949 MEETING OF THE PENNSYLVANIA ACADEMY OF PHYSICAL MEDICINE will be held on Saturday the 12th at the Berkshire Hotel, Reading, Pa. An



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elaborate program has been planned to consist of full afternoon and evening sessions, dinner, and a Sunday tour of the countryside. When final details of the program have been completed, further announcement will be made by letter and through the journals.

RICHARD B. EISENBERG, M.D., a resident physician and instructor in pathology at the University of Pennsylvania, Philadelphia, has been named as one of two winners of the first Damon Runyon Memorial Fund fellowships for clinical research in cancer, as announced by the American Cancer Society in New York. A native of Erie, Dr. Eisenberg has been on a fellowship at the University of Pennsylvania for three years, doing specialized study in pathology. This fellowship expires in March.

THE PENNSYLVANIA BOARD OF MEDICAL EDUCATION AND LICENSURE, at a meeting held on Dec. 16, 1948, reinstated the license to practice medicine and surgery in the Commonwealth of Pennsylvania of the following:

Morton Reese, M.D., 141 Market St., Mount Clemens, Mich., whose license had been revoked on April 26, 1944, for violation of the Federal Narcotic Laws.

Harold A. Daugherty, M.D., Grove City, Pa., whose license had been revoked on Oct. 17, 1947, for violation of the Federal Narcotic Laws.

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For Sale.—Home and office, ten rooms, white frame. Drugs and equipment included. Most of good rural practice will go to purchaser. Address Dept. 144, PENNSYLVANIA MEDICAL JOURNAL.

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Wanted.—House physician, male or female, licensed to practice in Pennsylvania, in general hospital, 550 beds, to start February 1, 1949. Salary \$300.00 per month and full maintenance. Write SUPERINTENDENT, The Western Pennsylvania Hospital, Pittsburgh 24, Pa.

Wanted.—Resident for active Rochester General Hospital, Rochester, Pa., 25 miles north of Pittsburgh; fully approved by A. C. S.; excellent opportunity for varied observance and experience. Write N. D. ROBERTS, Administrator.

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DUE MARCH ONE—NOT THIRTY-ONE

As revised by our 1948 House of Delegates, 1949 county and state medical society dues must be paid by March 1, rather than March 31 as in the past. Failure to pay dues on time results in loss of medical defense benefits if sued or threatened with suit for alleged malpractice. In spite of the current \$25 American Medical Association assessment due in 1949 from all active members of each state medical society, 2870 (more than same date in 1948) have to January 25 paid their 1949 county and Pennsylvania State Medical Society dues.

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NEW AND NONOFFICIAL REMEDIES

The following additional articles have been accepted as conforming to the rules of the Council on Pharmacy and Chemistry of the American Medical Association for admission to New and Nonofficial Remedies. A copy of the rules on which the Council bases its action will be sent on application.

AUSTIN SMITH, M.D., *Secretary.*

MANNITOL HEXANITRATE (See New and Nonofficial Remedies 1947, p. 254).

The following dosage form has been accepted:

COLE CHEMICAL CO., ST. LOUIS 8

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PENICILLIN (See New and Nonofficial Remedies 1947, p. 144).

The following dosage form has been accepted:

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Crystalline Procaine Penicillin G in Oil: 300,000 units per cc. in sesame oil, 10 cc. vials.

STREPTOMYCIN (See New and Nonofficial Remedies 1947, p. 150).

The following dosage form has been accepted:

PREMO PHARMACEUTICAL LABS., INC., SOUTH HACKENSACK, N. J.

Streptomycin Calcium Chloride Complex: Vials containing streptomycin calcium chloride complex equivalent to 1 Gm. of streptomycin base.

SULFAMERAZINE-U. S. P. (See New and Nonofficial Remedies 1947, p. 125).

The following dosage form has been accepted:

S. E. MASSENGILL CO., BRISTOL, TENN.

Tablets Sulfamerazine: 0.5 Gm.

DIPHENHYDRAMINE HYDROCHLORIDE (See New and Nonofficial Remedies 1947, p. 20).

The following additional dosage form has been accepted:

PARKE, DAVIS & CO., DETROIT 32

Kapseals Benadryl Hydrochloride: 25 mg.

U. S. Trademark 416,252.

ESTROGENIC SUBSTANCES (WATER SOLUBLE) (See New and Nonofficial Remedies 1947, p. 346).

The following additional dosage form has been accepted:

AYERST, McKENNA & HARRISON, LTD., NEW YORK

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—*Journal of A.M.A.*, Dec. 4, 1948.



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By Maurice Feldman, M.D. 901 pages, illustrated,
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BOOK REVIEWS

VASCULAR DISEASES IN CLINICAL PRACTICE. By IRVING SHERWOOD WRIGHT, M.D., Associate Professor of Clinical Medicine, Cornell University Medical College; Chief of Section on Vascular Diseases of the Department of Medicine, New York Hospital. 512 pages with 135 illustrations. Chicago: The Year Book Publishers, Inc., 1948. Price, \$7.50.

This is a well-written text on peripheral vascular diseases presented by an authority in his special field. The book is concise and is easy to read. There is a comprehensive classification of blood vessel diseases and a practical outline of methods of study. In addition to the usual vascular diseases, Dr. Wright describes the hyperabduction syndrome as first emphasized by him. The section on dicumarol therapy likewise is valuable because of the extensive experience of the author with anticoagulant therapy. The book should prove to be a handy reference volume for practitioners of medicine.

RECENT ADVANCES IN SURGERY. By HAROLD C. EDWARDS, C.B.E., M.S., F.R.C.S., Surgeon and Lecturer in Surgery, King's College Hospital, London; Surgeon to the Evelina Hospital for Sick Children; Dean of the Medical School, King's College Hospital; Late Consulting Surgeon, Central Mediterranean Forces. Third edition; 437 pages with 131 illustrations. Philadelphia: The Blakiston Company, 1948. Price, \$6.50.

This book is the first new edition of this work to appear in twenty years and represents one in the publisher's series of books entitled "Recent Advances in . . ." The author and his colleagues have presented a small handbook which fulfills the concept of the title, though it may appear that some recent subjects have received scant attention.

The text is composed of thirty chapters which are organized into seven large groups as follows: (1) general, (2) alimentary tract, (3) thorax, (4) nervous system, (5) blood vessels, (6) ductless glands, (7) radiotherapy in malignant disease. The printing is good and the illustrations appear adequate. References may be found at the end of each chapter. There is an index at the end of the book.

The authors have incorporated in this text almost all of the recent advances; however, because of the compactness of this book, such a text cannot be recommended to replace the standard texts of the various fields which the student, intern, and specialist should consult and have on hand.

PRACTICAL THERAPEUTICS. By MARTIN EMIL REHFUSS, M.D., F.A.C.P., Professor of Clinical Medicine and Sutherland M. Prevost Lecturer in Therapeutics, Jefferson Medical College of Philadelphia, and Attending Physician to Jefferson Medical College Hospital; F. KENNETH ALBRECHT, M.D., formerly Clinical Director of U. S. Marine Hospital, Baltimore, Md., and Co-director of Division of Tuberculosis Control, Kansas State Department of Health; and ALISON HOWE PRICE, A.B., M.D., Assistant Professor of Medicine, Jefferson Medical College of Philadelphia, and Assistant Physician to Jefferson Medical College Hospital. Baltimore: The Williams & Wilkins Company, 1948. Price, \$15.00.

This volume is the result of well-integrated contributions by thirteen clinical teachers. Its 824 pages are filled with thousands of prescriptions and specific directions on how to control every condition a physician may encounter.

The text is divided into four sections consisting of general therapeutic principles, symptomatic therapy, treatment of specific disorders, and special treatment. In these sections the reader will find much practical information on physical therapy, psychotherapy, psychosomatic medicine, occupational therapy and rehabilitation, and industrial therapy plus radiation and radioactive isotope therapy. Special emphasis is placed on pre- and postoperative care, and therapies in dermatology, ophthalmology, otorhinolaryngology, and pediatrics are discussed in detail. Supplementing the descriptive matter are 70 full page plates that help to crystallize much of the information.

The theme throughout the text is the organization of a well-directed therapeutic program for each malady. So well has the material been handled that your reviewer recommends this book unreservedly for all physicians and students of medicine.

HANDBOOK OF ORTHOPEDIC SURGERY. By ALFRED RIVES SHANDS, JR., B.A., M.D., Medical Director of the Alfred I. duPont Institute of the Nemours Foundation, Wilmington, Del.; Visiting Professor of Orthopedic Surgery, University of Pennsylvania School of Medicine, Philadelphia. In collaboration with RICHARD BEVERLY RANEY, B.A., M.D., Associate in Orthopedic Surgery, Duke University School of Medicine, Durham, N. C.; Lecturer in Orthopedic Surgery, University of North Carolina School of Medicine, Chapel Hill, N. C. Third edition; 574 pages with 159 illustrations. St. Louis: The C. V. Mosby Company, 1948. Price, \$6.00.

The authors have written a new edition of this handbook so as to include developments that have made their appearance during the past few years. This edition continues to serve the purpose for which this manual has been written. It is believed that this handy little book should prove useful to orthopedic surgeons and students alike. The text is composed of twenty-four chapters, and is so organized that all essential material is available. A list of reference books is appended for anyone who wishes details. The printing is good and the illustrations are simple and adequate. Some of the topics that have been added and expanded in this new third edition include the following: eosinophilic granuloma, osteoid osteoma, treatment of clubfoot, typhoid infection of bone, affections of the low part of the back, and infantile paralysis.

This work is recommended as either a text or reference for the medical profession and allied groups who are interested in the subject.

A-B-C's OF SULFONAMIDE AND ANTIBIOTIC THERAPY. By PERRIN H. LONG, M.D., F.R.C.P., Professor of Preventive Medicine, Johns Hopkins University School of Medicine; Physician to Johns Hopkins Hospital. 231 pages. Philadelphia and London: W. B. Saunders Company, 1948. Price, \$3.50.

Of articles on sulfonamides and antibiotics, there is a surfeit. Drug houses have filled the practitioner's desk with charts and colored brochures and summaries of the literature which have confused the reader and raised questions of the commercial rather than educational motive of the purveyors.

This little book—you can carry it without an unsightly bulge in your coat pocket—appears under the authorship of the professor of medicine at Johns Hopkins, a man whose name has been conspicuously concerned with the development of this therapy.

It is brief, direct in its approach, simple in its outline, and easily understood. Not only does it give specific administration instructions for the various drug preparations but it discusses the application of these drugs to 153 clinical entities from the common cold to Haverhill fever. The opinions expressed are positive, the instructions simple and direct. It is a valuable addition to the working armamentarium of the practicing physician who has not time to wade through the exhaustive discussions in current literature.

BRITISH SURGICAL PRACTICE. Under the general editorship of SIR ERNEST ROCK CARLING, F.R.C.S., F.R.C.P., Consulting Surgeon, Westminster Hospital, and J. PATERSON ROSS, M.S., F.R.C.S., Surgeon and Director of Surgical Clinical Unit, St. Bartholomew's Hospital; Professor of Surgery, University of London. In eight volumes (with index volume). Volume 3. St. Louis, Mo.: The C. V. Mosby Company, 1948. Price, \$15.00.

This volume is complete and up to date and continues to uphold the high standards of the first two volumes

of this contemplated eight volume set entitled "British Surgical Practice." The subject matter contained in this book extends from cesarean section to eyelids, each subject being contributed by an authority of the British Isles. In all, there is little to criticize and again the reviewer may say this book is recommended.

ABDOMINAL OPERATIONS. By RODNEY MAINGOT, F.R.C.S. Eng., Surgeon to the Royal Free Hospital, London, and to the Southend General Hospital. Second edition; 1298 pages with 468 illustrations and 32 tables. New York: Appleton-Century-Crofts, Inc., 1948. Price, \$16.00.

This book is another recent English textbook which presents the latest techniques and other surgical data to aid surgeons, hospital residents, and surgical interns in reducing operative mortality and restoring functions. The author and contributors have taken the opportunity presented by the appearance of this new edition to revise much of the material. The text is clearly written and the contents are logically presented in eleven main parts and sixty-three chapters. The following sequence is used: (1) abdominal incisions, (2) stomach and duodenum, (3) spleen, (4) pancreas, (5) gallbladder and bile ducts, (6) liver, (7) appendix, (8) peritoneum, (9) hernia, (10) intestines, (11) postoperative chest complications and portal hypertension. There is both an author and subject index. The printing is good and an adequate index completes the book. Drawings, photographs, and tables help to graphically emphasize the text throughout the volume. It is believed that this book may be recommended as reading by every doctor and medical student.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

NEW AND NONOFFICIAL REMEDIES—1948.

Containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on June 15, 1948. Issued under the direction and supervision of the Council on Pharmacy and Chemistry of the American Medical Association. Philadelphia: J. B. Lippincott Company, 1948. Price, \$3.00.

SYNOPSIS OF PSYCHOSOMATIC DIAGNOSIS AND TREATMENT.

By FLANDERS DUNBAR, M.D. With the assistance of Jacob Arlow, M.D., Raymond Hussey, M.D., Bertram Lewin, M.D., Robert C. Lowe, M.D., and members of the staff of the Departments of Medicine and Psychiatry, Columbia-Presbyterian Medical Center, New York City. St. Louis: The C. V. Mosby Company, 1948. Price, \$6.50.

A TREATISE ON CONTEMPORARY RELIGIOUS JURISPRUDENCE. By I. H. RUBENSTEIN of the Illinois bar. Chicago: The Waldain Press, 1948. Price, \$2.50.

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For catalog and full particulars write WILLIAM N. PARKINSON, M.D., Dean, Broad and Ontario Streets, Philadelphia 40

PSYCHIATRY IN GENERAL PRACTICE. By MELVIN W. THORNER, M.D., D.Sc., Assistant Professor of Neurology, Graduate School of Medicine, University of Pennsylvania. Philadelphia: W. B. Saunders Company, 1948. Price, \$8.00.

EDUCATION FOR PROFESSIONAL RESPONSIBILITY. A report of the proceedings of the Inter-Professions Conference on Education for Professional Responsibility held at Buck Hill Falls, Pa., April 12, 13, and 14, 1948. Pittsburgh: Carnegie Press, Carnegie Institute of Technology, 1948.

RIISING FROM THE ROUGHS. By RUFUS HENDERSON CLICK, author of "Looking at Life," "Poor Nell and Other Poems," "Chimney Fire Poems," and "Parting the Driftwood of Life." Boston: The Christopher Publishing House, 1948. Price, \$2.00.

THE FIVE STORIES OF MAN. By DAVID GORDON, inventor and scientist, and author of *The Atom of the Solar System*. Illustrated by the author. Boston: The Christopher Publishing House, 1948. Price, \$2.00.

THE SURGERY OF ABDOMINAL HERNIA. By GEORGE B. MAIR, M.D., F.R.F.P.S.G., F.R.C.S.E., Surgeon, Law Junction Hospital, Larnarkshire; formerly First Assistant, Professorial Unit of Surgery, University of Durham. Baltimore: The Williams & Wilkins Company, 1948. Price, \$7.00.

ACUTE INTESTINAL OBSTRUCTION. By RODNEY SMITH, M.S., F.R.C.S., Assistant Surgeon, St. George's Hospital, London; Consulting Surgeon, Wimbledon Hospital; Hunterian Professor, Royal College of Surgeons. With a chapter on radiologic diagnosis by ERIC SAMUEL, M.D., F.R.C.S., F.F.R., D.M.R.E., Late Radiologist, The Middlesex Hospital, London. Foreword by Rupert Vaughan Hudson, F.R.C.S. Baltimore: The Williams & Wilkins Company, 1948. Price, \$5.00.

HUMAN BIOCHEMISTRY. By ISRAEL S. KLEINER, Ph.D., Professor of Biochemistry and Director of the Department of Physiology and Biochemistry, New York Medical College, Flower and Fifth Ave. Hospital; formerly Associate, The Rockefeller Institute for Medical Research, New York. With 77 text illustrations and 5 color plates. Second edition. St. Louis: The C. V. Mosby Company, 1948. Price, \$7.00.

THE SHAME OF THE STATES. By ALBERT DEUTSCH. "Lunacy, like the rain, falls upon the evil and the good; and although it must forever remain a fearful misfortune, yet there may be no more sin or shame in it than there is in an ague fit or a fever."—*The Philosophy of Insanity*, by a late inmate of the

Glasgow Royal Asylum for Lunatics at Gartnavel (1860). New York: Harcourt, Brace & Company, 1948. Price, \$3.00.

DIABETIC MANUAL. For the Doctor and Patient. By ELLIOTT P. JOSLIN, M.D., Sc.D., Clinical Professor of Medicine, Emeritus, Harvard Medical School; Medical Director, George F. Baker Clinic at New England Deaconess Hospital; Consulting Physician, Boston City Hospital, Boston, Mass. Eighth edition, illustrated. Philadelphia: Lea & Febiger, 1948. Price, \$2.50.

AN INTRODUCTION TO GASTRO-ENTEROLOGY. Fourth edition, revised and enlarged. By WALTER C. ALVAREZ, Professor of Medicine, University of Minnesota, The Mayo Foundation, and a Senior Consultant in the Division of Medicine, The Mayo Clinic; author of "Nervousness, Indigestion and Pain." With 269 illustrations. New York: Paul B. Hoeber, Inc., 1948. Price, \$12.50.

THE CASE AGAINST SOCIALIZED MEDICINE. A Constructive Analysis of the Attempt to Collectivize American Medicine. By LAWRENCE SULLIVAN. Washington, D. C.: The Statesman Press, 1948. Price, \$1.50.

CLINICAL UROLOGY. Essentials of Diagnosis and Treatment. By LOWRAIN E. MCCREA, M.D., F.A.C.S., F.I.C.S., Clinical Professor of Urology, Temple University Medical School; Attending Urologist, Philadelphia General Hospital. With 263 illustrations, 7 in color. Second edition. Philadelphia: F. A. Davis Company, 1948. Price, \$6.50.

PATHOLOGY. Edited by W. A. D. ANDERSON, M.A., M.D., F.A.C.P., Professor of Pathology and Bacteriology, Marquette University, School of Medicine, Milwaukee, Wis. With 1183 illustrations and 10 color plates. St. Louis: The C. V. Mosby Company, 1948. Price, \$15.00.

SMOKE-SCREEN. By SAMUEL B. PETTENGILL, former member of Congress (Indiana); author of "Jefferson, the Forgotten Man," and "Hot Oil." New York: Southern Publishers, Inc., 1948.

FOR AMERICANS ONLY. By SAMUEL B. PETTENGILL, former member of Congress, and PAUL C. BARTHOLOMEW, Ph.D. New York City: America's Future, Inc., 1948.

OUTLINE ON HISTOLOGY. By MARGARET M. HOSKINS, Ph.D., and GERRIT BEVELANDER, Ph.D., Departments of Histology, College of Dentistry and The Graduate School of Arts and Science, New York University. Second edition. St. Louis: The C. V. Mosby Company, 1948. Price, \$3.50.



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1. Follis, R. H., Jackson, D., Eliot, M. M., and Park, E. A.: *Am. Jour. Dis. Child.*, 66:1, July, 1943.

2. Stearns, G.: *Jour. Lancet*, 63:344, Nov., 1943.

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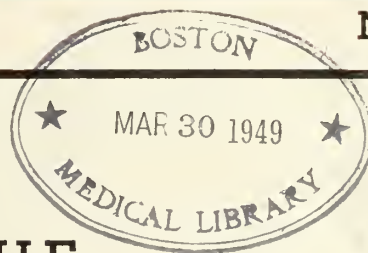
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AMNIOTIN is the *ONLY* complex of naturally occurring mixed estrogens for use by three routes: intramuscular, oral, and intravaginal. Its great range of potency and flexibility of administration enables you to individualize the therapy for each and every patient with a single preparation.

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The unusually high caloric value supplies a generous proportion of the total calories supplied in the feeding supplement.

Each bottle of QUAKER MAID syrup is double-sealed and tamper-proof so that it arrives in the home in the same sanitary condition in which it left the refinery.

QUAKER MAID syrup is economical because it is distributed only in areas that can be reached without adding high freight rates to the selling price.



The formula given the baby shown here contained Quaker Maid syrup exclusively as a carbohydrate supplement.

ANALYSIS

Moisture	23.20
Solids by drying (Vacuum 70°C.)	87.84
by Refraction	86.80
Ash	0.72
Chlorides as Sodium Chloride	0.18
Sugars, Before Inversion	33.21
As Invert	32.13
As Dextrose	
Sugars, After Inversion	39.13
As Invert	37.66
As Dextrose	4.50
Sucrose	66.3
Glucose	
(211°V)	
Total Sugars after Prolonged Acid Inversion (Includes Dextrines)	68.3
As Invert Sugar	65.9
As Dextrose	25.4
Dextrins (calc.)	144
Calories, per fluid ounce (calc.)	



QUAKER MAID SYRUP is a product of the
Atlantic Syrup Refining Corp., Philadelphia, Pennsylvania

Prove CAMEL MILDNESS *for Yourself!*



Two women are shown in the lower half of the advertisement. They are both smiling and holding cigarettes. The woman on the right is holding a lit cigarette, and smoke is visible. The woman on the left is holding a cigarette and has a small white box over her mouth. A sign is placed in front of them.

Money-Back Guarantee!

Test Camel Mildness for yourself in your own "T-Zone"—T for taste, T for throat. If, at any time, you are not convinced that Camels are the mildest cigarette you ever smoked, return the package with the unused Camels and we will refund its full purchase price, plus postage. (Signed) R. J. Reynolds Tobacco Company, Winston-Salem, North Carolina.

In a recent coast to coast test of hundreds of people who smoked only Camels for 30 days, throat specialists, after weekly examinations, reported:

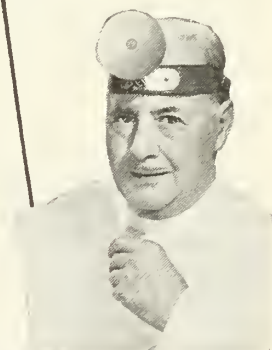
“Not one single case of throat irritation due to smoking CAMELS!”



Hundreds of men and women were included in this coast to coast test. These men and women smoked Camels—and only Camels—for 30 consecutive days. They smoked on the average of one to two packages a day. Each week noted throat specialists examined the throats of these Camel smokers—a total of 2470 careful examinations. In every report, the findings of these throat specialists were the same—“not one single case of throat irritation due to smoking Camels.”



According to a Nationwide survey:
**MORE DOCTORS
SMOKE CAMELS**
than any other cigarette



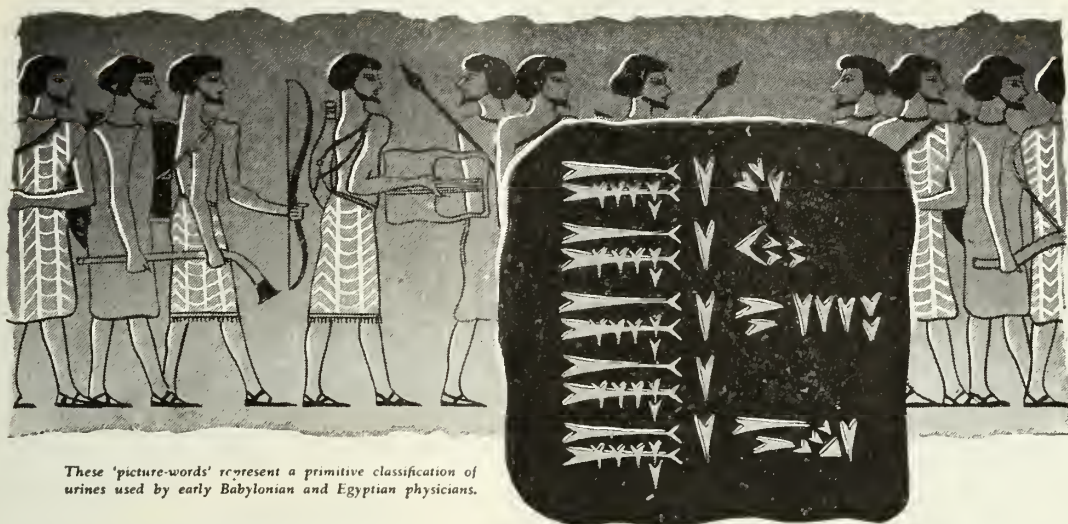
Doctors smoke for pleasure, too! And when three leading independent research organizations asked 113,597 doctors what cigarette they smoked, the brand named most was Camel.

LIST OF COUNTY MEDICAL SOCIETIES OF PENNSYLVANIA

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS
Adams	John J. Knox, Gettysburg	Raymond M. Hale, Arendtsville	Monthly
Allegheny	Thomas McC. Mabon, Pittsburgh	William F. Brennan, Pittsburgh	Monthly†
Armstrong	F. O'Neil Robertson, Jr., Kittanning	Cyrus B. Slease, Kittanning	Monthly*
Beaver	George R. Boyd, Beaver Falls	J. Willard Smith, Beaver Falls	Monthly
Bedford	John A. Topper, Hyndman	Joseph A. Eyler, Bedford	Monthly
Berks	Archibald R. Judd, Hamburg	Clair G. Spangler, Reading	Monthly
Blair	Robert M. Keagy, Altoona	George R. Good, Altoona	Monthly*
Bradford	George E. Boyer, Troy	Stanley D. Conklin, Sayre	Monthly
Bucks	Clifford Laudenslager, Doylestown	Walter J. Hendricks, Perkasie	6 a year
Butler	Charles B. Turnblacer, Butler	Joseph Van S. Donaldson, Butler	Monthly*
Cambria	Francis T. Carney, Johnstown	Warren F. White, Johnstown	Monthly
Carbon	Marvin Evans, Lansford	John L. Bond, Lehighton	Bimonthly
Centre	William L. Welch, State College	Hiram T. Dale, State College	Monthly
Chester	Alfred L. Chicote, Phoenixville	Francis Jacobs, West Chester	Monthly
Clarion	George P. Davey, Rimersburg	James M. Hess, Fryburg	Quarterly
Clearfield	Maximo J. Tornatore, Clearfield	George C. Covalla, Clearfield	Monthly
Clinton	William C. Long, Jr., Lock Haven	David W. Thomas, Lock Haven	Monthly
Columbia	Joseph V. M. Ross, Berwick	Jesse G. Fear, Berwick	Monthly
Crawford	John P. Hobson, Cambridge Springs	Robert G. Pett, Meadville	Monthly
Cumberland ...	E. Blaine Hays, Carlisle	Richard R. Spahr, Mechanicsburg	Bimonthly
Dauphin	A. Harvey Simmons, Harrisburg	Hamblen C. Eaton, Harrisburg	Monthly*
Delaware	Walter E. Wentz, Jr., Media	Walter E. Egbert, Chester	Monthly
Elk	Augustine C. Luhr, St. Marys	Robert J. Dickinson, Ridgway	Monthly*
Erie	James H. Delaney, Erie	Russell B. Roth, Erie	Monthly
Fayette	Harold L. Wilt, Brownsville	Rudolph E. Medlen, Uniontown	Monthly
Franklin	Robert B. Brown, Waynesboro	Earl Glotfelty, Waynesboro	Monthly
Greene	Wayne E. Booker, Waynesburg	John A. McAfoos, Carmichaels	Monthly
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Indiana	Warren L. Whitten, Indiana	Harry B. Neal, Jr., Indiana	Monthly
Jefferson	Raymond F. O'Connor, Punxsutawney	E. Nicholas Sargent, Falls Creek	Monthly
Juniata	Samuel F. Metz, Thompsontown	Robert P. Banks, Mifflintown	Bimonthly
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McKean	Homer A. Wilson, Bradford	Persis Straight Robbins, Bradford	Monthly
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† Except June, July, and August



These 'picture-words' represent a primitive classification of urines used by early Babylonian and Egyptian physicians.

centuries to perfect seconds to perform

When Sumerian and Babylonian physicians, *circa* 4000 B.C., noted the varying colors and constitutions of the "water of the phallus," they were probably not the first uroscopists in history. They were assuredly not the last, for fifty-odd centuries were to elapse before Fehling's first paper on the copper reduction test for urine-sugar appeared in 1848.

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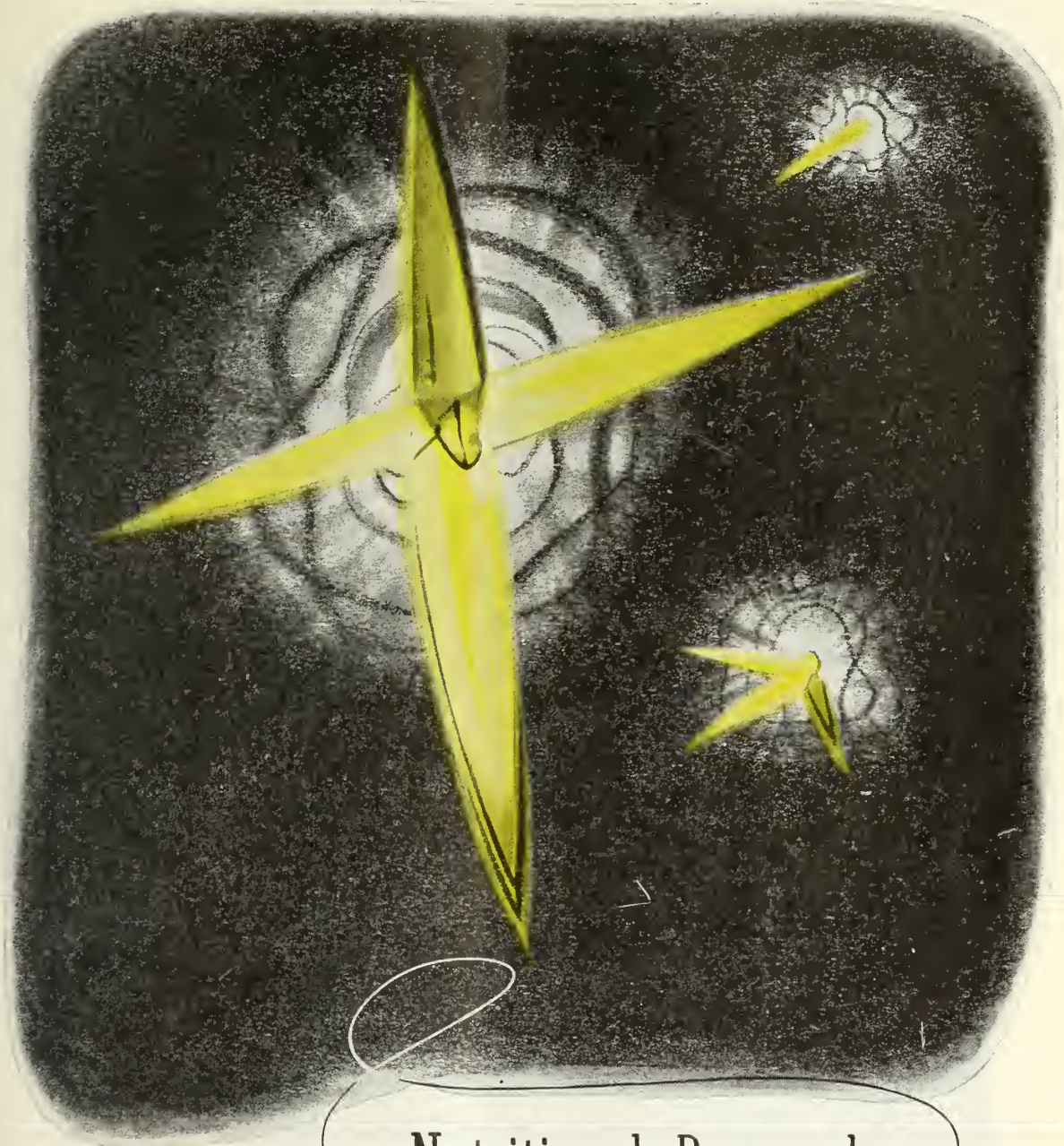
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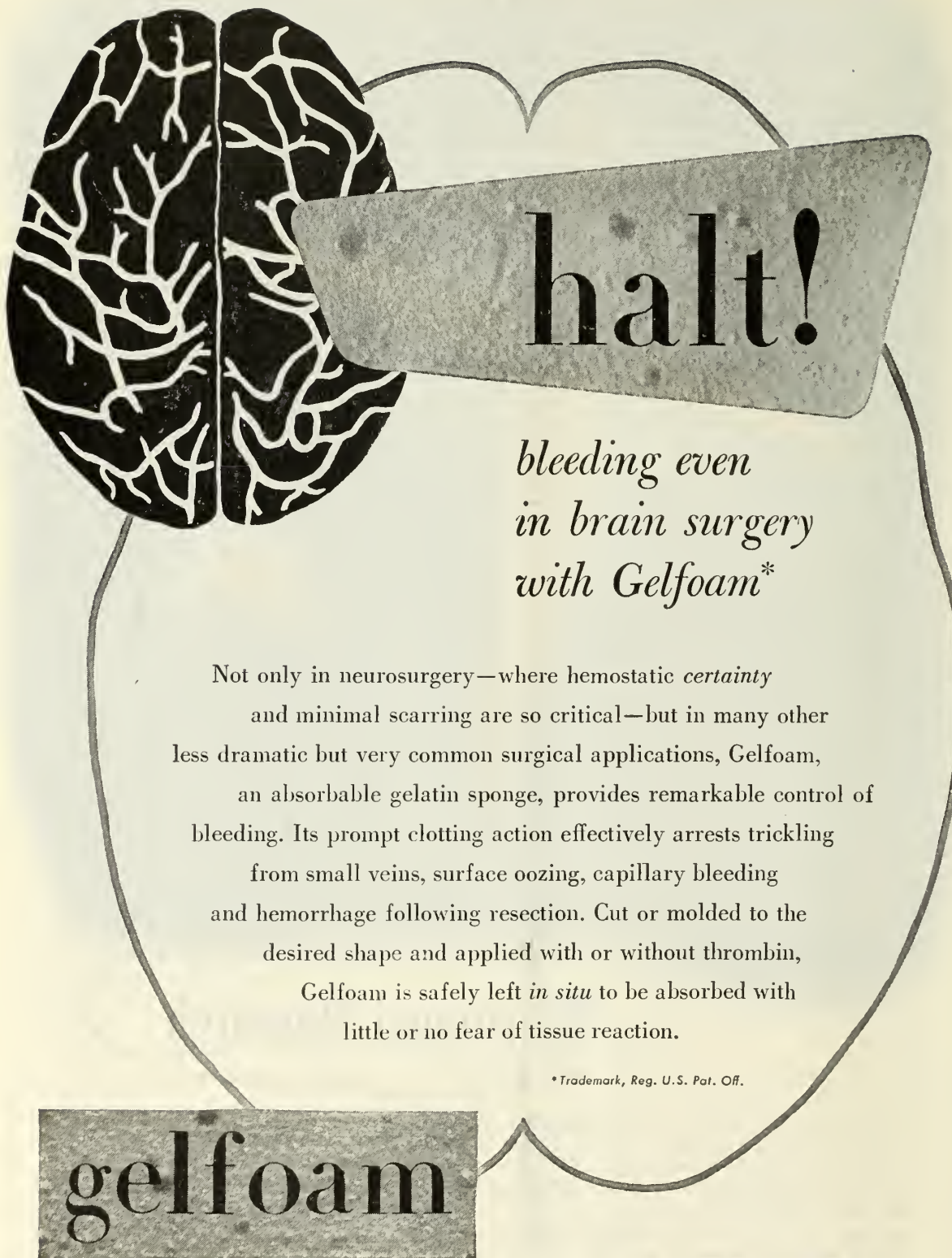
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in brain surgery
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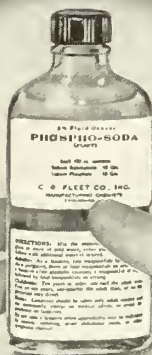
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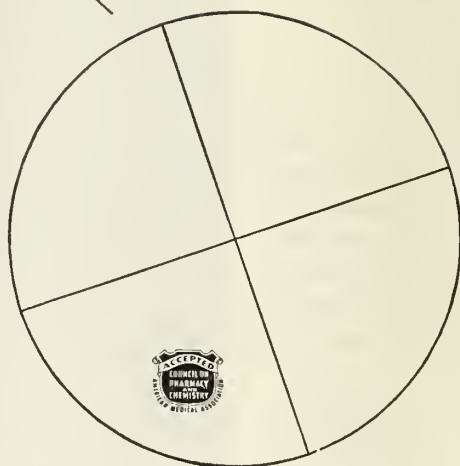
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THE PENNSYLVANIA MEDICAL JOURNAL

The Early Diagnosis of Tumors of Bone

BRADLEY L. COLEY, M.D.
New York, N. Y.



THE medical profession in general does not appreciate the fact that the interval between the manifestation of early symptoms of bone sarcoma and the establishment of a correct diagnosis averages from four to five months. Undoubtedly this long intervening period is responsible in part for the unfavorable prognosis, and the blame for it must in most instances be shared by patient and physician alike. The patient's failure to appreciate the importance of pain in an extremity and his tardiness in seeking medical attention indicate the need of a more extensive education of the laity, especially of the sort that has been so successful in dealing with women who have developed a lump in the breast. On the other hand, the physician must answer for the deplorable tendency to regard the symptom of pain, which is usually the initial complaint in cases of bone sarcoma, as a trivial affair calling merely for the use of liniments, physiotherapy, or even exercise in the mistaken belief that the condition is traumatic, rheumatic, or neuritic.

One must hope that the greater emphasis which medical schools are now placing upon the early diagnosis of neoplastic disease, and the more thorough training of orthopedic residents in the prompt recognition of bone tumors, will soon bear fruit. If the possibility that the patient's symptoms may be due to a bone sarcoma

is not even suspected by the doctor who first sees him, it is unlikely that the proper measures toward a correct diagnosis will be instituted.

It is impractical in this paper to discuss in detail the steps necessary for a complete diagnostic survey, although obviously such is desirable whenever the presence of a bone neoplasm is suspected. There is no substitute for a carefully elicited history and a thorough physical examination, nor can too great emphasis be placed upon the value of prompt roentgenographic examination.

We have found in the Bone Tumor Department of Memorial Hospital that, even with all the diagnostic aids available, it is sometimes extremely difficult to arrive at a correct diagnosis of lesions of the skeletal system. No less an authority than Brailsford, the eminent British roentgenologist, has emphasized these difficulties. In 1948 he stated that "the clinical signs and symptoms of tumors of bone are so variable in their manifestations that except in a small proportion of cases they are of little or no value in determining the nature of a bone tumor. . . . These tumors are so variable in all their characters and manifestations that they defy any scheme of classification. We should be lucky indeed if we could readily separate the simple from the malignant. They are so rare in any one surgeon's practice, unless he is a recognized authority to whom many of his colleagues refer their cases, that little practical experience in diagnosing and treating these bone tumors can be obtained; yet the general practice is for the surgeon to treat his own cases."

Presented before the Section on Pathology and Radiology at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 5, 1948.

Brailsford emphasizes the unreliability of biopsy and stresses the occasional reported cases, which would indicate that reliance on histologic examination has resulted in radical surgery which was not justified. He concludes, "the catastrophes which may follow erroneous interpretation of malignancy in such cases should warn any surgeon against biopsy."

In contrast to the "unsatisfactory nature of the evidence provided by biopsy" Brailsford feels that "better evidence is being supplied with increasing accuracy by radiology."

While granting that great progress has been made by radiologists in the correct interpretation of bone neoplasms, we are still of the opinion that the histologic criteria afford a higher degree of accuracy; at the same time we must confess to a sense of greater confidence when both the pathologist and the roentgenologist arrive at the same conclusions in a given case. We would, however, take strong exception to the view expressed by Brailsford that "it is unjustifiable to record lesions as 'fully proven' malignant tumors though the clinical, histologic (and perhaps the radiographic), appearances suggest malignancy, if amputation results in a cure," for we have personal records of more than sixty five-year survivals of primary bone sarcoma in which microscopic study, carefully rechecked, leaves no shred of reasonable doubt of the correctness of the diagnosis.

Brailsford appears to be casting doubt upon the ability of the pathologist to diagnose, and the surgeon to cure malignant tumors of bone. But impartial observers would, I am sure, consider that the roentgenologist has had no better record in diagnosing these cases than has the pathologist, and certainly no better results in curing them than the surgeon.

In our humble opinion all three should be regarded as a team rather than as rivals and should be proud to collaborate fully, to the end that the patient may receive the most intelligent care at the earliest possible moment.

Turning now to some of the difficult decisions that may arise, we have selected those which seemed of special importance. It is needless to point out that mistakes in diagnosis may lead to serious consequences.

Myositis Ossificans and Osteogenic Sarcoma.—While neither of these conditions is common, there have been a number of instances in which the differential diagnosis has proved exceedingly difficult even with the aid of an open biopsy. This is due to the fact that both conditions are associated with bony swellings often located in

the lower part of the thigh; both give rise to new bone formation which may be difficult of interpretation on early roentgenograms; and finally, the microscopic appearance of tissue removed from an early case of myositis ossificans may so closely simulate osteogenic sarcoma as to bewilder even highly trained pathologists.

Here, the distinguishing features to be relied upon are:

1. In myositis ossificans the swelling follows almost immediately upon a rather severe trauma; it reaches a peak promptly and tends to diminish in size slowly thereafter.
2. Pain in myositis ossificans lessens rapidly with the passage of time, whereas in osteogenic sarcoma it increases steadily by insensible gradations.
3. Stereoscopic views of myositis ossificans reveal the cortex to be unbroken and all the new bone formation to be in the overlying soft parts. This is the salient distinguishing feature—it is never found in osteogenic sarcoma; therefore, stereoscopic views may be required in order to establish the diagnosis.

Bone Cyst, Giant Cell Tumor, Central Chondroma.—The distinction between bone cyst or giant cell tumor and central chondroma can usually be made by roentgenograms. Having seen a considerable number of cases in which an incorrect diagnosis of one of the first two named was made—the pathologist later reporting the lesion to be central chondroma—we believe it important never to institute roentgen therapy for central bone lesions until histologic confirmation has been obtained. This is especially important since the same mode of treatment is not indicated in the two conditions.

Chondroma calls for surgical measures rather than irradiation. If one irradiates a suspect lesion on the assumption that it is a cyst or a giant cell tumor and later finds—from its lack of response or from subsequent biopsy—that it is a chondroma, it may then be too hazardous to employ the definitive surgical measures that were definitely indicated in the first place. For experience has shown that after irradiation, local operative procedures on bone are often followed by failure of the bone to regenerate and by imperfections of wound-healing. As the initial procedure then, we favor the complete eradication of all such lytic central bone lesions, followed by the filling of the cavity with bone fragments. This will not only assure the pathologist all the material for microscopic study but may prove sufficient to control the disease whether it be bone cyst, giant cell tumor, or central chondroma. If,

on the other hand, the condition is found to be one of medullary chondromyxosarcoma, further and more radical surgical measures may be undertaken promptly, such as segmental resection or even amputation. Nothing is more tragic than the case of a low-grade chondrosarcoma which has been subjected to irradiation, conservative surgery, and finally to amputation only to be followed by pulmonary metastasis when such a case might well have been treated successfully by surgery as the primary measure.

This seems to be an appropriate place to emphasize the fact that benign tumors of cartilage are of real consequence since they constitute a definite threat of future transformation into secondary chondrosarcoma, the change usually taking place insidiously. So often have we observed this transition and so unpredictable is its occurrence that we have come to regard chondromas as precancerous lesions deserving of serious consideration and calling for surgical removal whenever feasible. Furthermore, these cartilaginous tumors may present some areas which are histologically benign in appearance and other closely adjacent ones that are definitely malignant. This unhappy feature has been responsible for the frequent misinterpretation of biopsy material obtained by the removal of bits of tissue rather than the entire tumor. As a corollary it may be asserted that aspiration biopsy of cartilage tumors is not reliable, and unless chondrosarcoma is reported by the pathologist, one cannot place reliance on the findings. Certainly for such tumors a complete surgical removal constitutes the only safe method of biopsy.

Ewing's Sarcoma and Reticulum Cell Sarcoma.—Despite a contrary view held by a few pathologists, we regard Ewing's sarcoma and reticulum cell sarcoma of bone as two distinct diseases. Both are radiosensitive—the latter much more so—and for both, irradiation is the method of choice. It is important nevertheless to determine which of the two lesions is present because in Ewing's sarcoma the treatment is usually followed by a fatal issue, whereas in reticulum cell sarcoma the outlook for long survival or cure is definitely better.

We believe that a distinction can generally be made if one takes into consideration the age of the patient, the roentgenographic features of the lesion, and finally and of great importance, the microscopic appearance of the tumor itself. Ewing's sarcoma is unusual in patients over 25, whereas reticulum cell sarcoma is most often seen in patients past that age. The roentgenographic picture is characteristically different al-

though occasionally it may be quite similar. Ewing's sarcoma tends to split the cortical layer of the bone, to provoke periosteal reactive bone, and to produce bulky swellings. Reticulum cell sarcoma, also osteolytic, destroys bone in a more irregular manner and produces a "cracked-ice" appearance. The histologic picture is superficially similar if not identical and it requires an experienced pathologist to discern the distinguishing features. We advise against accepting the histologic diagnosis of Ewing's sarcoma in patients over 30 years of age without a review of the sections by pathologists who have had experience in such problems.

Eosinophilic Granuloma and Malignant Tumors of Bone.—Among the benign conditions which may present diagnostic difficulties must be considered eosinophilic granuloma. Although usually giving rise to milder symptoms than do most malignant neoplasms, its roentgenographic features may in children suggest an osteolytic variety of osteogenic sarcoma or a Ewing's sarcoma, while in adults it has simulated metastatic cancer, reticulum cell sarcoma, or other primary bone sarcomas.

It produces an irregular area of radiolucency, is purely osteolytic, and even reactive bone at the margins is entirely lacking. It is generally monostotic save in the form seen in young children, which is known as Hand-Schüller-Christian's syndrome and which often presents multiple lesions.

The microscopic examination is usually decisive because the histologic picture is clear-cut and characteristic. Aspiration biopsy has been successful in many instances. Once the diagnosis has been clearly established, mild doses of roentgen therapy may be employed and are usually successful.

Metastatic Cancer and Plasma Cell Myeloma.—It is sometimes difficult to decide whether a destructive process in a patient over 40 years of age is due to cancer metastasis or to plasma cell myeloma. This is particularly true of solitary lesions of considerable size. Thyroid cancer, for example, may produce a large lytic area in the ilium which may resemble a solitary plasma cell myeloma. Multiple small metastatic foci in the skull, ribs, and spine may appear on the roentgenogram as areas which might well be due to myeloma. There is a complete absence of marginal reactive bone production in patients with myeloma so that the areas appear to be punched out of normal bone, whereas some degree of reactive osteoblastic activity is commonly demonstrable about similar areas of metastatic cancer.

Aspiration biopsy of accessible lesions is usually diagnostic, while sternal marrow puncture may reveal plasma cell myeloma and thus establish the presence of that disease. Other corroborative evidence may be afforded by the plasma protein level of the serum and by the presence of Bence Jones bodies in the urine.

Paget's Disease and Bone Sarcoma.—In a clear-cut case of Paget's disease the roentgenogram may be sufficient to determine its presence. Sometimes it is not easy to decide whether or not a pagetoid bone is also the site of a form of osteogenic sarcoma which has been appropriately termed Paget's sarcoma; and not infrequently when one bone has presented such a secondary transformation another may be the seat of a similar process. It is difficult to describe the roentgenographic features of an early Paget's sarcoma, although they are recognizable by the roentgenologist. It has seemed advisable to keep patients with osteitis deformans under continuous observation in order to be on the lookout for sarcomatous transformation. The importance of persistent pain in one area of bone affected by Paget's disease as indicating malignant alteration should be emphasized. Elevation of the serum alkaline phosphatase level occurs in both osteogenic sarcoma and Paget's disease, so that this test is not usually helpful. Microscopic sections of a suspected area will settle the question definitely.

Hyperparathyroidism and Metastatic Bone Cancer.—The problem of differentiating the bone changes of hyperparathyroidism as well as those of widespread osseous bone metastases and other osteolytic bone lesions from carcinoma is occasionally encountered. Blood chemistry determinations will usually decide the question because in hyperparathyroidism the consistent elevation of the serum calcium is a constant finding.

Osteitis and Ewing's Sarcoma.—Perhaps the most puzzling of all differential diagnostic problems in the field of skeletal disease is that posed

by the close similarity that may occur between inflammatory bone lesions and Ewing's sarcoma. The patient, usually between the ages of 5 and 20 years, may present symptoms of pain, swelling, slight disability, fever, leukocytosis, and an increased sedimentation rate. Even the roentgenograms may show a close resemblance. There is bone destruction, often involving a considerable length of the bone shaft of a long bone. The earlier the process the more difficult it is to make the distinction.

It is not surprising then that so often cases of early Ewing's sarcoma are operated upon under the mistaken impression that the condition is an osteomyelitis. In such cases the surgeon fails to find frank pus but may mistake the tissue encountered for inflammatory material, and pack the wound with gauze. This, of course, leads to disastrous consequences, such as fungation of the wound, secondary infection, bleeding, etc.

On the other hand, it is most important not to administer roentgen therapy to a patient in whom the diagnosis of Ewing's sarcoma has not already been established by histologic examination. As we have repeatedly pointed out, once even a small dose of roentgen rays has been administered, a biopsy specimen taken thereafter will not reveal the true nature of the lesion but will suggest to the pathologist an inflammatory process. This is due to the marked *temporary* radiosensitivity of this tumor.

Conclusions

In trying to arrive at an early diagnosis of a neoplasm of bone, the following measures are essential: a careful history, a thorough physical examination, roentgenograms, a study of the serum phosphorus-calcium-phosphatase, and a microscopic examination of tissue removed by aspiration or open biopsy. While in our experience the last-named is the most reliable aid, we would emphasize the necessity of relying on the correlated information gained from all of these sources rather than from any one of them.



The Tyranny of the Inconsequential

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President, Gettysburg College
Gettysburg, Pa.

THE year 1848 was an important one in world history. Cataclysmic change swept through the world. In Europe—crowns fell, thrones tottered, dynasties were changed. In America—there were vast changes, but these were orderly and in keeping with the American tradition. The effort to take the burden of life from human shoulders and place it on machines was everywhere at work. Mechanical reapers increased production and decreased the heavy labor resting on the vast multitudes living on farms. The covered wagons were moving westward. Creative minds were struggling to meet human needs. Men and women were dreaming their dreams and following them as guides.

One of the really significant events in the year of 1848 was the organization of The Medical Society of the State of Pennsylvania—the first such organization in the history of our country. We assemble, this week, to pay our respect—our grateful tribute—to those who during the century helped to elevate medical practice in our State to great prominence in the nation as a whole. Within the past century, greater progress has been made in the practice of medicine than in all the centuries preceding.

Against such a background, there came into existence this great organization. Emerging from the loneliness and hardships, there arose a bond of fellowship. This fellowship was professional it is true, but in a nobler sense it was a fellowship to acquire knowledge, stimulate study and research, and to lend to its members the courage that results from the meeting of kindred minds.

We honor that group of men who, in laboratory and classroom, nobly gave of their best to enrich the instruments through which the medical profession might be better prepared to meet the ills of mankind. These brave souls sought to find in each new discovery some means for extracting elements that would minister to physical well-being. They were intrepid pioneers and

foundation builders in the field of modern medicine.

We think of those unsung heroes of the medical profession—those who tasted the hardships of undeveloped highways, physical inconveniences, personal exposure. In the darkness of the forest, on primitive roads—exposed to danger and the rigors of weather—like the Great Physician two thousand years ago—their ministry brought a little bit of Heaven wherever they went. I can conceive of no more fitting tribute to the past or a more adequate preparation for the century that lies ahead than that we walk with these heroes and catch their spirit.

As I have thought of this great company and recalled the wide differences in the fields to which they gave themselves, I have sought to find the great secret of their careers. They differed so greatly in native endowment, personal taste, and field of work. Yet heroism, courage, and supreme devotion were the qualities that ran throughout the profession. What was the common bond that gave birth to these high qualities? I think, without a doubt, we can find it in the realm of the dreams they cherished.

We clamor today for realism. We tend to look askance at the dreamer. By all means, let us be realistic but let us be sure that our quest for realism does not become superficial and inadequate. In appraising human life, let us take into account that the value of the youth starting life is determined not so much by social rank, unusual endowment, or the assistance of friends. His value is to be found, rather, in the nature of the dream, the size of the dream that dwells like a flame in the secret altar of his soul.

I am thinking of a ten-year-old lad on a humble mid-western farm decades ago. Tired hands put away plows and tasks of the farm and prepared for the quiet of the night. As a rugged, hard-working farmer came to his home, he was met by a mother who told him in distressed tones that their youngest son had become ill and a doctor was needed. Mounting a horse, the father rode down the crude pathway in quest of the

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physician. The little ten-year-old boy sat watching the road. After what seemed an endless time, the dust of the road marked the coming of the physician. As the father and the doctor entered the humble home, the ten-year-old slipped through the door and quietly entered the sick-room. He sat silently in the corner watching. No, it was not the sick bed nor his brother—nor even the doctor. The lad's eyes were fastened on the face of his mother. The kerosene lamp cast a weak and imperfect glow but it was enough for him to see every line of his mother's face. After carefully examining the younger brother, the doctor looked up and said to the mother, "Your son will live." There was a creak of the door and the ten-year-old was gone. Had you walked within the home that night, there would have been no apparent change. Something had happened however—a great dream had been born.

Human dreams are footprints of God in the struggle of mankind.

Years passed and the ten-year-old had grown to young manhood. One day a discussion arose among a group of students. A wise teacher said to the class: "At the foundation of every great achievement lies a great dream. Has anyone in the room a great dream?" Turning to the ten-year-old—now a young man—the teacher asked: "Have you a dream in your life?" From the lad, there came a prompt reply. It was the story of this great experience of his childhood. He said: "It is my dream to bring to many, many faces the smile that I saw on the face of my mother when the doctor restored hope to her soul."

More years passed. That lad of ten, now one of the most distinguished members of the medical profession, dedicated his life to the carrying out of a great dream. In your great profession, let us be careful—in presenting it to youth—that we do not overlook the fact that a college may bestow a diploma, but only a great dream builds a real physician.

In the annals of 1948, this one hundredth anniversary of The Medical Society of the State of Pennsylvania will rank as an important occasion. The heritage which has been built up through a century of hardships, dreams, and heroisms comes to us as a solemn obligation—a trust.

I stood, one night, on the top of St. Paul's in London. Darkness was falling like snowflakes. The chill of the air came with it. Wherever I looked, there seemed the promise of only darkness. Suddenly, far down, I noticed the glimmer of a single light—then another—and another. The lights radiated in all directions. The London gaslights were being illumined by the lamp-lighters who began to plod along their destined

task. Wind and weather meant nothing to them. You could trace them through the darkness by the path of lights they left behind them.

So, as I stand here today, and look back over the century, I can see the heroic lamp-lighters of the medical profession. They found their way through the streets of the cities and towns and villages. Wherever men and women were struggling to live, wherever children were born or the weak needed tender care, those indomitable lamp-lighters were on their way. Wherever they went, they brought hope, cheer, and a bit of Heaven.

Let us recognize the strange malady which has fallen like a fog upon this land that we love. In every area of life, its blinding hand is obvious. I speak of the tyranny of the inconsequential in our thinking. We have struggled through the years to save time. Time-saving instruments are everywhere at hand. These were designed to afford more time for leisure and inner contentment. As a people we have bent our energies on life-saving devices in order that those who labor in the many avenues of life might be blessed with longer years and better health. Our own country, along with many other countries of the world, has sought for the last three decades to provide the foundations for a greater sense of security. In spite of all of these efforts, so noble in themselves, has there ever in the history of the world been an age so dominated by a fear of insecurity, uncertainty, and apprehension? Has there ever been an age in which people of every walk of life suffered so much confusion and bewilderment? Where now is the time that has been saved? Where is the peace of mind and sense of security which we sought?

In our everyday thinking, how large a place is filled by things that are really of small account—thoroughly inconsequential? Mankind has been suffering mentally, physically, and spiritually under the tyranny of the inconsequential. How large a place in our thinking is dominated by things that are thoroughly inconsequential! The thoughts of today determine life's tomorrows. Every nook and corner of the modern mind seem to me to be dominated by the inconsequential—by things of meager importance.

In the realm of our conversation, the inconsequential has occupied the most important place. The conversations of the home, the conversations of the club, the free conversations with our neighbors—all furnish one with a most important field of study. What are we talking about? What are the words most frequently used? The subjective reaction of the words we use is beyond all computation. Do we use great vigorous

words like "duty," "destiny," "courage," and "heroism"? I am afraid not. Words play a great part in the building of a life. The words we use in our ordinary conversation may reveal what we are, but we forget too often that they determine what we will become.

In the modern sense of values, the paralyzing influence of the inconsequential is so evident. What are the things that we exalt? What are the things held before the youth of America as of supreme value? The *science of getting* is far more prominent than the *art of giving*. We have somehow associated success with the things we possess in the field of the tangible. We talk so glibly of what we *own*—so falteringly of what we *owe*. If there is one thing that undergirds the greatness of America, it has been the completeness with which the great builders of days that are gone dedicated themselves to the high art of giving themselves rather than securing for themselves.

Years ago, the greatest Physician of all human history labored under the Syrian skies. He walked the highways and ministered to the ills of body and soul. It is written of Him that He "had not where to lay His head." After the tragedy of the cross, when greedy hands reached to grasp His belongings, all they could find to contend for was the simple garment that he wore. The wisdom of the ages was in His mind, the aroma of eternity was in His words, the love of God possessed His heart. How truly we may say of Him that He alone understood the art of heroic living. He gave new luster to that simple verse of scripture: "He who loseth his life shall find it."

Is it not true that those of us who have passed the years of youth and perhaps of middle age need to go back to the great dreams with which we started? We have shared the heat of the day. We have felt the exhaustion of sustained and devoted effort. How much we need to go back to our moments on the mountain top! This walking again with the dreams of youth will keep us young, courageous, and strong.

It has seemed to me that one of the reasons for the loss of enthusiasm which somehow comes with the passing of years is due to the fact that we have seriously overlooked the greatest source of power in the world. We are numbed because we ourselves have permitted our lives to be restricted by the inconsequential, the unimportant. We have failed to link our lives up with the one great unfailing source of power. Religion has been the most misunderstood potential power in the modern world. We have clothed it in a terminology often as lifeless as paper flowers. A

very wise man of God said centuries ago: "Except the Lord build a house, they that build it labor in vain." The delicate mechanism of the human mind has been fashioned for faith—not fear.

In the days that lie ahead only that man will be able to keep his feet on the ground and nobly serve his day and generation whose heart is sustained by a simple faith in God. Mankind is so often mistaken. So much is made available which would add to the joy of life and the effectiveness of living!

Many years ago, mankind discovered fire as a means which could be commanded. Who can ever estimate the blessing to the world resulting from this primitive discovery! It has lifted the shadows of night. It has taken from human shoulders great burdens. It has made available to life more conveniences than can be estimated. One may use it or one may neglect to use it.

The combustion engine and automobile have come into human hands for their use. You may avail yourself of the blessings of the automobile or you may refuse to use them.

In 1876, Alexander Graham Bell gave the world the telephone—we may refuse to have one in our homes. Yet I think of the dark days in the world war when our sons' voices came to us over thousands of miles because we decided to make use of a means for enriching life.

To deny ourselves the use of those forces made available for us for larger power, for service, and for greater personal happiness is to restrict life.

Religion has come to increase our awareness of the fact that we live not in a world of blind chance but under the guiding hand of God. What we do with Jesus Christ and His message to the world determines more than we dream the richness of our personal happiness and the breadth of our personal service.

In the days that lie ahead, fear-ridden, anxious men and women will seek from you not the prescription that you write but the influence of what you are. As you stand by beds of pain, as you stand by minds wracked with fear, your own rugged character will yield a measure of healing beyond your dreams.

We shall need to be men and women who have walked with God, who have lived in His precepts, who walk with steps that are sure because in the preparing of ourselves for life, we have exercised our bodies—cultivated our minds—and walked humbly and constantly with God—so that we will go in and out among our fellow-men strong in a strength that is His gift to those who seek Him.

Chemotherapy and Antibiotics in Surgical Infections

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IN THE broadest concept of this subject every chemical or antiseptic which has been applied to the skin, open wounds, within a body cavity, and given orally, subcutaneously, intramuscularly, or intravenously would of necessity be considered; however, for practical purposes we wish to consider skin antiseptics, the compounds of the sulfa group, penicillin, streptomycin, and the newer mycine group with a passing comment on zinc peroxide and Dakin's solution.

Wherever possible accurate bacteriologic diagnosis is always advisable in relation to chemotherapy, since application of these compounds is indicated only in the treatment of pure or mixed infections due to susceptible organisms. In many instances, however, the surgeon is justified in making a presumptive clinical diagnosis and proceeding with chemotherapy without delay.

Fortunate are those who, having practiced surgery in the pre-chemotherapy period, have been permitted to continue practice during this modern age. The recent graduates have all the advantages of the present modes of prophylaxis and therapeutics, but are lacking in the knowledge of the complications of the past and are less likely to recognize similar complications which may arise in cases which are resistant to modern prophylaxis.

The addition of the sulfa compounds, penicillin, streptomycin, and others to our armamentarium and their exploitation prophylactically and therapeutically have reduced mortality and morbidity. Serious operations formerly done in multiple stages are now accomplished in one phase with a substantial saving in time, risk, and cost to the patient. New fields hitherto inaccessible or accompanied by prohibitive risk are now entered with confidence and safety.

Each surgeon has his own choice of a local antiseptic; however, the present trend is toward the acriflavine group or the quaternary ammonium compounds, of which zephiran is an example.

Developed during World War I, Dakin's solution has stood the test of time as an efficient form of chemotherapy in open wounds; however, in the past decade its virtues have been rapidly supplanted by the recently developed chemicals in certain types of infection.

Zinc peroxide has its place in the care of certain anaerobic infections, notably with the microaerophilic *Streptococcus hemolyticus*. The use of this drug in forty undermining ulcers was described in 1939 by Meleney and Harvey. Those who have seen these continuous burrowing wounds which fail to heal under all types of management will be pleased with the results obtained by the application of this medium in the proper manner.

The importance of culturing an area of gangrene in the skin cannot be overemphasized. Recognition of the infecting organism leads to appropriate therapeutics. Certain types of gangrene due to the *Entamoeba histolyticus* will respond to drugs of the emetine group.

The development of *sulfanilamide* opened a new era in chemotherapy. Since the original synthesis of this chemical, many improved forms have been developed. Chemicals of these derivatives are used locally, orally, and intravenously.

The local effectiveness of the sulfonamides and the antibiotics or any other antibacterial agent is limited (1) by its solubility in body fluids; (2) by its diffusibility from the vehicle in which it is applied; (3) by its inhibition by dead tissue, pus, blood, or any other product of tissue disintegration; (4) by the inactivating action of bacterial contaminants; and (5) by the resistance of the causative organisms.

It is true that the sulfonamides in general, with the possible exception of sulfamylon, are inhibited by necrotic tissue and by organic acids which are present in exudates. Furthermore, they are relatively insoluble so that they may act as foreign bodies and be mechanically irritating. This is particularly true of sulfathiazole and sulfadiazine.

Recently, three of the sulfa drugs have been combined for oral administration in an attempt

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to avoid crystalline deposits. The combination of sulfamerazine, sulfadiazine, and sulfathiazole has been advantageous in preventing crystalline deposits in the urine.

In 1939 Jensen, Johnsrud, and Nelson reported the local implantation of sulfanilamide in 39 cases of compound fractures. This was followed by a wave of enthusiasm for the copious exhibition of this chemical.

Experience has shown that the large amounts previously used locally delayed healing and that a mere frosting of wounds was sufficiently effective to prevent local infection and permitted primary healing. About the same period C. W. Mayo and Joseph M. Miller described the use of this drug in colonic resection. Experience again proved that light dusting was more effective.

From the work which has been done on chemotherapy in colonic resection, the one-stage procedure of resection and primary anastomosis received considerable impetus. Further, application of this drug in purulent appendicitis has permitted closure of many wounds which formerly required drainage.

In addition to the local use of sulfanilamide, systemic medication proceeded. In the early phase of medication with the sulfa drug, blood levels were carefully watched, inasmuch as over-exploitation of this drug was prone to produce unfavorable reactions, such as acute leukemia, agranulocytosis, hematuria, and hepatitis. Experience has proven that 4 grams daily orally is usually an adequate dosage.

Sulfanilamide, being poorly soluble, was occasionally used in proctoclysis and subcutaneously. The development of sodium sulfadiazine, which could be given intravenously, was of great value in further therapy. Sulfathiazole was found to result in less unfavorable reaction when taken by mouth, and sulfaguanidine, sulfathaladine, and sulfasuxidine were found to be more efficient in intestinal surgery.

During the treatment of ulcerative colitis and ileostomies with sulfathaladine, stools become formed and odorless, abdominal cramping subsides in forty-eight hours, blood in the stools disappears, and evacuations are reduced substantially. A high concentration is obtained locally, and only about 5 per cent is absorbed systemically.

Penicillin was discovered in 1929 by Alexander Fleming, of St. Mary's Hospital, London. This discovery was practically dormant for a period of ten years. In 1939 this drug was investigated by Howard W. Florey, of Oxford University, and the era of antibiotic therapy began.

In the early stages this drug was found to maintain an adequate blood level with a dosage of 20,000 units every three hours.

During the war this drug was used extensively as far as the supply was available. In general its use was limited to the severest cases or to severe chest or abdominal wounds.

Chemical research permitted the preparation of this drug on a large scale and extensive use is now permitted. Romansky developed the penicillin oil and beeswax preparation which permitted 300,000 units daily, one dose medication. Further developments have permitted the solution of this drug in peanut oil or sesame oil, which are less irritating. The latest forms include one of the procaine derivatives which reduces the pain of injection and the more recent crystalline form which permits the injection of an aqueous solution, containing one million units in 1 cc. Depocillin (300,000 units) maintains a therapeutic level as long as ninety-six hours.

The urinary excretion of penicillin may be reduced with a consequent increase and prolongation of blood concentrations by the oral administration of 2 Gm. sodium benzoate or 2 to 4 Gm. caronamide every four hours.

A word about penicillin locally. This drug can be used in powder form implanted directly into the wound, or when dissolved in procaine it can be used as a local antiseptic and anesthetic in infected wounds. This work was first published by Drs. Glenn H. and Marlin W. Heilman, of Tarentum, Pa.

Penicillin may be used advantageously in the prevention of (1) infection in traumatic or post-operative wounds and compound fractures; (2) empyema following lung resection; (3) gas gangrene following amputations; (4) infection of skin grafts; (5) ocular infection after penetrating injuries, burns, etc.; (6) ophthalmia neonatorum; (7) puerperal infection following abortion or severe dystocia; (8) septicemia following surgical operation or manipulation in osteomyelitis; (9) intracranial infections following operations on the mastoids or sinuses; (10) peritonitis after rupture of the appendix, abdominal wounds, etc.; (11) infection following perforating wounds of the hands or feet; and (12) subacute bacterial endocarditis after extractions of teeth, tonsillectomy, etc.

Streptomycin is one of the more recent additions to our armamentarium and represents a distinct advance in chemical therapy. Its application fills the space which was lacking after the two previous drugs had been applied, caring for

the organisms which were unsusceptible to these other drugs. It was originally believed necessary to divide the daily dosage into three-hour intervals; however, experience has shown that, in certain conditions, division of the daily dosage of 1 Gm. into two doses, twelve hours apart, is adequate.

The greatest *disadvantage* lies in the application of submaximal doses which may introduce streptomycin fastness in which the organism has become resistant to its application. Fastness also applies to the sulfa group and penicillin.

On a prophylactic basis the three drugs may be given in cases where organisms susceptible to each are anticipated. In intestinal resection, sulfasuxidine should be given by mouth preoperatively, four or five days, and penicillin (300,000 units) and streptomycin hypodermically may be given twelve hours preoperatively. Following operation, penicillin and streptomycin may be continued hypodermically, and sulfa drugs are given intravenously in cases where oral medication is interdicted.

Treatment failures may be due to any of many causes, among which may be mentioned: (1) mistaken clinical or bacteriologic diagnosis; (2) infection due to organisms possessing a high natural or so-called acquired resistance to penicillin or streptomycin; (3) doses too small, intervals of administration too long, or duration of treatment too brief; (4) overwhelmingly severe infections or too long delay in the institution of treatment; (5) localization of infections in areas inaccessible to penicillin or streptomycin; (6) inadequate surgical treatment or failure to use other adjuvant measures of helpful value; and (7) the occurrence of spontaneous new infections or superinfections with other organisms in-

dicating the frequent need for repeated bacteriologic examinations during treatment.

Tyrothricin is a mixture of gramicidin and tyrocidine produced by *Bacillus brevis*. It is highly active against staphylococci, streptococci, pneumococci, *M. catarrhalis*, *Lactobacillus acidophilus*, and mouth spirochetes. It is dispensed as a 2 per cent solution in alcohol and in ointments.

This compound, however, is too hemolytic and otherwise toxic for parenteral administration and is relatively ineffective when administered orally. Consequently, it is used only as a topical application. A 1:5000 colloidal suspension in sterile water (0.2 mg. per cc.) is usually well borne.

Tyrothricin is worthy of trial in the prevention and treatment of surface infections by gram-positive organisms, including wounds, burns, skin grafts, osteomyelitis, postoperative sinuses, chronic ulcers, sinusitis, mastoiditis, purulent rhinitis, otitis media, empyema, cystitis, suppurative arthritis, ophthalmic infections, furuncles, carbuncles, eczematoid dermatitis, and others.

Bacitracin is a new antibiotic agent produced by a member of the *Bacillus subtilis* group. It has been found highly active against gram-positive organisms, especially streptococci and staphylococci, and its bactericidal activity is stated not to be materially reduced by plasma, blood, pus and tissue products.

It has been employed only in the treatment of local infections by injections of aqueous solutions into lesions (0.1 to 5.0 cc. carrying 100 units,) and by topical applications of ointment prepared in a water-soluble base.

We are indeed fortunate to have these powerful therapeutic agents available in our armamentarium and should handle wisely the talents entrusted to our hands.

1949 SCIENTIFIC EXHIBIT APPLICATIONS AVAILABLE

The forms for applying for space in the Scientific Exhibit of the 99th Annual Session which will be held at the Hotel William Penn, Pittsburgh, Sept. 26 to 29, 1949, may be secured from Elwyn L. Heller, M.D., Chairman, Committee on Scientific Exhibits, Presbyterian Hospital, Pittsburgh 13, Pa.

Completed application forms must be returned to the committee by May 1 to receive consideration.

EARLY AMBULATION IN SURGERY

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EARLY ambulation in surgery is not a new concept. Ries in 1899 discussed its applicability—but not until the last ten years has there been a wide gain in its application. The dangers of bed rest not leavened with exercise have been stressed in numerous papers and symposia.

Sporadically in years past early ambulation happened. McDowell found one of his patients doing the wash on her fifth day. A hernia repair on a doctor's son was not influenced by his leaving the hospital on the third day, and driving his car on the sixth day—twenty-three years ago. Later, as a resident on Dr. John B. Deaver's services in 1927, I can remember another resident who played tennis on the third day after being operated upon for acute appendicitis.

The change has been that instead of on occasion, and often as a stunt, early ambulation now definitely has a part in modern surgical practice.

General Physiologic Problems.—In any operative procedure, and especially in abdominal and thoracic work, we are familiar with the changes in diaphragmatic function, in peripheral vascular tone, in the intestinal musculature, in bladder function, not to mention the problems of morale and the functional state.

Voluntary coughing releases mucous plugs. When lying in bed this is not as effective. Recumbency leads to a lessened respiratory exchange, so that when no rales can be heard when lying down, they often can be when standing.

Loss of fluids, reflex neurovascular changes, and the absence of muscular activity to encourage venous and lymphatic return are factors not aided by absolute bed rest. The changes in blood coagulability are most important, being enhanced by the trauma of surgery, by anoxemia, by hemocoagulation and decreased flow.

Intestinal distention when it occurs is a further liability. Nervous control and reflexes initiated by the procedure are still other agents. Inability to void and bladder distention can be added to a list of sequelae that can be further enlarged.

Applications and Preventive Measures.—Early activity lessens these tendencies. If on the first day a patient rises, coughs voluntarily, and walks, the cycle is broken. Respiratory exchange increases, the circulation rate improves, and bowel action is more normal. The bladder empties and renal stasis does not exist. Wound healing is enhanced, as Newburger, among others, has demonstrated.

Responsibility of the Surgeon.—It is our responsibility to do a number of things to carry out this program. The patient should be educated as to its desirability, and often it is well to do this before operation. The nursing personnel must be sympathetic and realize the advantages.

Among the more technical details we believe that adequate hydration and nutrition are most important. Gentle handling of tissues promotes good healing and comfort to the patient. The type of incision bears consideration. Transverse and oblique types are anatomic, to be used with increasing frequency. However, right or left rectus approaches have been freely used in ambulant patients without difficulty. A mid-line approach can be a strong incision. As to suture material, our own preference is a fine cotton, but we do not hold any special brief. Silk, fine catgut, or fine wire can give excellent results when used adequately.

Anesthesia by a medical anesthetist or under his supervision leads to earlier recovery of reflexes than will occur from anesthesia by inexperienced anesthetists. We believe that spinal anesthesia does not preclude early ambulation, nor does it serve to diminish respiratory complications. One factor that could be used more often in our experience is local nerve block to diminish the need for sedation, with its depressing effects especially on respiratory exchange.

Responsibility of the Nurses.—With the shortage of the nursing personnel, problems arise. It takes nursing time to educate patients to be ambulant and to watch over them. On the other hand, there is a great economy in avoidance of bed pans and general care. Here qualified nurses (Q.N.'s) could find increasing functions under

ward supervisors or (R.N.'s). (The Q.N.'s would be those happy individuals who like caring for the ill, possibly with two years of training, and R.N.'s would be those with a year of the fundamental sciences, etc., and training in supervision in addition.)

Contraindications to Early Ambulation.—Just as there are certain indications there are certain contraindications. Hemorrhage, shock, and certain debilitating states such as severe burns, spreading peritonitis, and the like, we have excluded from early ambulation, although peritonitis is not a contraindication in the opinion of some.

Aids to Principles of Early Ambulation.—Two things in practice are worthy of mention. Where varicosities and circulatory stasis exist in the legs, it has been our practice to use Unna's boots or elastic adhesive dressings with satisfaction. We have gotten patients with thrombophlebitis of moderate degree ambulant with good effect on this régime.

Pillows under the knees lead to venous stasis, and this is one reason why we do not use the so-called Fowler's position. It is better to elevate the head of the bed eight to twelve inches with a back-rest of four inches in addition. Then the patient can well do leg and ankle exercises.

Certain practical points could be noted. Before operation the patient can be taught a scheme of exercises embodying the principles of deep breathing even though it hurts, of frequent foot, ankle, and knee movements, of contracting flexors against extensors in arms and legs, and contracting the buttock muscles. In the first twenty-

four hours a patient is not often ambulant very much and any deficiency in this regard must be made up.

When a patient first gets up, he can lie on the side of the bed with his legs prepared to dangle. The back-rest can then be raised, overcoming the not infrequent first giddiness. It is then not so difficult to make the first step to the floor by means of a footstool. By the fourth or fifth day all such symptoms are usually gone.

In persuading some of the more hesitant patients to get out of bed and walk, the permission of walking to the bathroom is a persuasion. "I don't mind pain, I don't mind operations, but I do hate the bed pan" is an expression we hear frequently in our county.

A good aphorism is that it is safer to walk than to sit. The sitting position leads to the same venous stasis that pillows cause beneath the knees.

Conclusion

Early ambulation is now part of the philosophy of surgery, in which it is recognized that bed rest is harmful. Exercises, fluid balance, nutrition, anesthesia, minimal sedation, and technique are integrated in this concept.

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LEST YOU FORGET

The spring sessions of the Graduate Education Institute begin the first week of April in each of the ten centers.

Mark your calendars now so that you will not miss the opening session.

BLOOD AND BLOOD SUBSTITUTES

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WITHIN recent years there have been extensive studies on whole blood, plasma, and possible substitutes for these complex substances. The subject has become one of primary importance, for within its scope are included the answers to shock, to fundamental nutritional problems, to immunologic concepts, and to a large number of basic physiologic processes ranging from the clotting of blood to the physicochemical relationships which maintain blood volume and determine protein balances between circulating plasma and tissue cells.

Extensive researches by Professor Cohn and his group, under the direction of the Blood Substitutes Subcommittee of the National Research Council, in the field of plasma fractionation have made available for clinical use many of the individual components of blood. Albumin with its strong osmotic action is used in nephrotic states and in other specific disorders where complete blood is not indicated. The gamma globulins, carrying the immunologic principles, have been separated and concentrated and, to quote Cohn, "may come to be recognized as the most important fraction of the plasma from the point of view of public health."¹ Fibrin film and fibrin foam were usefully employed during the war, and the search for more readily available substitutes led to the appearance of gelfoam and oxidized cellulose, already of proved value. Prothrombin was another product developed from the process; and from the fractionation of group-specific plasma have been isolated the isohemagglutinins for the typing of whole blood.

Suffice it to say that this field of research is in its early phase, and will continue to be "new" for many years.

While transfusion of whole blood is not new, the large quantity of blood used in individual cases certainly constitutes a recent concept, and more directly is the result of war studies. It was found in cases of blood loss in the wounded that total replacement of what was lost was essential

to satisfy all the requirements of ideal recovery—alleviation of primary shock and prevention of secondary shock, support of the soldier through extensive operative procedures, maintenance of his nutritional balance throughout convalescence, and insurance against uncontrollable infection and faulty tissue repair. Lyons² and many others have shown the relationship of depleted blood to infection. Every surgeon actively engaged in treating the severely wounded came to accept large quantities of blood as an absolute necessity, and methods of obtaining it in sufficient quantity were soon developed by bleeding neighboring resting troops. In the years since the war the principles have been applied to civilian problems and have been found similarly applicable.

The theoretical and experimental background for the present concept of the use of blood goes back to a long time before the war. The need for parenterally administered protein led to Elman's work on injectable solutions of protein digests and to the later purified solutions of crystalline amino acids. The concepts of "acute surgical starvation" and chronic protein depletion were developed. Ravdin's work³ demonstrated the relationship of this depletion to edema about surgical anastomoses and to many other surgical problems, further stressing the importance of protein function. Whipple's researches⁴ on the production, utilization, and physiology of the plasma proteins and hemoglobin are well known. He and his group have shown that there is a "steady state" or dynamic equilibrium between the body protein stores, protein production, and protein wear and tear, and that proteins can pass readily from plasma into cells or the reverse. The implication here is clear, for depletion of the readily available plasma proteins results in an upsetting of this balance with deficiencies which are often concealed, and which are closely related to increased susceptibility to infection and intoxication. Whipple has also shown the selective protein flow to the formation of hemoglobin when this substance is depleted. In order, then, to correct tissue protein needs effectively the hemoglobin must be replaced first.

¹A presentation of What's New in Surgery at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 6, 1948.

²From the Department of Surgery, University of Pittsburgh School of Medicine.

It has been suggested that plasma and whole blood therapy is not an efficient means of elevating plasma proteins,⁵ but recent studies of Allen, Bogardus, Egner, and Phenister⁶ show that plasma and blood are effective if used in sufficient quantities. Both plasma protein and hemoglobin, they indicate, may be utilized directly for tissue repair. The previous misconception apparently arose because insufficient amounts of plasma or blood were used. Assuming a protein need of 130 grams daily in a severely wounded soldier, Lyons² gives the following amounts needed: 750 cc. of whole blood or 2000 cc. of plasma; or if both are used, 500 cc. of each. This has been our own experience in treating cases of high intestinal fistula. When these large quantities of blood or plasma were used, the entire status of the patient was changed for the better and he could be ideally prepared for corrective operations which he then stood without shock or setback. An interesting accompaniment of this volume replacement was the appearance and maintenance of large, normally distended peripheral veins where there had been but threads before.

It was apparent early that accurate methods of measuring blood and plasma deficits must be found. Indirect estimates of these deficits by measuring the specific gravities of blood and plasma by the copper sulfate method⁷ served during the war when dealing for the most part with blood loss in young healthy adults. But the more complicated determinations of total blood volume by the use of Evans blue dye, and more recently by the use of radioactive isotopes, were necessary to properly evaluate deficits due to chronic debility from many causes. Obviously the red blood count and hemoglobin value are very inadequate guides, for with depletion of both plasma and red cell mass, these values could be normal even in a pronounced anemia, an anemia not demonstrated unless plasma volume were corrected to normal. Whole blood transfusions in such cases, for the same reason, do not result in higher red blood counts but rather in no change in the count, since the total blood volume is increased proportionately. In a patient who has lost weight, the volume deficit must be determined in relation to his normal weight.

These facts are of tremendous importance, and are the basis of modern methods of therapy in radical surgery, severe burns, in cases of delayed or faulty healing, stubborn infection, and complicating edema. When blood volume determinations are made, the amounts of whole blood found necessary for correction are surprisingly high. Clinical estimations of the state of the pa-

tient are no longer justified. Facts must be obtained, for the subclinical malnutrition of Elman, the "chronic shock" state of Clark et al.,⁸ can be evaluated only by this means. The present clinical attitude is well expressed by Allen et al.⁶ when they say "This work suggests that the fear of overtransfusion is unwarranted except where the cardiovascular reserve is reduced. It also emphasizes the importance of great enlargement of facilities for obtaining blood and plasma and the wisdom of using blood in some patients in place of plasma because of the gain in oxygen-carrying cells and the possible utilization of hemoglobin to form tissue protein." Beling and his associates⁹ have recently outlined a simplified technique for measuring blood volumes which is designed for use in the ordinary hospital without elaborate facilities. The method, while not ideally accurate, constitutes a very valuable addition to the evaluation of seriously ill patients.

Blood Banks Essential

To make available adequate supplies of blood, the bank is essential. It works efficiently for hospital requirements of about 50 pints per month up to very large amounts. It makes blood immediately available for emergencies and for planned procedures requiring many pints. The saving of time for visiting and house staffs is great. Donors are not turned away because they are the wrong type, nor do they have to wait for typing or serologic tests. Adequate blood will be available for clinical use if two donors are obtained for the first transfusion and one for each additional transfusion; but the physicians in charge must insure that this minimal donor requirement is met. For plasma production and research needs a more liberal supply of donors must be obtained, and financial remuneration for donors, who do not have the incentive of a sick friend or relative, has been found to be satisfactory. This question of incentive must be considered carefully, for the average person will not donate blood without specific reasons except during emergencies such as the recent war or for disasters. The handling of the whole problem must be kept entirely within the profession. The large banks in operation now on a strictly non-profit basis have already proved their efficiency and economy.

Small banks will have trouble with a suitable distribution of types, and in such situations arrangements with other nearby banks on a trade basis will help greatly. Large central banks become the logical development. These banks can have all types available because of their size, and can more efficiently function from the standpoint

of economy of personnel, uniformity of processing, effectiveness of research, and so forth.

Ashby¹⁰ has concluded that the average life of the transfused red blood cell is over one hundred days, with variations dependent upon the physical state of the patient. Although several important constituents of blood are lost within a few days by the storage process, the protein and hemoglobin content remain effective. The commercially prepared anticoagulant solutions prolong the safe storage time of blood, and the use of completely disposable transfusion sets practically eliminates the pyrogenic reactions which are frequent when materials are re-used, except under ideal conditions which are difficult to control. Present-day reaction rates should be less than 2 per cent, and the 2 per cent will be found to be mostly urticarial in nature. Accurate cross matching and Rh determinations are assumed. The usual maximum storage time is about three weeks, but in a well-run bank the average age of the blood when given approximates three days. About 5 per cent of blood units must be discarded because of age, positive serology, or for other reasons.

Just as subclinical protein deficiencies exist, so also do concealed blood needs. Before the institution of a blood bank the average number of transfusions given per month in a Pittsburgh Medical Center hospital of 350 beds was fifty. The opening of a bank immediately increased this number to over a hundred. At present, two years later, about 240 per month are given. Not all of this increase is due to a change in the character of the surgery or of other therapeutic measures; much of it represents a previous inevitable and undesirable deficit due to the difficulty

of obtaining blood in the absence of bank facilities.

Thus, in conclusion, it is seen that blood and the numerous complex components of blood, which are just beginning to be studied adequately, constitute a field of the utmost importance. Already the known clinical applications are such that proper patient care demands the availability of large amounts of blood. Blood banks are essential, and the incentive of the donor must be preserved. At present this incentive is engendered by the sick relative or personal friend, or by frank financial remuneration. Meanwhile the search for more readily procurable substitutes for blood goes on, but because of the vast complexities of this substance, success in this search does not seem near at hand.

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Cytologic Diagnosis of Cancer of the Lung

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THE purpose of cytologic examinations which we have been doing on bronchial secretions is to make an earlier diagnosis in carcinoma of the lung. This paper shall be divided into three parts—procedure, presentation of a few illustrative cases, and results.

Procedure

We examine bronchial secretions rather than sputa because we think that the probability of finding neoplastic cells is much greater when the material is concentrated than when it is dilute. One of the most important items in the procedure, which we cannot emphasize too much, is the proper collection of the material. First of all, the lesions are localized in roentgenograms. Then, an ordinary bronchoscopic examination is performed and secretions are secured from the area which drains only the suspected tumor site. If secretions are not available, the same area can be washed with a minimal quantity of normal saline. We might say that this technique ought to be precise because, if too much saline is used, the results are universally poor. The material is collected in a special or ordinary collector, sent to the laboratory, spread thinly on six clean slides, and stained according to the Papanicolaou technique.

Illustrative Cases

In each of the following cases bronchoscopic examination, except for the presence of secretions, revealed no intrinsic or extrinsic evidence of carcinoma.

CASE 1.—A man, 53 years of age, had pain in the right shoulder, a slight amount of cough, and some expectoration of four months' duration. The roentgenogram disclosed a destructive lesion of the middle ribs of the right side of the chest. It was considered to be possibly a primary tumor of bone or a primary tumor of the pleura. Being cancer-conscious at Jefferson, a bronchoscopic examination was performed, secretions were secured, and study disclosed neoplastic cells of a keratinized variety. The patient was operated upon under the assumption that the tumor was primary in the

pleura or that the lung pleura and ribs might be removed. The lesion, however, was not resectable, but a biopsy was secured and the cytologic diagnosis of carcinoma was sustained.

CASE 2.—A man, 60 years of age, complained of cough and blood-tinged sputum over a period of five weeks. A roentgenogram disclosed a shadow in the mid-portion of the left side of the chest that was considered to represent a carcinoma. A bronchoscopic examination was performed. Neoplastic cells were found in the removed secretions and a diagnosis of carcinoma was made. The patient was advised to have an operation, but he and his physician decided that he did not have cancer and he went home. He returned six weeks later with a massive pleural effusion and, at that time, insisted upon an operation. An exploratory thoracotomy showed an inoperable carcinoma.

CASE 3.—A man, 45 years of age, complained of hemoptysis over a period of ten months. He consulted his physician, who discovered a roentgenographic shadow in the apex of the right lung. This he considered to represent tuberculosis and accordingly he watched the shadow grow over an eight-month period. When it increased to involve almost one-half of the right lung, the patient was sent to Jefferson Hospital. Bronchoscopic examination was negative, but secretions secured at this time showed numerous neoplastic cells. At operation the lesion was not resectable.

CASE 4.—A man, 52 years of age, gave as his only complaint a cough of one year's duration. Roentgenograms revealed a shadow in the upper lobe of the left lung that could have been tuberculosis or carcinoma. Bronchoscopic examination was negative for neoplastic involvement, but smears of secretions revealed neoplastic cells. In this case it was not too late, for at operation the entire lung was removed. The cancer was confined to a small segment of the main upper lobe bronchus and to the immediately adjacent peribronchial tissue.

CASE 5.—A man, 51 years of age, had had two bouts of fever. At that time he was on the Pacific Coast. A roentgenogram was taken of his chest, a diagnosis of virus pneumonia was made, and he was given penicillin. The lesion cleared, but he was advised, when he came back East, to have another roentgenogram taken. This he did and, although he was perfectly asymptomatic at this time, the entire apical and medial portion of the left lung revealed an opacity. Bronchoscopic examination was entirely negative. Secretions that were obtained, however, showed numerous neoplastic cells. The lung was removed entirely upon the results of the cytologic examination for, at operation, Dr. John H. Gibbon, who performed the pneumonectomy, said he could feel absolutely nothing in the lung. The lesion was confined entirely to the mucosa of the bronchus.

Presented before the Section on Pathology and Radiology at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 5, 1948.

There was no bronchial or peribronchial cellular infiltration by the tumor.

CASE 6.—A man, 53 years of age, complained of cough and mucoid expectoration with some blood for a period of three months. A roentgenogram of the thorax disclosed a shadow in the medial and lower portion of the lower lobe of the right lung. Bronchoscopy was completely negative, but by inserting the aspirator deep into the medial subdivision bronchi, we were able to secure several drops of secretion. These contained numerous neoplastic cells of a keratinized type with occasional pearl formation. A diagnosis of squamous cell carcinoma was made and the lung was removed. The tumor was located just beneath the pleura.

CASE 7.—A man, 58 years of age, complained of frequent chest colds and fever of five weeks' duration. An x-ray disclosed what was considered to be an abscess in the mid-portion of the right lung. Bronchoscopic examination disclosed only purulent material escaping from the right middle lobe bronchus. Smears of this material showed numerous neoplastic cells. It was apparent grossly that the entire central portion of the tumor became necrotic, had discharged through a bronchus, and all that was left was a mere shell.

CASE 8.—A woman, 53 years of age, complained of fever and pain in the right side of the chest of three months' duration. A roentgenogram disclosed a shadow in the mid-portion of the right lung field that was thought to be carcinoma. Examinations of the sputa were repeatedly negative for acid-fast bacilli. Bronchoscopic examinations showed no evidence of tumor. Smears of secretions revealed numerous circumscribed collections of ciliated regular epithelial cells. Based on this finding a tentative diagnosis of tuberculosis was made. This was subsequently confirmed by culture.

CASE 9.—A man, 50 years of age, complained of fever, night sweats, loss of weight, and fatigue of one year's duration. Acid-fast bacilli were said to have been found when he was examined at another institution and he was thus considered to have tuberculosis. Roentgenograms on June 15 disclosed a shadow in the lower lobe of the left lung that seemed to have cleared considerably by September 12. Examination at our institution disclosed no acid-fast organisms. At the time of bronchoscopic examination, secretions were secured, smears were made, and neoplastic cells were found. A total pneumonectomy was successfully performed. Grossly the tumor was still confined to one of the subdivisions of the main bronchus and the peribronchial tissue.

CASE 10.—A woman, 56 years of age, complained of cough and pain in the left shoulder of several months' duration. She had some wheezing and some dyspnea. A roentgenogram of her chest disclosed an opacity in the mid-portion of the left lung. A clinical diagnosis of carcinoma was made. Repeated bronchoscopic examinations were negative for the presence of a tumor. Six examinations of bronchial secretions showed no neoplastic cells. However, the surgeon felt that the lesion was a carcinoma, so he removed the lung. Upon examination subsequently three bronchi were found to be stenotic, and distal to these there were bronchiectasis and abscesses. There was no cancer present.

CASE 11.—A 42-year-old schoolteacher was asymptomatic, but an opacity was discovered in the left lung during the course of a routine roentgen survey. It was thought to be a carcinoma. Bronchoscopic examination revealed no evidence of tumor and an examination of the bronchial secretions revealed no neoplastic cells. Because the lesion was a carcinoma clinically, the lung was removed. Subsequent gross and microscopic examination disclosed not a cancer but a lipoid pneumonia.

Results

As of Sept. 1, 1948, we have examined a total of 237 cases of primary carcinoma of the lung. In this group neoplastic cells were present in smears of bronchoscopically removed secretions in 213, or 89.8 per cent. In this same group, a positive endoscopic biopsy was performed in only 86 cases, or in 36.2 per cent. There was indirect evidence of tumor in the form of stenosis, fixation, distortion, and so forth in 46 additional cases in which biopsy could not be obtained. In this same group, the cytologic examination of bronchial secretions was positive, and bronchoscopy was completely negative in 75, or in almost one-third of all cases.

Conclusion

From the evidence presented we think it is safe to conclude that a search for neoplastic cells in bronchoscopically removed secretions is of distinct value. It is of particular importance in patients harboring a pulmonary carcinoma that is beyond the reach of a bronchoscope.



LEUKEMIA IN CHILDHOOD

Preliminary Report of Response to Aminopterin

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THE discovery of the inhibitory effect of 4-aminopteroylglutamic acid (aminopterin) upon childhood leukemia by Farber and associates^{1,2} makes it more necessary than ever for the clinician to have a clear conception of the natural history of leukemia, if he is to appraise intelligently the possible benefits of treatment in his patients by such a therapeutic agent. Improvements due to therapy need to be differentiated from spontaneous remissions, and toxic symptoms resulting from overdosage or sensitivity need to be distinguished from unfavorable manifestations of the disease itself.

Before describing our experiences with this new chemotherapeutic agent, therefore, a review is presented of experiences with 67 cases of childhood leukemia seen at the Children's Hospital of Philadelphia between July, 1932, and October, 1948. The majority of the patients have been seen by at least one of the writers, but the responsibility for their care and the keeping of the clinical records has been in the hands of many different physicians, and all the desired data are not available for every case. The last ten cases of the series have received aminopterin, and seven are alive at this writing. In order to have a basis of comparison for the phenomena exhibited while under treatment by aminopterin, we have excluded from the analysis of the clinical manifestations of untreated childhood leukemia those observations made after the beginning of aminopterin or urethane therapy. In general, the natural history of the disease as demonstrated by this series of cases has not been unlike that described in other similar series. (For comprehensive bibliographies, see the reports of Falkenstein and Fowler,³ Sullivan, Rice, and Cassidy,⁴ and Silverman.⁵)

Classification of Cases.—The same difficulty in identification of cell types described by others was also encountered in this series. It was not always possible to make a precise diagnosis despite repeated peripheral smears and bone marrow aspirations. Of the 67 cases, 22 seemed to be myelocytic; 41, lymphocytic; one, monocytic; two, undifferentiated; and one, unidentified.

Age Incidence.—The onset of symptoms was more frequent in the first five years than later, with the peak being in the two- to four-year age group (Fig. 1). There were 37 males and 30 females in this series, in contrast to the more customary ratio of two boys to one girl in most of the other series reported. All except two of the children were white, despite the fact that approximately 40 per cent of the clinic population served by this hospital consists of Negroes.

Chief Clinical Features. — Pallor, enlarged lymph nodes, enlarged liver and spleen, fever, malaise, hemorrhages, and acute infection at the time of recognition were the clinical features most commonly seen (Table I). These features were not all or always present at the time the child came under observation; in many instances they developed later. Prior to the days of chemotherapy, many of the patients exhibited infectious phenomena such as furuncles, local cellulitis, bronchopneumonia, otitis media, and terminal septicemia. Such infections are now controllable by penicillin and the sulfonamides, and in the past few years have been less common and less serious. Two of the patients were mongoloids; one had coincident far-advanced tuberculosis; one had hypertension; and several had coincident local masses which might be deemed features of lymphosarcoma or leukosarcoma.

Hemorrhagic Phenomena. — Sixteen of the children, or 28 per cent, exhibited hemorrhagic phenomena of more severe degree than simple petechiae or proneness to undue petechial show-

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ers, when a tourniquet was applied to the arm. Twelve of these had epistaxis; eight had gastrointestinal hemorrhages; five had skin ecchymoses; three had bleeding from the gums; two had subarachnoid hemorrhages; and one had urinary tract bleeding.

Skeletal Changes.—One or more roentgenographic examinations of the long bones were carried out in 52 patients of this series. Some had the examinations early in the disease; others near the end. In 26 of the 52, or exactly 50 per cent, roentgen changes were noted. Of the four kinds of changes discussed by Silverman⁵—transverse zones of diminished density at the growing ends of long bones, osteolysis, sclerosis, and periosteal elevations—the transverse zones were the most frequent. Breakdown of the data according to duration of the symptoms at the time the roentgen examinations were made failed to indicate that bone lesions were more likely to be demonstrated late rather than early in the disease, or in any particular age period. Nor was it possible to demonstrate any correlation between morphology of cells or the degree of leukocytosis and the presence or absence of bone involvement.

Leukocyte Count of Peripheral Blood.—The leukocyte counts ranged from a low of 300 to a

high of 680,000. In 30 of the 67 patients, or 45 per cent, the maximum detected count was not above 20,000; in 13, between 20,000 and 40,000; in 24, above 40,000. In four patients, no count above 5,000 was found; in four others, none above 10,000. No correlation was found between maximum detected counts and age—as many high counts occurred in the upper age levels as in infancy; nor was there any correlation between the period of survival following onset of symptoms and the height of the white cell count. There was a tendency, evident in nearly every case, for the absolute number of immature and abnormal forms to increase as the disease progressed. Generally speaking, the prognosis for length of life seemed poorer when early counts were high in abnormal forms.

At the initial examinations the percentage of leukocytes which were immature or clearly abnormal ranged from below 1 per cent to 99 per cent. In two patients no leukemic cells were found in the first few hundred cells counted, and it was necessary to scrutinize many fields in order to uncover any abnormal cells. In these two cases the early diagnosis was made from the clinical findings and the demonstration of leukemic infiltrations on marrow aspiration. One of these children had a differential count of 99 per cent lymphoblasts in a specimen of sternal marrow on the same day that the peripheral blood smear was entirely devoid of abnormal appearing cells.

Red Cell Count and Hemoglobin.—A review of the red cell counts and hemoglobin levels of these patients on arrival at the hospital showed that nearly all exhibited some degree of anemia, and that about 10 per cent were severely anemic (red cell count below 1,000,000) at the time of first observation. In this connection it must be remembered that many of the patients had been ill for some time and under the care of physicians elsewhere before being referred to this clinic.

Other Laboratory Tests.—Assorted data are available on the results of other laboratory tests in many of these patients. Of 12 patients tested for *serum icterus*, four had mild but distinct elevations at some time (icterus index above 6 or van den Bergh readings above 1.0 unit). Of 8 patients whose *total serum proteins* were measured, only two had levels below 6.8 per cent (4.8 and 5.3 respectively). The *finger tip bleeding time* was less than ten minutes in 32 patients; more than ten minutes in 18 others. The slowest *venous coagulation time* (Lee and White method) was below five minutes in 11; between five and ten minutes in 37; between ten and

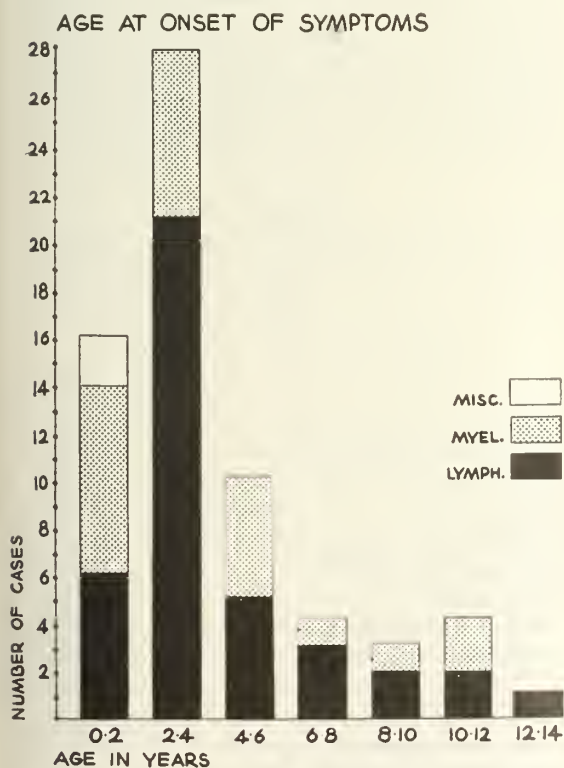


Fig. 1.—Graph showing age and cell type distribution of 67 children with leukemia.

fifteen minutes in one; and twenty-seven minutes in one. *Clot retraction* on standing was normal in 26; defective or absent in 12. The lowest *platelet count* (often done only once or twice) was above 200,000 in four; between 150,000 and 200,000 in seven; between 100,000 and 150,000 in three, and below 100,000 in forty. Ten children in the lowest group had had high counts of above 150,000 on earlier tests, and two others were between 100,000 and 150,000 on earlier tests. Thus, 21 of 54 children with leukemia, or approximately 40 per cent, exhibited platelet counts above 150,000 on at least one examination, showing that marked thrombocytopenia is not as universal in leukemia as is often believed.

Bone Marrow Studies.—Bone marrow aspirations (single or repeated) were made and deemed satisfactory in 36 cases. In 32 of these the examinations showed the presence of primitive or abnormal forms characteristic of leukemia; in two the marrow was aplastic; in two others it seemed free of leukemic cells. Of the last two cases, one was later verified at autopsy to be leukemia, and the other showed the characteristic cell picture in subsequent marrow examinations.

Total Duration of Symptoms.—Of 54 fatal cases for whom data are available, six had a duration of life of less than one month after onset of symptoms; twelve between one and two months; six between two and three months; eight between three and four months; twenty between four and eight months; and two survived more than eight months. This series of cases showed a poorly marked trend for the clinical course to be more acute or malignant in myelogenous than in lymphatic leukemia, and in the younger age group, i.e., below 7 years of age. (None of these 54 cases had been treated with aminopterin.)

Autopsy Findings.—Eighteen patients were autopsied. The more frequent positive findings are listed in Table II. Enlargement of the liver and spleen and dilatation of the heart were the most common features. Infiltrations were seen in a variety of organs. Two patients had erosions or ulcerations in the intestinal mucosa; this is important in view of the current suspicion that aminopterin itself may give rise to ulcers in the intestine as a toxic response.

Transfusion.—Transfusions, often in great numbers, were given to the majority of these patients. Forty-two patients failed to exhibit any recognizable response, whereas 13 had some benefit at least temporarily. In 8 patients the

effect was not recorded. Only 4 children in the entire series received no transfusions. The beneficial responses to transfusions seemed to be the result of the replacement of hemoglobin-containing red cells previously lost, and were manifest solely as improved color, strength, and appetite. Remission of the leukocytosis or decrease in the percentage of abnormal cells seemed never to follow as a direct consequence of a transfusion. In some of the children who were not noticeably helped by transfusions, occasionally oft-repeated, the red cell and hemoglobin levels would drop back to the pre-transfusion level within a period of but a few days. In other children hemolytic reactions of increasing severity would occur within a few hours after all or only some transfusions. Since such reactions were seen but rarely in the patients studied more recently than 1943, when routine testing for Rh compatibility was begun at this hospital, it is believed that most, if not all, of the hemolytic reactions in the patients transfused before that time may be ascribed to Rh-negative patients being given Rh-positive blood.

Urethane.—Radioactive phosphorus, urethane, nitrogen mustard derivatives, irradiation, and related other forms of therapy have been widely tried in childhood leukemia and not proven satisfactory. For purposes of record, we include a case history of a child whose leukocyte count was always lower when urethane with sodium benzoate was given than in the intervals when these drugs were temporarily discontinued. It was the clinical impression that this child would

TABLE I
PRINCIPAL FINDINGS IN 67 CHILDREN WITH ACUTE
LEUKEMIA
(Exclusive of or prior to therapy with aminopterin)

	No. of Cases	Per Cent
Pallor	61	91.5
Lymph node enlargement	55	82.5
Enlarged liver	54	76.5
Fever	51	76.5
Palpable spleen	49	73.5
Fatigue, malaise, anorexia	45	67.5
Acute infection at onset	40	60.0
Cough, dyspnea	23	34.5
Bone and joint complaints	17	25.5
Hemorrhagic phenomena	16	28.1
Diarrhea	8	12.0
Abdominal pains	5	7.5
Edema	2	3.0
Nausea and vomiting	2	3.0
Hypertension, skin nodules, icterus, convulsions, headache	1 each	1.5

have expired much earlier were it not for these medications.

R. Z., a white male, aged 11 months, was hospitalized Oct. 29, 1947. This infant had had a cold two months previously, which was treated by the family physician. Soon after, he exhibited a skin eruption, lassitude, puffy eyelids, enlarged nodes, and anemia, and the diagnosis of leukemia was made. Physical examination on hospitalization revealed in addition to these findings a greatly enlarged liver and a spleen which was hard and firm and extended down into the pelvis. The admission blood examination showed a white cell count of 59,450, with 100 per cent small lymphocyte-like cells.

The patient was treated with transfusions and oral sodium benzoate and urethane. Sodium benzoate was administered in a dosage of 1 Gm. twice a day, and the urethane was given in a dosage of 10 mg. daily. No improvement in the vigor or nutrition of the patient was noted during the treatment. The white cell count came down from 33,000 to normal levels in about two weeks, but no change in the character of the cell type was noted, and blast forms continued to constitute a majority of the peripheral blood leukocytes throughout the next few months until death. The platelets were greatly reduced in number, and the bone marrow showed no response during observation except for an apparent lessening of the absolute number of cells in the marrow. The blast forms remained at a level of approximately 95 to 100 per cent. On careful study of the cells from the marrow and peripheral blood, it appeared that this was a case of myelogenous leukemia.

The patient developed hemorrhagic phenomena, and was comatose for about the last month of his stay in the hospital. During this time he could be aroused only by strong stimulation. There were several intervals during which the urethane and sodium benzoate were stopped. In these intervals the blood count would again rise to high levels, reaching 130,000 on one occasion. The liver and spleen became much smaller during the first course of chemotherapy, and then enlarged in the first interval when it was discontinued. When the urethane and sodium benzoate were given again, the liver and spleen failed to subside. The patient never had enough clinical improvement for discharge to be considered. He remained in a state of stupor and emaciation for many weeks, and died on March 8, 1948, almost five months after admission.

Preliminary Report of Results of Treatment with Aminopterin

In April and again in June, 1948, Dr. Sidney Farber, of Boston, reported that 4-aminopteroylglutamic acid (aminopterin) had induced remissions in ten of 15 children with acute leukemia.^{1, 2} Through the kindness of Dr. Farber and the Lederle Laboratories, aminopterin was made available for clinical trial in May, 1948. The clinical improvement noted with this new substance in some patients has been so striking that a preliminary report seems worth while.

Aminopterin is a folic acid analogue. It has the same molecular architecture as folic acid (pteroylglutamic acid), except that an $-NH_2$ group is substituted for an $-OH$ group in the

No. 4 position of one benzene ring. Aminopterin has proven strongly antagonistic to folic acid in investigations with bacteria, rats, and chicks, as reported recently by Oleson, Hutchings, and Subbarow.⁶ It inhibits bacterial growth under experimental conditions which require the presence of folic acid. It is also highly toxic to rats, if given in slightly greater than folic acid-inhibiting doses. In these experimental studies, aminopterin has seemed to enter into the intracellular enzyme systems which require the presence of pteroylglutamic (folic) acid or related substances, and to block the nutritional availability of these substances. This inhibition by analogues has been reversible when competitively proportioned amounts of these substances were given in the presence of smaller amounts of aminopterin.

It would appear from clinical observations that leukemic cells need unusual amounts of pteroylglutamic acid, and are therefore unusually susceptible to this blocking agent. Some patients described by Farber, whose leukemia had been treated with folic acid and pteroyldiglutamic acid and pteroyltriglutamic acid, displayed extraordinary leukemic infiltrations of bone marrow and viscera when later autopsied.

As already stated, the ten most recent of the 67 cases have been treated with aminopterin.* Of the 10 cases, two were profoundly ill when hospitalized and died within seventy-two hours; one had monocytic and the other myelocytic leukemia. Since these children did not survive a long enough time to receive treatment in any amount, they are excluded from the further tabulations. One other child who failed to manifest any benefit from aminopterin was a boy aged 6 years with typical myelocytic leukemia, who died after six weeks of observation. Despite intensive treatment he showed no clinical improvement, and his marrow and peripheral blood failed to undergo any evidences of remission.

The remaining seven children exhibited marked clinical improvement at least temporarily, with reversion toward normal of the bone marrow and the peripheral blood. The diagnosis of myelocytic leukemia was made in three, and lymphocytic leukemia in four. Generally speaking, within two weeks or even one week after the first dose was given, the marrow showed the reappearance of megakaryocytes, a return of erythropoiesis (in some to a hyperplastic degree), and a marked diminution in mitotic activity of the white cells and in the number of atypical and

* In addition to these 10 cases, another group of 13 children with leukemia have been or are being treated with aminopterin under our direction, and the responses in general have been much the same as here described.

blast cells. In five of these patients initial recovery proceeded to such an extent that in single specimens of bone marrow it was not possible to demonstrate any abnormality. Three of these five children again exhibited leukemic changes in later specimens.

Only one of the children with a remission due to aminopterin has died. This child exhibited hemorrhagic phenomena after receiving aminopterin continuously for ten days, in treating a relapse of the leukemic state. When the hemorrhages began, the aminopterin was discontinued; a week later the peripheral blood exhibited a marked increase in the number of circulating immature cells, and death occurred from generalized hemorrhages. Autopsy showed multiple leukemic infiltrations of all organs. In retrospect, the survival time might have been longer had the therapy not been stopped when it was.

Three typical case histories are briefly summarized below. Two of these patients responded dramatically at the beginning of therapy, but have been a problem in maintenance. The third continues to respond successfully.

CASE 1.—D. D. B., a white male, aged 2½ years, was hospitalized July 15, 1948. This boy had had frequent colds since the age of three months. In February, 1948, he had an attack of pneumonia, with a relapse, but had seemed well since except for dyspnea on exertion. Four days before hospitalization, on July 15, a left pleural effusion appeared. The admission examination uncovered also a large liver and spleen and generalized lymph node enlargement. The peripheral blood showed no leu-

kocytosis and no abnormal cells. A thoracentesis yielded 200 cc. of fluid, which showed leukemia cells in the sediment. Roentgenogram showed a mediastinal mass and pleural effusion, "probably lymphosarcoma." A marrow examination on July 20 showed 76 per cent "blast forms" of a type suggestive of myelocytic leukemia; on this day the peripheral blood showed 14 Gm. hemoglobin and a 7500 white count with 42 per cent lymphocytes and 44 per cent neutrophils. There were 2 per cent abnormal "blast" forms. Platelets were plentiful. On July 24 a lymph node biopsy was diagnosed as chronic lymphadenopathy. On July 23 aminopterin was begun in 1 mg. daily doses. Clinical improvement promptly followed, with cessation of the dyspnea. The x-ray report on August 4 showed the mediastinal shadow to be within normal limits. No abnormal cells were found in the peripheral blood; platelets were plentiful, and the child appeared clinically well.

Injections of aminopterin were stopped on August 5 when the child was taken on vacation. On August 27 he was brought back with malaise, dyspnea, and recurrence of pleural effusion, this time on the other side. The bone marrow contained 98.5 per cent myeloblasts; the peripheral blood count was 20,000 white cells, with no abnormal forms (28 per cent lymphocytes, 72 per cent neutrophils, platelets plentiful). The hemoglobin level was 12 Gm. Aminopterin injections (1 mg. daily) were resumed in conjunction with crude liver extract (1 cc.). The thoracic mass disappeared quickly. One more thoracentesis was done. The patient was discharged on September 15 with a practically normal chest film.

He was then followed as an out-patient, receiving aminopterin 1 mg. tri-weekly. He did well for several weeks, maintaining a normal white count and hemoglobin level. On October 2 enlargement of the axillary and supraclavicular nodes appeared. Aminopterin was increased to 1 mg. every other day, but despite this, the nodes continued to grow larger, and the platelet count dropped. The peripheral white count and hemoglobin remained normal. On October 13 the mass of axillary nodes had reached about 5 cm. in diameter, and chest x-ray showed recurrence of the mediastinal mass. Aminopterin was therefore increased to 1 mg. daily. One injection was given on October 13 and one on October 14. On October 15 the patient suddenly began to bleed from the nose and gastro-intestinal tract and was readmitted in a critical condition.

The axillary nodes had disappeared completely over this two-day period, as had the mediastinal mass. Marrow aspiration at this time showed complete disappearance of blast forms, but also marked aplasia of all elements. After five days of treatment with transfusion, folic acid, and no aminopterin, the bleeding stopped and the patient improved rapidly. As soon as the marrow had begun to regenerate, a maintenance dosage of 1 mg. aminopterin every other day was again started, and he is at present ready for discharge.

CASE 2.—S. B., a white male, aged 2 years, was hospitalized July 27, 1948. The patient had had pneumonia at eight months of age and a rapid succession of head colds during the winter of 1947-48, for which he often received sulfonamides and penicillin. Three weeks before admission, a fever of 101 F. began, with irritability, pallor, loss of appetite, and easy bruising. No response was obtained from chemotherapy. Large nodes developed in the neck. No gross bleeding was noticed. Blood studies by the family physician showed a white count of 624,000 and a red count of 2,740,000. The diagnosis of

TABLE II

SIGNIFICANT FINDINGS AT AUTOPSY IN 18 CASES

Enlarged liver	15
Enlarged spleen	14
Enlarged kidneys	7
Multiple petechiae and ecchymoses	6
Pulmonary edema	4
Pneumonia	4
Splenic infarcts	2
Bowel erosions	2
Ascites	2
Icterus	1
Hemothorax	1
Hemoperitoneum	1
Brain hemorrhage	1
Abscess of buttocks	1
Mastoiditis	1
Leukemic infiltrations in	
Liver	10
Spleen	8
Heart	4
Bowel	4
Kidney	4
Lung	4
Pancreas	3
Stomach	3

leukemia was made and the child referred for hospitalization. Physical examination on admission showed pallor, grunting respirations, many ecchymoses on the extremities, and enlarged liver, spleen, and peripheral lymph nodes. The chest showed some dullness in the left upper mediastinum, with local suppression of breath sounds. Bone marrow examination on July 28 revealed 98 per cent blast forms, deemed characteristic of myelogenous leukemia. The white count at this time was 350,000, with approximately 99 per cent blast forms.

Aminopterin injections were begun, 1 mg. daily. By August 6 the white blood count had fallen to 9000. Some blast forms were still present, but many normal granulocytes had begun to appear. The aminopterin was stopped on August 6 because stomatitis appeared. A bone marrow examination at this time showed that erythrocytic cells comprised about 25 per cent of the total number of cells. Megakaryocytes which previously had been absent were present in reduced but appreciable numbers. On August 10 tenderness and swelling developed at the site of an intravenous injection in the left ankle. Therapy with heat and penicillin locally gradually caused the cellulitis to localize, and a large amount of sanguineous pus was drained on August 13. Ecchymoses developed at the sites of needle punctures, but ceased after two blood transfusions and some folic acid injections.

On August 13 the hemoglobin level was 11.5 Gm., and the marrow showed practically normal differentiation of the various forms. The smear of the peripheral blood also showed practically normal forms, with 4 per cent blast cells in a total count of 9900. On August 24, however, the white count rose to 61,000; aminopterin therapy was reinstituted and the folic acid was stopped. The patient appeared better clinically. He was discharged on September 1 to the out-patient department with a white count of 23,000 with 12 per cent blast forms. He was seen and given aminopterin at weekly or biweekly intervals. On September 7 the white count was 130,000. He was given 2 mg. of aminopterin intramuscularly in one dose and was rehospitalized to receive 1 mg. daily. In a few days the white count fell to 8600 with 15 per cent blast forms. He was discharged on September 16. On September 18 the white count was 30,000. Aminopterin (1 mg.) was given bi-weekly. On September 22 the count was 117,000.

On September 25 it was 372,000, and the patient was readmitted. Aminopterin was given in the dose of 1 mg. daily again. By September 29 the count had fallen to 26,000 and aminopterin was stopped. On October 1 he had severe hemorrhages from the mouth, nose, and gastro-intestinal tract, which persisted until October 7. During this interval the white count continued to drop, and by October 6 it was 2200 with no abnormal cells. Progressive hypoplasia of the marrow had occurred during the week after aminopterin had been discontinued, and in spite of folic acid therapy which was being given. By October 13 the white count had risen to 24,000 again, with 20 per cent blast forms. Aminopterin was reinstituted at 0.5 mg. daily, despite which the count rose slowly. On October 19 the dose was increased to 0.75 mg. daily, but the count continued to rise to 84,000 with 60 per cent blast forms by October 21. The dose was then increased to 1 mg. daily, given for two days, after which the white count fell to 20,000 and the drug was discontinued. The count continued to drop, reaching 2000 by October 28, when hemorrhage again occurred from the gastro-intestinal tract. On October 23 the patient had a cerebral accident, presum-

ably a hemorrhage. (The patient remained in a coma until death on Dec. 1, 1948.)

CASE 3.—H. K., a white male, aged 2 years, was hospitalized on Aug. 30, 1948, with a history of fever, anorexia, sudden and progressive pallor, and enlargement of the posterior cervical glands. These symptoms had been noticed for only one week. He was acutely ill and prostrated, with a marked pallor, generalized lymphadenopathy, liver edge 3 cm. below the rib margin, and marked splenomegaly, with the tip of the spleen extending below the pelvic brim. The hemoglobin level was less than 4 Gm.; the red cell count, 930,000; the white cell count, 1800, with 79 per cent lymphocytes and 21 per cent neutrophils; platelet count, 20,000. Sternal bone marrow aspiration showed 92 per cent myeloblasts.

The patient was given frequent transfusions. Aminopterin (1 mg. daily) and crude liver extract (1 cc. daily) were started on September 2. On September 5 he exhibited ulcerations of the lips and bleeding gums. Bone marrow examination on September 7 showed a reduction of blast forms to 32 per cent, with the appearance of normal erythrocytic and granulocytic cells. On September 8 he had epistaxis and purpuric areas, and a marked increase in bleeding time was noted. Aminopterin was discontinued (a total dose of 7 mg. had been given) and folic acid (10 mg. daily) was begun. During the week of treatment the tip of the spleen had become barely palpable, the liver was not palpable, and the adenopathy had disappeared.

The bleeding stopped on September 10 and the patient improved rapidly except for the development of a localized abscess in the thigh, which responded to penicillin and surgical drainage. By September 15 the patient had a hemoglobin level of 8 Gm., a platelet count of 80,000 normal coagulation responses, and an entirely normal cytologic pattern in the bone marrow, with 25 per cent of the cells being in the erythrocytic series (these cells were of the megaloblastic type). Folic acid was discontinued on September 18, and then aminopterin ($\frac{1}{2}$ mg.) was given daily until September 24. The patient was discharged home on September 29 with a hemoglobin level of 11.5 Gm. and a white count of 6050, with normal differential and platelet count of 120,000. He has been treated as an out-patient since that time, receiving aminopterin (1 mg.) twice weekly. At the present time he appears normal clinically. During the first month after discharge the hemoglobin level rose spontaneously to 15 Gm., and the platelet count to 190,000. He has gained four pounds in weight and is strong and active, with a good appetite. The bone marrow at this time is still normal.

Comments on Aminopterin Therapy

Dosage.—It is not possible to make a rule for dosage which will fit every case. The quantity of aminopterin given has to be adjusted to the response of the patient. The dosage recommended by Farber and associates is 0.5 to 1.0 mg. per day, intramuscularly. At the beginning of treatment the child should be hospitalized and the progress carefully followed by bone marrow aspirations and peripheral blood studies several times weekly. At this stage a dosage of 1 mg. daily has been given. If the response is poor, it is said that the dosage may be raised to 2 mg. daily, but we have employed this amount only

once, for one day, in a child who had undergone a severe relapse following discontinuance of earlier aminopterin therapy. Resumption of treatment in this patient was followed by a prompt remission.

Once a remission has been established—as indicated by recession of the enlarged liver, spleen, and lymph nodes, rise in hemoglobin level and platelets, and reversion of peripheral blood and bone marrow towards normal—the patient is discharged for care at home and is observed regularly in the out-patient department or physician's office. In this series, 1 mg. has been employed as the maintenance dose, given from two to five times weekly. Blood studies are carried out every few days, and bone marrow examinations at least once a week.

The dosage which proves adequate for good maintenance has varied considerably from patient to patient, and even from week to week in the same patient. The policy in treatment should be to individualize the doses.

Toxicity.—Aminopterin can be toxic. The complications reported have been spongy gums, stomatitis, gastro-intestinal and other hemorrhages, suspected atrophy of the gastro-intestinal tract, aplasia of the bone marrow, and sundry other phenomena which may or may not be caused by the drug itself. Under experimental conditions with *Streptococcus faecalis* R, rats, and chickens, folic acid in comparatively large amounts will counteract the toxic manifestations of aminopterin.³

In our experience, ulceration of the lips, buccal mucosa, and tongue has been the first sign of intoxication and has occurred in varying degree in all the patients but one.

The serious complication of hemorrhage from the nose and gastro-intestinal tract has been seen in five. Whether this bleeding is due basically to local damage to the mucous membrane, to blood vessel wall damage, to further depression of platelets by aminopterin, or to some other mechanisms, has not been determined.

In three of the cases, bleeding stopped about five days after the drug was discontinued, and the bone marrow at that time showed regeneration with a high percentage of normal cells. The marrow had probably been aplastic during the period of hemorrhage. In the other two cases, death followed several days of hemorrhage, and in neither case had the bone marrow exhibited any response to the drug in spite of large doses.

It is not always easy to differentiate toxic phenomena caused by aminopterin from the naturally occurring complications of the leukemic

state. For example, one child who showed severe hemorrhagic tendencies on admission received the drug in spite of continuing hemorrhage. After seven days all bleeding stopped and there was a striking remission of all signs and symptoms.

One child had a prothrombin time of 75 per cent. His ecchymoses ceased following the giving of vitamin K in adequate amounts. Several other children with hemorrhagic tendencies may have been somewhat benefited by the receiving of vitamin K, but as a rule the hemorrhagic tendency is not relieved by this substance. Tolidine blue has also been injected intravenously, in amounts of 1 mg. per kilogram of body weight, in every child with hemorrhagic phenomena, but has not proved of any definite aid.

In most of the marrow specimens taken after beginning aminopterin, the regenerating red cells have shown megaloblastic characteristics. This suggests the existence of folic acid deficiency in these patients. Liver extract injections or folic acid by mouth have at times been given to such patients as a marrow stimulant. Marked hypoplasia of the marrow has occurred with overlarge doses, following which event the marrow has usually regenerated rapidly when the drug was stopped and folic acid given.

Prognosis.—Of the eight patients who have received aminopterin for more than a month, two have died and six are still living. At the time of writing, one has been under treatment for six months, three for four months, and two for two months.

The patients seen by us seem to fall into three groups with respect to response to aminopterin therapy. First, a minority of the patients manifest no benefit from the therapy, as exemplified by our one patient who died of severe hemorrhages after six weeks. We have recently seen one other such patient, not included in this series.

A second group, four cases in this series, have a good initial response, but soon become progressively more difficult to control, with the therapeutic dose overlapping into the range of serious toxicity. One of our four patients showed an excellent initial response with reversion of the bone marrow to normal, but died later in a relapse. The other three are requiring frequent hospitalizations; they all have recurrent serious hemorrhages from the nose and gastro-intestinal tract, when the dosage is increased very slightly above a level that is apparently inadequate for control of the leukemia.

The third group undergoes a remarkable and prolonged remission. This has been seen in three of our cases. All of them have been returned to

a state of apparently normal health, and have maintained a normal hemoglobin level and fairly normal platelet counts. The white and differential counts seem entirely normal, as well as the bone marrow, in two of the three cases. One of these patients has been under treatment thus far for six months. With all, however, it remains necessary to keep a continuous close observation and careful regulation of the maintenance dose of aminopterin, and none may be adjudged as "cured."

Summary and Conclusions

Experiences with 67 cases of acute leukemia in childhood are summarized. Of eight children treated with aminopterin for more than a few days, seven have exhibited surprisingly good remissions. Aminopterin (4-pteroylglutamic acid) appears to inhibit the growth of leukemic cells by taking the place of folic acid in the intracellular enzyme systems as a metabolically inert substance.

Aminopterin has proven far superior to blood transfusions, urethane, and all other methods employed in the past for the alleviation of leukemia in childhood.

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ABSTRACT OF DISCUSSION

EDWARD SMITH (Philadelphia): We have a patient at St. Christopher's in whom we have seen regeneration of the bone marrow and clinical improvement with aminopterin. Although you did not see any spontaneous remissions in your series, we know they do occur, and I would like to ask if you see bone marrow regeneration, or are they simply clinical remissions?

DAVID A. SAMPSON (Philadelphia): How much of the disappearance of the lesion is due to the drug? Was any of the tissue removed?

JOSEPH A. GILMARTIN (Pittsburgh): I would like to ask Dr. Wolman if he has any record as to how long the remissions lasted.

HERBERT M. SHARKIS (Philadelphia): I would like to ask Dr. Wolman why it was originally stated that

liver should be given with aminopterin, with a comment on the antagonism.

DR. WOLMAN (in closing): On the question of spontaneous remissions, in this series there were none, but I saw some years ago in a child with chronic myelogenous leukemia. That child had clinical remissions and fluctuations in the liver and spleen, which would get bigger and smaller.

In those days bone marrow examinations were not done regularly, and we have no information as to what happened to the bone marrow. In our children, much more striking than the blood and marrow findings was the clinical improvement within a few days after the injections were begun. These children felt stronger, their appetite returned, and they became active again.

One child had had so much bone pain that he was in bed for several weeks prior to the onset of treatment and was receiving morphine regularly from the attending physician. Within a few days after aminopterin was begun, the bone pain stopped, and in about a week or nine days he was walking around.

As to how long these remissions last, nobody knows the answer to that. Aminopterin has been available for such a short time that it will be a number of months, or perhaps years, before enough data will be accumulated to answer that question.

Of the eight children whom we have treated, six are still alive. They have been under medication for one to five months. There are several others who have just started, whom I am not going to speak about, but there were not many from our original series who survived five months. At least two of these six have survived five months.

As to the case in which pleural effusion existed, 200 cc. of fluid was withdrawn at the time the child came into the hospital, but there was plenty of fluid left. Following aminopterin therapy, it cleared up. In addition, there was quite a large mediastinal mass which later cleared up entirely.

When we began to use aminopterin, the treatment would be stopped when toxic symptoms developed, and usually within a week or two thereafter a relapse would follow. More recently the treatment has been given continuously, with better results. When a child is first seen, he is usually hospitalized, and the drug is given daily in 1 mg. doses. Hospitalization should last for one, two, or more weeks, until the remission is actually induced. The youngster then goes home to be brought back regularly for injections anywhere from once to five or six times a week, depending on the individual case. It is not possible to make any uniform rules; one has to follow the bone marrow frequently; do peripheral blood counts and platelet counts two or three times a week; and watch the general appearance of the youngster. Individualization is the secret of the best treatment. In our experience maintenance treatment less than twice a week has almost always resulted in a relapse, so that this seems the minimum frequency for injections. Oral treatment is being studied. Doses below 0.5 mg. have not given good results.

Aminopterin, of course, results in folic acid deprivation. Giving folic acid in large amounts when toxic symptoms develop may cause slight alleviation of the toxicity, but usually with severe symptoms the reaction probably cannot be reversed by administering folic acid, even in large doses. In trying to combat toxic reactions, at least 20 mg. of folic acid daily should be given.

EASTER SEALS



A young laboratory technician, like thousands of other individuals, is well aware of the meaning of Easter Seals. She knows from experience that Easter Seals provide handicapped boys and girls with a chance for normalcy.

This chance was given to the young technician, and today she—let's call her Mary—is leading a normal useful life. Thousands of others have been given the same

opportunity by Easter Seals, sold annually by the Pennsylvania Society for Crippled Children and Adults and its local affiliated units.

Mary is a technician in one of Pennsylvania's largest hospitals. She conducts her highly specialized and responsible duties with the utmost efficiency for eight hours daily. Afterwards she returns home and assumes the role of housewife.

Even today only a few of Mary's friends and associates are aware that she was considered almost a hopeless cripple a few short years ago. So complete is her recovery that there virtually is no telltale evidence of her former affliction.

In her fight and determination to become a normal useful citizen, Mary underwent two orthopedic operations, and received clinical care, treatment, and training from the Crippled Children's Society in her county.

As she began to improve, Mary received swimming instructions from the Crippled Children's Society. Soon her ability in the water became apparent and upon her own request Mary was permitted to enter swimming meets. Within two years she placed second three times in meets in which she was the only handicapped participant.

Mary later went to college, trained in a hospital and became a technician. She was married recently and now has her own home which she keeps in immaculate order. Mary continues to express her gratitude to her Crippled Children's Society for this opportunity.

Thousands of other youngsters and adults throughout the Commonwealth received similar opportunities. Thousands more will derive the same benefits in future years if you and your neighbors continue to buy and use Easter Seals. The sale this year will be conducted from March 17 to April 17.

Activities of the Pennsylvania Society for Crippled Children and Adults, 1107 North Front St., Harrisburg, Pa., and its local affiliated units, are financed solely by the annual Easter Seal campaign, conducted always during the month prior to Easter.

The purchase of Easter Seals and their use on letters will help assure the continued effective care of these thousands of handicapped individuals. The Society does not duplicate or overlap the efforts of other organizations as indicated by its huge case load and the ever increasing demands for assistance.

Funds realized from the forthcoming, or sixteenth annual sale of Easter Seals will be used to maintain functional training centers, training for the homebound and in sheltered workshops, treatment centers for those afflicted with cerebral palsy, physical therapists to give all crippled persons treatment to improve their handicap, clinics, swimming classes, speech clinics, purchase of braces, crutches, and prosthetic devices, and Camp Daddy Allen, a summer health center conducted annually in the Pocono Mountains.

THIS IS GOOD PUBLIC RELATIONS IN ACTION

In a recent issue of the *Perrysburg Journal*, there appeared a letter from the Board of Education, reading in part as follows:

"The Board of Education of Perrysburg extends its sincere appreciation to the medical men of the village who gave so freely and generously of their professional attention to the pre-school pupils during the school clinics held recently. Without the assistance of Drs. James J. Bayer, James R. McAuley, Paul F. Orr, and L. S. Pugh, the school district could never have realized the benefits derived from the clinics."

In our opinion, the physicians named also made a real contribution to the public relations of the medical profession.

Unfortunately, there are some physicians who haven't learned as yet that good will and public esteem are intangible benefits which are far more valuable in many instances than additions to their bank accounts.—*The Ohio State Medical Journal*, July, 1948.

PROVE AUREOMYCIN VALUABLE AGAINST FOUR DISEASES

Aureomycin, the new golden-colored antibiotic drug, is being used to treat patients with Rocky Mountain spotted fever of the eastern type, undulant fever, typhoid fever, and certain infections of the urinary tract, report five researchers from the Department of Preventive Medicine, Johns Hopkins University School of Medicine, Baltimore, Md.

Writing in the September 11 issue of *The Journal of the American Medical Association*, the researchers (Morton S. Bryer, M.D., Emanuel B. Schoenbach, M.D., Caroline A. Chandler, M.D., Eleanor A. Bliss, and Perrin H. Long, M.D.) report on clinical tests in the treatment of these diseases with aureomycin and on tests with animals to determine the effectiveness of the drug against other diseases.

Aureomycin is one of the newer drugs produced from molds. It is manufactured from the chemicals made by a thread-shaped mold that belongs to the group that produces streptomycin.

Five patients with Rocky Mountain spotted fever of the eastern type who were treated on the third to the fifth day of illness had no fever and showed no symptoms of the disease within twelve to seventy-two hours.

A patient with chronic undulant fever had no fever three days after aureomycin therapy was begun. Laboratory cultures of the patient's blood, which had been repeatedly positive for the disease, became sterile forty-eight hours after treatment with aureomycin was begun. This patient has shown no fever and no symptoms for more than two months, and blood cultures have remained sterile for the same length of time.

Two typhoid fever patients treated with aureomycin showed "favorable initial responses."

Infections of the urinary tract (notably colon bacillus) in two patients "were sterilized, and evidence of inflammation disappeared when patients were treated with aureomycin by mouth," the article says.—*Illinois Medical Journal*, November, 1948.

Treatment of Urinary Tract Infection

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THE subject of infection in the urinary tract has been widely investigated and profusely written on in the past fifty years. The literature is flooded with scientific research, pseudo-scientific musings, and case reports concerning one or more aspects in this field. It is only in the last few years, however, that real progress has been made toward the ultimate goal of specific, sound, scientific, accurate, and should we add sensible diagnosis and treatment of infection, not only of the urinary tract but all other systems as well. It is the purpose of this paper to review the literature from the point of view of the urologic clinician rather than the scientist and to try to boil down to basic principles, as far as possible, what the laboratories and investigators offer us and what we in turn can offer our patients who seek aid for one of the commonest, and still one of the most distressing of afflictions.

As far back as 1860, Butlerow, a chemist, produced methenamine, a substance dependent on the liberation of formaldehyde in an acid urine. This, of course, was not the first urinary antiseptic, as such a substance as oil of santal is an ancient remedy for gonorrheal urethritis. Methylene blue, used as an antistaphylococcic drug, came next chronologically and was first used by Einhorn in 1891. Acriflavine, mercurochrome, gentian violet, and others followed and each had its peak of popularity followed by the inevitable decline. Considering the previous preparations as the "first period," we then enter what may be called the "intermediate era" of urinary antiseptics begun by the discovery of pyridium by Ostromislensky in 1926. Hexylresorcinol, Clark and Helmholtz's ketogenic diet in 1932, and Rosenheim's mandelic acid in 1935 may be included here and these preparations are still not outmoded although they are rapidly being superseded. The advent of the sulfonamides is a line of demarcation for the beginning of the "modern era," penicillin and streptomycin rounding out

the big three of current scientific approach to this problem.

Successful therapeutic measures must still include diagnosis, drainage, dilution, and drugs. Diagnosis has become more and more important with the discovery of new drugs, and accurate smears and cultures are now available to all physicians. We must know exactly what organism we are dealing with, as modern therapy depends on etiology. Drainage, a time-honored urologic procedure, still ranks high in importance. Free flow of urine without obstruction, absence of foreign bodies in the urinary tract, absence of wounds with granulating surfaces communicating with the urinary tract, and sufficient renal function to secrete the chemotherapeutic agents in bactericidal concentration must all be considered. Dilution is not as necessary now as previously, but is still an adjunct to successful therapy. Drugs, however, leaped from a poor fourth to the lead in therapeutics of urinary infections. We shall only consider the current views on the modern drugs and not discuss the pros and cons during their early development.

Although the ketogenic diet, methenamine, and mandelic acid have a scientific basis for usage, the first specific therapy was made possible by the introduction of the sulfonamides. Through trial and error we have reached almost general agreement that large doses are not necessary for the usual urinary tract infection. One-half gram four times a day is usually sufficient combined with one gram of sodium bicarbonate. In our experience sulfadiazine is the drug of choice, giving the fewest toxic reactions and unwanted side effects. Sulfathiazole is still widely used and both of these preparations are highly efficient against *Staphylococcus albus*, *Staphylococcus aureus*, *Streptococcus hemolyticus*, *Streptococcus faecalis*, *Streptococcus viridans*, *Neisseria gonorrhea*, and the diphtheroid bacilli. It is an accepted procedure now to combine two sulfonamide drugs in order to decrease the incidence and severity of side reactions due to precipitation of crystals. Larger doses may be necessary in the presence of *Streptococcus faecalis* infections

Read before the Section on Urology at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 6, 1948.

From the Department of Urology, Mercy Hospital, Wilkes-Barre, Pa.

or with a coexistent bacteremia. Nesbit and Glickman believe that sulfathiazole is more efficient against *Streptococcus faecalis* in an acid urine than an alkaline urine. Sulfacetinide (Sulamyd) has been favored by many as the peer of sulfonamides. It has been stated that it has a high solubility in the physiologic acid range of the urine and combines good antibacterial activity, low toxicity, rapid renal elimination, plus a high urinary level. The dose is 3 to 4 grams daily for two to three days; then 2 grams (0.5 grams four times a day) for five to six days. Alkalinization is not necessary.

Other sulfonamides have been investigated. Both sulfathaladine and sulfasuxidine have been put forth for treatment of *Escherichia coli* infections. Everett and his co-workers found sulfathaladine effective in these cases using a dosage of 0.1 gram per kilogram of body weight daily and continuing therapy for two weeks following

the first sterile urine. Sulfasuxidine has likewise been used against *Escherichia coli* in daily doses of 0.25 gram per kilogram. The probable mode of action of both is inhibition of the source of infection in the bowel. A newer sulfonamide, designated as NU-445, has only recently drawn attention in the treatment of *Bacillus coli* and *Bacillus proteus* infections. Favorable reports indicate that this drug is efficacious against these organisms in a total daily dose of 6 to 8 grams daily and that it has a good tolerability with freedom from crystalluria. The favorable urinary pH for action of NU-445 is between 7.0 and 8.0. The various sulfonamides have also been used in conjunction with other drugs and this will be considered presently.

The most potent agent for eradication of gram-positive cocci is penicillin. The unfortunate aspect is that these organisms make up only a small percentage of etiologic agents in urinary

DRUGS—IN ORDER OF PREFERENCE

<i>Organisms (in order of frequency)</i>	<i>Sulfadiazine Sulfathiazole</i>	<i>Penicillin</i>	<i>Streptomycin</i>	<i>NU-445</i>	<i>Sulfathaladine Sulfasuxidine</i>	<i>Mandelic Acid</i>	<i>Methenamine</i>
<i>Escherichia coli</i>	—	—	1	2	2	2	3
<i>Aerobacter aerogenes</i>	—	—	1	—	—	2	—
<i>Proteus vulgaris</i>	—	—	1	2	—	2	—
<i>Pseudomonas aeruginosa</i>	2	—	1	—	—	1	—
<i>Staphylococcus albus</i>	2	1	—	—	—	—	3
<i>Staphylococcus aureus</i>	2	1	—	—	—	—	3
<i>Streptococcus hemolyticus</i>	1	1	—	—	—	—	—
<i>Streptococcus faecalis</i>	2	1	—	—	—	—	—
<i>Streptococcus viridans</i>	2	1	—	—	—	—	—
<i>Neisseria gonorrhea</i>	2	1	3	—	—	—	—
<i>Mycobacterium tuberculosis</i>	—	—	1	—	—	—	—
<i>Diphtheroid bacilli</i>	—	1	—	—	—	—	—
<i>Hemophilus influenzae</i>	2	—	1	—	—	—	—
Administration	Oral	Intra- muscularly	Intra- muscularly	Oral	Oral	Oral	Oral
Dosage	0.5 Gm. q 6 hrs.	20,000-30,000 units q 3 hrs.	0.25 Gm. q 3 hrs. for 3-5 days	6.0-8.0 Gm. daily	1.0-2.0 Gm. q 4 hrs.	3 Gm. q.i.d. Calcium mandelate	1 Gm. q 6 hrs.
Optimal urine reaction	Alkaline (except with <i>S. faecalis</i>)	Neutral	Alkaline pH 7.2-8.0	Alkaline 7.0-8.0	—	Acid	Acid pH 5.6 or below

tract infections. An added disadvantage is found in the fact that some gram-negative rods (e.g., *B. coli*) liberate penicillinase which destroys the inhibitory effects of penicillin. Therefore, in mixed infections, penicillin may fail to eliminate the coccal elements. Although its limited use is obvious, we must not ignore penicillin as an important form of treatment in this field. Renal carbuncles, pyonephrosis, acute epididymitis, post-traumatic infections, and postoperative infections all demand strong and complete therapy and penicillin is definitely indicated. With the newer methods of administration this drug may be given in full therapeutic doses with only one or two injections of 300,000 units each daily. This was certainly a welcome change from the patient's standpoint.

The gram-negative bacilli, causative organisms in the majority of urinary infections, were still a major problem to cope with until the appearance of streptomycin on the therapeutic scene. It is true that with methenamine, mandelic acid, acidifying agents, and the ingestion of large quantities of liquids we were able to make progress with a small number of cases, but more definite therapy was sorely needed. Streptomycin has filled this gap to a great degree in spite of the fact that it, too, is not the "all-healing" panacea for which we are seeking. Requisites for successful therapy are still in the process of extensive investigation. As with all other substances, there must be an unobstructed flow of urine. It is even more important that this be established in using streptomycin, as resistance develops more frequently and more rapidly and once developed is permanent. In early reports sensitivity *in vitro* was also a necessity, but this is impractical outside of a medical center and with the decrease in the price of the drug is no longer an actual "must." Preliminary study of the causative organisms should be done, as only gram-negative pathogens are sensitive. These include *Aerobacter aerogenes*, *Proteus vulgaris*, and *Escherichia coli* among others. *Pseudomonas aeruginosa* (*B. pyocyaneus*) is considered moderately sensitive. The gram-positive acid-fast *Mycobacterium tuberculosis* is also included in the moderately sensitive group. A high urinary pH is definitely needed, but various levels of pH 7.2 to pH 8.0 have been suggested. At any rate, sodium bicarbonate or sodium citrate should be given orally. However, with *Proteus vulgaris* infections, alkalinity favors bacterial growth and must be avoided, and likewise in the presence of phosphate stones a high pH is not desired during long periods of immobilization when calculi are apt to occur.

Dosage also is not yet completely studied, but a general review of the literature indicates that at least 2 grams daily for three to five days is necessary. The usual method of administration is 0.25 gram every three hours intramuscularly. With normal renal function the urinary level will vary inversely with the urinary volume. Streptomycin has been proved at least helpful if not curative in treating urinary tuberculosis. Conclusions on combined therapy with chaulmoogra oil (*Moogrol*), using 1 cc. of the latter with 0.5 to 1.0 gram of streptomycin daily for a month reveals definite clinical improvement in many; tuberculous epididymitis responds slowly if at all; it is of no value in the small contracted tuberculous bladder. It does hasten granulation healing of tuberculous wounds and is useful in bilateral renal tuberculosis where surgery cannot be performed. At least in all cases the spread of infection is impeded, but indications for surgery remain unchanged. When urographic evidence is present with demonstration of the acid-fast bacillus in the urine, surgical intervention is necessary with streptomycin a secondary consideration. Local instillations have proved of no value and, if the first course of parenteral treatment fails, then a second course is invariably a failure.

How, then, are we to evaluate the patient, what course of therapy are we to follow, what dosage is necessary, and what results may we expect? One may think that now it is only a matter of identifying the organism and proceeding with specific treatment, but we all know by experience that we have not yet reached that ultimate goal of simplification. The appended table shows the indicated drug for each organism found in most urinary tract infections with the optimum dose, the preference if more than one are used, the method of administration, and the optimal urine reaction. We must realize, however, that we are often confronted with causative agents that are resistant to one form of therapy or another, that become resistant while treatment is pursued, and the extremely large percentage in which are found mixed infections and therefore require attack from multiple channels.

Following endoscopic resections, Prince reports good results with routine administration of sulfadiazine and penicillin preoperatively and postoperatively. Favorable results are also shown by Crowley and O'Connor in the treatment of persistent colon bacillus infections with sulfasuxidine and streptomycin combined. Synergism of the antibiotics has been demonstrated in numerous papers, and we are now aware that we can use the sulfonamides in combination with penicillin, with streptomycin, with mandelamine,

or various other combinations of the latter three. Persistent gram-negative bacillary infection is probably the most distressing and difficult to attempt to eradicate. Carroll and Allen have outlined a sensible and scientific régime in these cases. The pH of the urine should be determined twice daily, a pH of 5.5 being most favorable for mandelic acid and a pH of 7.6 for streptomycin. They obtain alkalinity by alkaline ash diet and 2 drams of 50 per cent solution of sodium citrate orally every four hours. Acidity is achieved with an acid ash diet and ammonium chloride or nitrohydrochloric acid orally. They use mandelic acid in patients who cannot be hospitalized and where there is a high resistance to streptomycin. Mandelic acid is administered in the form of calcium mandelate (3 grams four times a day) or methenamine mandelate (three tablets four times a day). Of course, a thorough urologic examination is still a necessity.

Another problem only recently has confronted the urologist in the form of pleuropneumonia-like organisms, also labeled "L" organisms, which have been shown to cause many cases of urethritis, prostatitis, cystitis, and Reiter's syndrome. These organisms cannot be stained by the usual methods, and cultures can only be seen microscopically. This fact if nothing else shows us that we have not yet reached the end of this problem and perhaps have only scratched the surface, but we can be confident that this scratch is getting deeper and with intelligent scientifically based study of each case of urinary infection we are now in a position to offer the patient a greater hope of relief and a greater possibility of cure.

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ABSTRACT OF DISCUSSION

RUSSELL E. ALLYN (Harrisburg): May I be the first to congratulate Dr. Mayock upon his most excellent presentation of this subject. In my senior year at medical school, which was only a little over ten years ago, I can still remember Dr. David M. Davis's memorable lecture upon urinary tract infection. To quote Dr. Davis, "This is the first time that I have been able to state that we have a specific drug for urinary tract infection." With these words he opened his lecture upon mandelic acid therapy. In closing the lecture he further stated: "This is only the beginning, and now that a start has been made, I expect the progress to be rapid." He further added a word of warning: "If in the future one is able to control absolutely urinary tract infection by the use of drugs, it will indeed be a black day for urology." Not that the specialty would be outmoded and fall into disuse, but rather in treating the symptoms of pyuria instead of the underlying cause many correctible lesions would indeed become irreversible. Therefore, it behooves us always to search carefully for the underlying cause of pyuria. If this warning was timely then, it is no less so at the present time, with the great increase of therapeutic agents for sterilization of the urine.

In addition to Dr. Mayock's list of causative organisms, may we add one more, namely, *Bacterium aerogenes*. Until recently it has been our impression that the aerogenes has been considered non-pathogenic. However, recently it has been definitely proven that at times this organism loses its non-pathogenicity and becomes pathogenic. More recently proven bacteremia due to aerogenes has been reported. At the present time it is our belief that if no other organism can be demonstrated to cause the pyuria, this organism should be considered pathogenically and treated as such.

In closing, may we come to the defense of urotropin and acid sodium phosphate. Recently this drug has fallen into disrepute because of its low bactericidal property. However, in our experience we have often seen a pyuria cleared with its use when all other forms of therapy had failed.

DR. MAYOCK (in closing): I cannot help but feel that in treating long-standing urinary tract infections, we cannot expect too good a result from any therapeutic remedy or any antibiotic agent. As an old urologist who treated syphilis, we were always taught to believe that the longer a person had syphilis, the less chance there was to eradicate it, and I feel very keenly that we have the same condition in urinary tract infections. The diagnosis should be made early and a real attempt made to determine the identity of the organism or organisms and then try to get rid of the infection.

Recently, I saw a woman who had made the rounds. Of course, she had been infected for many years. When I looked at her organs, it was very evident that the use of drugs would be wasted. I believe that early diagnosis is very important if we are going to expect anything from antibiotics and therapeutic agents, or learn what their possibilities are.

The Role of Surgery in Solving the Peptic Ulcer Problem

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THERE is still much concern over the reputed poor results of surgery in the treatment of peptic ulcer and its complications. This is largely due to the empirical employment of various procedures without a clear-cut definition of the criteria of an acceptable operation for ulcer. The wave of enthusiasm which attended the revival of vagus nerve section as a possible solution of these problems is ample evidence of dissatisfaction with previously accepted methods. At this time we see no justification for discarding the practices and principles of ulcer surgery which we have followed over the past decade. Much of what is known today has been acquired at the expense of the patient in suffering, economic loss, and even the loss of life. The role of surgery is clear—it must first strive to reduce the mortality attending certain of the complications of ulcer, and second, offer the individual a better chance of freedom from symptoms and recurrence without imposing new difficulties upon him. We should steadfastly refuse to subject the patient to the uncertainty of new procedures unless there exists a reasonable expectation of furthering these aims.

Gastric Ulcer

The uncomplicated gastric ulcer is a surgical problem; the uncomplicated duodenal ulcer is not. It is impossible by methods now at our disposal to differentiate surely benign and malignant ulceration in the stomach. Ten to 15 per cent^{1, 2} of patients believed to have a benign gastric ulcer, after a thorough clinical survey including gastric analysis, x-ray, and gastroscopy, prove to have cancer. These carcinomas masquerading as ulcers often diminish in size and their attending ulcer-like symptoms improve on medical therapy. It is impossible to be certain of the diagnosis with the lesion under observation at the operating table. In 1936 Cole³ pointed out the pitfalls of the histologic examination in diagnosis. Twenty-three leading pathologists

were asked to study the microscopic sections of eight ulcerating gastric lesions. There was no agreement on the benign or malignant nature of any one of the eight specimens. The limitations of roentgen and gastroscopic diagnosis should then be obvious. Early operation upon these uncomplicated gastric ulcers is more conservative than the uncertainty of prolonged and often misleading trials of medical treatment.

Under such a policy some patients will be operated upon who would have done well on medical treatment. On the other hand, a number of malignant lesions will come to surgery without delay. In the larger clinics with a wide experience in gastric surgery the mortality of operation, now 1 to 2 per cent, is less than the loss of life that follows inoperability because of delayed surgical intervention in those lesions that prove to be malignant. Gastric resection for gastric ulcer is usually less difficult than operation for an adherent duodenal lesion and the late results are correspondingly better. Recurrent and marginal ulceration are exceedingly rare. We have never encountered recurrent or marginal ulceration following adequate resection for gastric ulcer.

Because of the potential malignancy of these gastric ulcers, a radical resection should be performed following the principles of any operation for a malignant process. The gastrohepatic omentum, the gastrocolic omentum, and the greater omentum should be resected together with the regional lymphatics. The lesion should be removed with a wide margin of grossly normal tissue. Only when this plan is followed have we fulfilled our responsibility to the patient. Allen¹ has shown that in this group of questionable lesions, when resection had been done with a diagnosis of benign ulcer only to have the pathologist find it cancer, the five-year survival rate was 40 per cent. The average five-year survival rate for resection in frank carcinoma of the stomach is less than 10 per cent.

Perforation

The role of surgery in the treatment of acute ulcer perforations into the free peritoneal cavity

Read before the Section on Surgery at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 5, 1948.
From the Graduate School of Medicine, University of Pennsylvania.

was scarcely questioned until a recent flurry of reports of non-operative management. In essence the method combines chemotherapy and antibiotic therapy with continuous gastric suction drainage. That such a regimen will be successful in many cases is unquestionably true. We find many perforated ulcers sealed off at the time of emergency exploration. There are others that could not possibly be successfully managed without operation.

These patients die from the direct and indirect effects of contamination of the peritoneal cavity. The mortality is higher when the contamination is greatest, either due to the large volume of material in the stomach at the time of the perforation, or a large defect, or a long delay between perforation and closure. The treatment of choice for these free perforations is still immediate operation. There should be no delay in order to obtain x-ray evidence of a pneumoperitoneum. Only such measures as are necessary to tide the patient over the immediate emergency should be employed. These individuals are in a shocked state regardless of the blood pressure level and in no condition to be subjected to major surgery.

Gastric suction and measures to combat shock should be instituted at once and the defect closed as rapidly and simply as possible. The omentum offers an effective means of closing the defect where the tissue is too friable to hold sutures along the ulcer margin. The contaminating material is then aspirated from the peritoneal cavity. Chemotherapy and antibiotics are important adjuncts. With this regimen we had not had a single operative death in 36 consecutive perforations seen within twenty-four hours of the perforation until several months ago. This patient was admitted in profound shock and was operated upon after his blood pressure was restored. It was impossible to maintain his blood pressure after operation and he died within twenty-four hours. Our only other operative deaths over a ten-year period have occurred in patients with perforations over forty-eight hours old and established peritonitis. Non-operative management may well find its place in these desperate risks and late cases.

For many years we have been led to believe that closure of a perforation usually rendered the patient free from further ulcer difficulty. This idea is unfounded and dangerous. Repeated perforations are not unusual. Evidence of continued or recurrent ulcer activity is so common that institution of a rigid medical regimen is imperative after operation. Definitive ulcer surgery

is necessary in a goodly proportion of these cases at a later date.

Obstruction

Not all obstructing duodenal ulcers require surgical intervention. The duration of the obstruction before treatment determines to a large extent the success or failure of medical management. Long-standing obstructions are usually irreversible. The surgical treatment for an obstructing ulcer that has failed to respond to conservative treatment is gastric resection. A gastrojejunostomy is occasionally adequate in elderly or poor risk patients with low gastric acidity or anacidity.

With this complication preoperative preparation is of the utmost importance. This is never an emergency. The dilated, atonic stomach should be decompressed by intermittent suction drainage to render it safe for surgery. The state of the patient's fluid balance and nutrition must be restored to normal. Here the principle of alternate feeding and drainage is useful in conjunction with intravenous supplements. By this method the stomach never becomes distended and is gradually decompressed. It aids in determining which cases can be managed medically and which should be operated upon. Those that reach the surgeon come to him better nourished, with a normal fluid balance and with much improved gastric tone, when compared with the group of patients who have an occasional aspiration or even continuous gastric suction for a day or two.

Hemorrhage

The place of surgery in the management of the patient with massive hemorrhage from peptic ulcer is still confused. A more general recognition of the risks run by patients with massive hemorrhage and the development of a plan of attack will salvage many whose lives might otherwise ebb away because of failure to control bleeding. We have tried to adopt a policy of armed expectancy, for without a doubt there is a small group of patients which surgery alone can save. The fundamental fact that we must bear in mind, whether the management is operative or non-operative, is that no patient can withstand repeated and prolonged episodes of shock. Irreversible damage to the brain and vital viscera will inevitably follow these periods of prolonged tissue anoxia. There is no place for surgery after these changes have occurred. Failure to maintain adequate blood volume during massive hemorrhage invites mortality. Withholding transfusion because of fear of dislodging a forming clot is a dangerous and unfounded practice.

The individual with massive upper gastro-intestinal hemorrhage presumably from ulcer should ideally be followed by the surgeon and the gastro-enterologist from the start. When it becomes apparent after the initial correction of the shocked state and the institution of a medical regimen that it is difficult or impossible to sustain an effective blood pressure, operative intervention should be considered without further delay. This is especially true in older patients with a long ulcer history and repeated bleeding episodes in the past. It is rarely necessary in the younger age group or in the presence of acute ulceration. We are now eminently better equipped to undertake major surgery in these cases than we were prior to the blood bank and expert medical anesthetization.

Wide adoption of this aggressive means of arresting hemorrhage from bleeding ulcer should be discouraged unless it can be concentrated in the hands of those experienced in gastric surgery and having available large volumes of blood and expert anesthesia. The period of bleeding is the most undesirable time of all to operate upon a patient. Control of bleeding usually entails extensive gastric procedures. The problem may be difficult on other scores. The diagnosis of ulcer as the source of the bleeding may be in doubt. This is minimized when one considers that roughly 85 per cent of massive upper gastro-intestinal hemorrhages occur from peptic ulcers, gastritis, or neoplasm, all amenable to control by gastric resection if the necessity arises.

We do not believe that all massively bleeding peptic ulcers should be operated upon, nor can all be controlled medically. We have been encouraged in recent years by our own limited experience with these desperate cases of uncontrolled bleeding. In 8 cases operated upon early, because it proved difficult to maintain normal blood pressure with repeated transfusions and a feeding regimen, we have had no deaths. All were over 45 years of age. One patient with an ulcer history proved to have an unsuspected advanced hepatic cirrhosis and was presumably bleeding from esophageal varices. He was closed after exploration and the bleeding stopped spontaneously. One patient was bleeding from a gastric ulcer which was simply excised and the stomach was resected at a later operation. The remaining six patients had gastric resections carried out with removal of the ulcer-bearing portion of the duodenum in five and of the stomach in one. In retrospect, after pathologic examination at operation, we are convinced that four of these patients would have died without surgical intervention.

The Intractable Ulcer and the Intractable Patient with Ulcer

Patients who secure adequate relief on conservative management, who avoid the complications, and who do not experience serious inconvenience because of dietary restrictions do not need surgery. There are, however, a large number of patients who suffer repeated recurrences of their ulcer and are disabled for several weeks to months at a time. These individuals welcome a procedure which holds a reasonable promise of relief. Their ulcers are commonly referred to as intractable. Often it is the patient who proves intractable. He comes to the surgeon because he is either unwilling or temperamentally unable to be regimented by a medical program.

Elective Operative Procedures for Peptic Ulcer

It has been found by bitter experience that any surgical effort that fails to effectively control the acid-pepsin factor in gastric secretion leaves much to chance and is followed by a high incidence of failure and recurrent ulceration. Today there is little or no place for gastrojejunostomy, pyloroplasty, or local excision in the treatment of the ulcer diathesis. There is likewise no place for procedures labeled gastric resection which do not effectively control the acid-pepsin factor in gastric secretion.

There are certain fundamental principles of gastric physiology which have a great bearing on the success or failure of any operation carried out to cure and prevent recurrence of peptic ulcer. Briefly, these facts are:

1. The average ulcer patient secretes more gastric juice in response to stimulation than the normal person, and what is perhaps more important, he secretes more gastric juice when no obvious stimulant is present.

2. *Gastric secretion is stimulated in various ways:*

- A. The *cephalic phase* is mediated through the vagus nerves. It occurs as a result of conscious cerebral stimuli associated with food and the emotions, but is chiefly important when digestion is not in progress, even during sleep. The latter is difficult to control medically.

- B. The *gastric phase* of gastric secretion is initiated by mechanical distention of the gastric wall and by the chemical stimulation of food materials and the products of their digestion. Delayed emp-

tying of the stomach may prolong this phase and distention augments it.

C. The *antral mucosa* of the stomach is the source of an internal secretion, gastrin, which stimulates the acid-secreting cells of the fundus. Removal of this area alone decreases acid-pepsin secretion. Failure to remove this area at operation is associated with a high incidence of recurrence in ulcer surgery.

3. Most of the parietal cells which secrete acid and pepsin are in the fundus of the stomach. These cells secrete regardless of the source of stimulation. To satisfactorily control the important acid-pepsin factor, one should attack the source of the secretion rather than individual sources of stimulation such as the vagus nerves. Complete vagotomy, for example, will not protect the dog from ulcer produced by histamine stimulation of gastric secretion. Adequate gastric resection will.

4. The *mucous membrane* of the *small intestine* becomes more vulnerable to the proteolytic action of acid and pepsin as you pass downward from the pylorus.

In consideration of these facts and clinical experience, it is our opinion that subtotal gastric resection, properly planned and executed, is the best surgical approach to the ulcer diathesis. The resection should remove enough of the secreting area of the gastric wall to effectively control the acid-pepsin factor during any and all stages of gastric secretion. The pylorus and ulcer-bearing portion of the duodenum should be removed when this is technically safe. When the antral portion of the stomach cannot be removed, its mucous membrane should be stripped off and removed to eliminate its humoral influence on gastric secretion. The end of the resected stomach should be anastomosed to the jejunum as close to the ligament of Treitz as possible since this area is less vulnerable to recurrent ulceration. There should be no delay in gastric emptying.

We have attempted to satisfy these criteria by using a modification of the Hofmeister or Polya subtotal gastric resection. Approximately 75 per cent of the stomach is removed including practically all of the lesser curvature and the greater curvature up to the vasa brevia, including all the branches of the left gastro-epiploic artery. Gastro-intestinal continuity is restored in ante-colic fashion as close to the ligament of Treitz as possible. We prefer an open procedure because of increased accuracy in the placement of sutures.

This resection practically removes the threat of recurrent ulceration with a risk to life that is less than that of the disease for which operative relief is undertaken. Furthermore, it offers the patient not only relief from pain but relief from much of the monotony of dietary restriction as well. Rarely in our experience has it imposed significant new difficulties on the patient.

Wangensteen⁴ has shown that this type of operation will protect against the ulcer regularly provoked by histamine in the dog. He has carried this into clinical practice and recently reported a series of 500 consecutive patients resected in essentially this way for ulcer. In this group there were two marginal ulcers that developed after operation. In both instances the resections were not liberal enough. Further resection at the proposed level effected a satisfactory result in each case.

Results of more conservative resections suggest their inadequacy. In 1945 Rienhoff⁵ reported his results following 260 consecutive resections that included approximately one-half of the gastric wall. There was proven or strongly suggestive evidence of marginal ulceration in 21 per cent. It is this type of resection that is responsible for the statement that gastric resection offers no more protection against recurrence than does gastrojejunostomy.

Our experience with liberal resection has closely paralleled that of Wangenstein. In over 200 resections performed by the authors and their associates in the past ten years, there have been only six instances of proven or suspected marginal ulceration. In each instance it was obvious that the primary operation was inadequate according to the criteria we have indicated. The usual causes of a poor result following gastric resection are inadequate resection of the gastric wall, failure to remove the antral mucosa or ulcer-bearing portion of the duodenum, gastrojejunal anastomosis too far down on the jejunum, mechanically imperfect anastomosis, and operation without proper indication.

The operative mortality for elective gastric resection is now remarkably low. In the larger clinics of this country it varies from 1 to 3 per cent. In the series mentioned above the mortality was 2 per cent. In 100 consecutive cases operated upon by the authors, there were no deaths. We have not been impressed with the fact that removal of 75 per cent of the stomach imposed significant new difficulties on the patient. Occasionally undesirable sequelae appear, but these rarely interfere with the patient's ability to work and are never so distressing as the

disease for which the operation was undertaken. There have been those who failed to gain weight after resection. A number complain of nausea on arising for several months. A few have symptoms suggesting transient hypoglycemia after eating. This is also of short duration. There have been no profound or incapacitating "dumping syndromes" in this series. We are therefore unwilling at the present time to discard an operation that carries such a prospect of precluding recurrent ulceration. It is hoped that some method of achieving the same result by lesser means will some day be found.

In conclusion, some statement regarding vagus nerve section in the surgical treatment of ulcer is fitting. Vagotomy undoubtedly has a place. We are not convinced of its value as a primary approach to the ulcer diathesis and its complications. We are mindful of premature judgment in the past. Lord Moynihan once stated that the accomplishments of gastrojejunostomy stamped it as one of the great operations devised by surgeons for the relief of ulcer. These seem like rather hollow words today. Adequate gastric resection has in our experience stood the test of time. Vagotomy has not. Physiologically, it removes only the cephalic phase of stimulation for gastric secretion and does not protect the experimental animal against other forms of stimulation such as histamine. In many cases it has imposed significant new difficulties on the patient in the form of prolonged emptying difficulties often requiring supplementary procedures.

There is no place for vagus section in the primary treatment of gastric ulcer. Resection controls the acidity with ease, is rarely followed by recurrent ulcer, has a mortality of 1 to 3 per cent, and actually removes a lesion which often proves to be malignant. We believe that vagotomy will find its principal use as an adjunct to other procedures for the treatment of peptic ulcer. It is probably worth while in addition to resection in those individuals with tremendously high gastric acids, in operative procedures which fall short of our criteria of adequacy, and in the management of recurrent ulceration after a three-fourth resection. Its shortcomings are obvious in the management of the complications of ulcer. Vagotomy is not an experiment that should be undertaken simultaneously in many places. Its foremost proponents will one day be in a position to truly evaluate the procedure. Until that time we propose to use it as an additional means of improving the results of resection.

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ABSTRACT OF DISCUSSION

HENRY L. BOCKUS (Philadelphia): Dr. Ferguson is always courageous, otherwise I am sure he would not have invited a gastro-enterologist to discuss his presentation. He and I have teaching sessions each Saturday, so we are accustomed to disagreement; indeed, we look for it in order to bring out certain points in teaching. He was kind enough to send me his paper to read in advance, and you may well imagine that I scanned it very carefully for anything that I might possibly disagree with, but, much to my amazement, and perhaps to his, I am afraid I shall have to say that I can agree with his presentation almost in its entirety.

He was able to give you only the abstract. I think I can say fairly that it is the best brief paper I have read on the surgical approach to the treatment of peptic ulcer up to this time, but, as a physician, I should like to sound this warning. The results that you hear from the Fergusons are not the equivalent of the results that are obtained in gastric surgery for ulcer throughout the breadth of this country, unfortunately. In other words, in any decision which a physician must make concerning the advisability of operation for a peptic ulcer, he must not only size up the pros and cons of the individual problem presented by the ulcer but he must have in the back of his mind the ability of the surgeon who will perform the operation.

Those of us who do gastro-enterology in large clinic centers see patients, of course, from everywhere, and there is a great difference between expertness in gastric surgery and average gastric surgery. These differences in the degree of expertness of available surgeons may modify our decision concerning the treatment of gastric ulcer. I cannot wholly agree with Dr. Ferguson's suggestions on the treatment of gastric ulcer.

It is true that no one can be absolutely sure whether any given gastric ulcer is or is not malignant. Some statistics which Dr. Ferguson quoted indicate that from 10 to 15 per cent of mistakes are made by calling an ulcer benign which is found to be malignant at operation, but let me put it a little differently. How many patients actually return to us who have had a thorough investigation initially, have been classified as having a benign ulcer, their ulcer has healed—how many patients do we have come back to us with gastric carcinoma—come back to us or to anyone else?

I am not going to quote my experience, but I know the experience of most of the leading gastro-enterologic internists in this country, and if you argue on that basis and insist upon expertness of study, not very many patients with gastric ulcer return to the internist when he has been satisfied by the strictest criteria that the ulcer was benign and that it healed. We believe that if there is any chance at all that the lesion is malignant, from any of the studies that have been made, certainly operation should be performed.

Approximately 10 per cent or less of gastric ulcers in the common location, along the lesser curvature of the stomach at the incisura angularis or above it, are malig-

nant. More than 90 per cent are benign. I think most of us now would rather have ulcers elsewhere in the stomach operated upon.

I was going to comment on the various complications which Dr. Ferguson covered, agreeing in a large measure with his argument concerning them, but I will merely close by saying that I can recommend the read-

ing of this paper very carefully, and I agree with Dr. Ferguson that the operation of choice at this time for the surgical ulcer is an adequately performed partial gastrectomy and, as an internist, I can say to you that during the last five years the results that we have obtained with this operation have been tremendously better than they were at any time previously.

PEPPER-SLAUGHTER FORUM DEBATE ON COMPULSORY HEALTH INSURANCE

Florida's Senator Claude Pepper, silver-tongued orator of the Senate, and Florida's distinguished author-lecturer-surgeon, Dr. Frank G. Slaughter, chairman of the Public Relations Committee of the Florida Medical Association, met head on in a lively verbal tilt in Jacksonville on November 18 in an open forum sponsored by the Jacksonville Junior Chamber of Commerce. "Should Congress Enact Compulsory Health Insurance Legislation?" was the subject of the debate.

The nation's foremost advocate of compulsory health insurance advanced the usual arguments, long since worn threadbare, to bolster his pet scheme, declaring the compulsory plan to be "the Democratic approach to the essential problem of prolonging the life and preserving the health of the American people." In the light of the truth, it takes intestinal fortitude possessed only by the very few—especially among those expected to be responsible and intelligent representatives of the citizenry—to have the temerity to drag out again and again the creaky skeleton of 40 per cent rejections in Selective Service and with clanging oratory lay this high rate to conditions resulting from lack of medical care. Too, the sob story indictment of the medical profession, charging it with neglecting the medical needs of the people and leaving millions of low income workers without medical care, grows boring, to say the least, to any person who will take the trouble to inform himself.

With scintillating clarity, Dr. Slaughter, in refuting these claims, characterized the Senator's favorite legislative child as "a hydra-headed brat, sired by three men in the pay of the Federal Government (Altmeyer, Ewing, and Falk), and designed further to regiment the American people." He was quick to remind the capacity audience and the radio listeners that the doctors of the country are giving away a million dollars a day in free medical services and are fostering nonprofit plans for prepaid medical care through the Blue Cross and Blue Shield whereby people may protect themselves. Point by point, Dr. Slaughter knocked down the Senator's straw men as he built up the case against socialized medicine, blasting into absurdities the pious claims and formidable-sounding statistics of his opponent. His brilliant rebuttal was abundantly attested by the overwhelming approval of the forum and the radio audience.

Stung by the exigencies of the moment into recanting somewhat in view of his wholly untenable position, Senator Pepper sought to mitigate his blistering accusations by suave speech and hollow expressions of personal admiration for the medical profession—an old,

old story all too familiar to Florida doctors and sorry camouflage indeed for an ardent proponent of socialized medicine, by whatever name it may be called. Every thinking man of medicine must realize that any advocate, much less an aggressive champion, of governmental control of the profession brands himself as its sworn enemy.

Having stated publicly his intention to introduce before the next Congress a proposal for compulsory health insurance, Senator Pepper specifically identified it as following the familiar Wagner-Murray-Dingell line. It is no happenstance that on the day he was in Jacksonville contending against Dr. Slaughter's cogent presentation of the true situation, Dr. Arthur Altmeyer of the Social Security Board announced that not only would compulsory health insurance be proposed to the next Congress but also compulsory insurance for wage loss from sickness, the second head of proposed legislation described by Dr. Slaughter as the "hydra-headed brat." And the day following, Mr. Oscar Ewing, Federal Security Administrator, made a similar statement before a national labor group.

The physicians of America face today the most critical fight in their entire existence, the fight for survival as a free profession. The enemies of medicine, led by Altmeyer, Ewing, and Falk, powerful triad in the Federal Security Administration and the Bureau of Research and Statistics, have as their spokesman one of America's finest orators, the man whose tongue is feared most of all on the floor of the Senate. His mellifluous tones promise to unwary voters a Utopia which could only be a pitfall. Not only would it wreck the health record of American medicine and the American people but all too soon it would engulf the nation's health and the national economy in a maelstrom of destruction from which there would be no escape.—*Journal of the Florida Medical Association*, January, 1949.

MATERNAL DEATHS BY COUNTIES

On page 512, this issue, will be found a listing of "Deaths from Selected Causes in Pennsylvania, August, 1948." The column "Maternal Deaths" totals 14, divided by counties as follows: Philadelphia, 3; Allegheny, Beaver, and Lancaster, 2 each; Blair, Clearfield, Delaware, Elk, and Lehigh, 1 each. It is important that the causes for these deaths were determined and discussed by members of the medical societies in the counties where such deaths occurred.

Survey of Diphtheria Immunization of 5661 Pupils in the Philadelphia Public Schools

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THE incidence of diphtheria has increased in the United States. This increase has occurred especially along the eastern seaboard. Older children and young adults have largely been the victims of the increase.

It is believed that more intensive immunization could substantially reduce this high incidence. Acting upon this surmise, the Medical Division of the Philadelphia Board of Public Education called a conference on April 7, 1947, to discuss the problem. Those participating in this first conference included health officers from Philadelphia and Harrisburg, school physicians, nurses, and representatives of the Philadelphia Pediatric Society.

At this conference it was decided that efforts should be made to determine the duration of immunity to diphtheria before any definite program of immunization could be outlined. Consequently a Schick test survey was advocated of 1000 pupils in each of the even grades, the second through the twelfth, so that at least 5000 pupils in the Philadelphia public schools could be studied. For the sake of accuracy, we included only pupils who had been immunized by the school medical inspectors.

All too frequently statements made by the parents as to immunization procedures completed before admission to school are incomplete or inaccurate.

The written record given to the parents by the private physicians or health centers is often lost, so that the school physician does not obtain conclusive evidence of past immunizations.

The pupils included in this survey had been immunized by the school medical inspectors and were later found Schick-negative. None had received a booster dose of diphtheria toxoid.

Prior to the spring of 1944 the material used

for this protective treatment had been three doses of toxin-antitoxin. Since that time two doses of alum-precipitated toxoid have been used instead of the toxin-antitoxin. Both products were prepared in the laboratory of the Philadelphia Department of Public Health.

Written permission of the parents was obtained for the survey. Only medical inspectors experienced in Schick testing were assigned. Although controls were not used, the tests were read on the fifth day to eliminate false positives.

A total of 5661 pupils were Schick-tested and 903 or 16 per cent had reverted to positive. As was expected, a very small proportion (12 per cent) of the pupils immunized had positive Schick tests after the first three years. Beginning with the fourth year, the percentage of positive reactors rose to 15.7. After the seventh year, the percentage of positive reactors rose rapidly from 18.1 in the eighth year to 39.1 after the twelfth year. Beyond that period the number of pupils tested was so small that any deduction would not be significant.

Parenthetically, it is interesting to note that over 90 per cent of the public school pupils enrolled in grades one through four and pupils under 12 years of age in special classes are im-

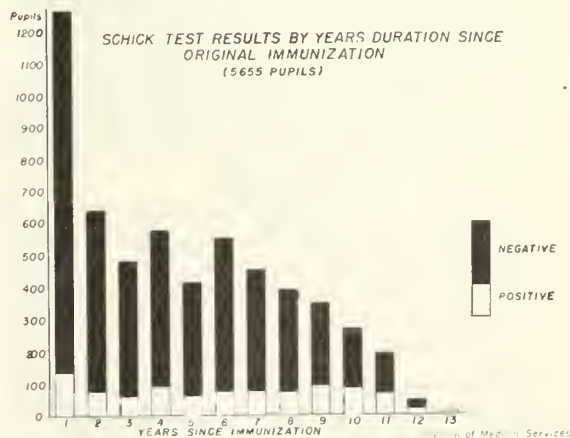


Fig. 1

Read before the Section on Preventive Medicine and Public Health at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 5, 1948.

Dr. Owen is director of the Division of Medical Services, Philadelphia Board of Public Education.

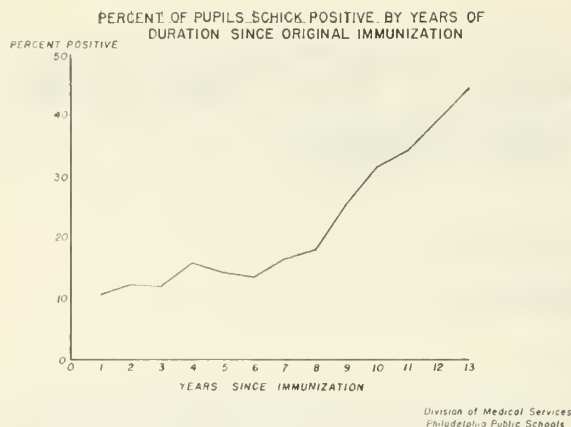


Fig. 2

munized against diphtheria as shown by negative Schick tests.

San Francisco reports approximately 80 per cent of all school children under 10 years of age immunized against diphtheria according to Dr. J. C. Geiger, Director of Health.

The Health Department of San Francisco conducted a small pilot study of Schick and Moloney tests of students in five senior high schools in that city. Their pupils were divided into three major groups: (1) those with immunization dates within a five-year period, 1942-1947; (2) those with immunization of unknown date; and (3) those without record of immunization. As was to be expected, because of the large proportion (80 per cent) of immunized elementary school pupils, there was a relatively small number of high school students with Schick-positive reactions. It is interesting to note the difference in percentages of positive Schick tests in the three groups. Of 663 pupils tested, 78.4 per cent had been immunized previously and 19 per cent of these had a positive Schick test; 44 per cent of the non-immunized group had positive Schick tests and 29 per cent of the group with unknown immunization history were Schick-positive.

A second phase of the Philadelphia survey, as recommended by the conference, was the study of pre-school children to be conducted by the Division of Child Hygiene of the Philadelphia Department of Public Health.

A total of 1110 children immunized in infancy in the health centers by two doses of alum-precipitated toxoid who had had negative Schick tests three months later were re-Schick-tested in the summer of 1947, just prior to admission to school. Only 88 of these children or 7.3 per cent were found positive. At the end of three years 3.8 per cent were positive; at four years 8.7 per cent; and at five years 10.8 per cent.

The results of these two surveys were dis-

cussed in detail by the groups mentioned previously. Questions were raised as to the proper time to give booster doses, the product and dosage to be used, and whether single, double, or triple antigen should be recommended, realizing the possibility of severe reactions in older children with the use of triple antigen.

The need for continuing extensive Schick-testing programs in the schools was also discussed. The program as finally outlined was then submitted for criticism and revision to the Philadelphia Pediatric Society, the Philadelphia County Medical Society, the Philadelphia College of Physicians, the Philadelphia Department of Public Health, the Department of Health of Baltimore, the Pittsburgh Department of Health, the Pittsburgh School Medical Division, and the Department of Health of the Commonwealth of Pennsylvania.

The program was approved by Dr. Norris W. Vaux, Secretary of Health of the Commonwealth of Pennsylvania, and is being recommended by him for adoption throughout the Commonwealth.

Consideration was given not only to protection of children against diphtheria but also against whooping cough, tetanus, and smallpox.

Important highlights of the program are summarized as follows:

Program

Basic immunization for diphtheria, tetanus, and whooping cough should be started at 4 to 6 months of age and completed before the end of the first year, using one of the so-called triple vaccines. Four to six months later a booster dose of the triple antigen should be given. This completes the basic immunization for diphtheria, tetanus, and whooping cough and no Schick test is required.

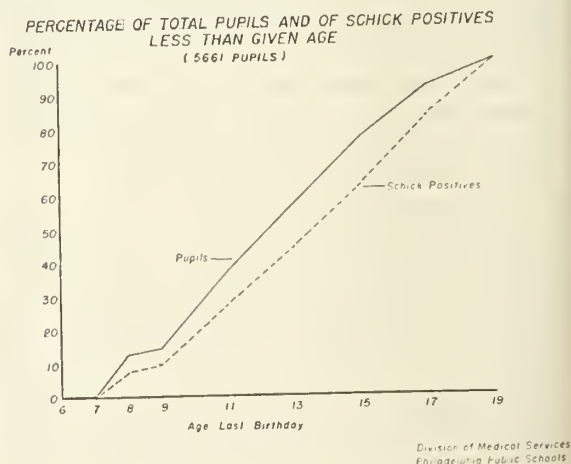


Fig. 3

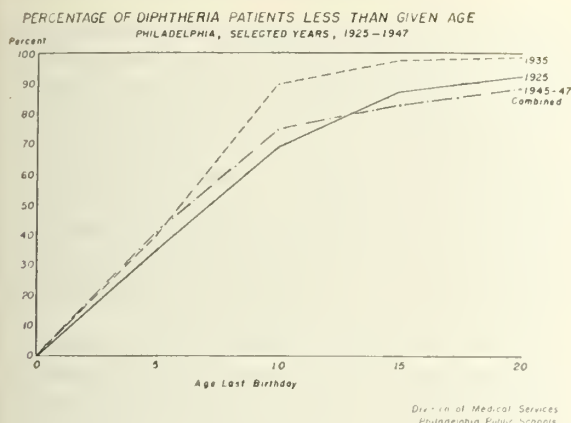


Fig. 4

If conclusive evidence is presented that basic immunization was given in infancy, a booster dose of diphtheria toxoid should be given on admission to school. A booster dose of tetanus toxoid should also be given, but not simultaneously with the diphtheria toxoid.

If basic immunization has not been given in the pre-school period, two doses of diphtheria toxoid should be given a month apart on admission to school. The triple antigen is *not* recommended for children over 5 years of age due to the possibility of constitutional reaction. Tetanus toxoid should be given to the child who has not received this basic immunization in the pre-

TENS OF CASES AND NUMBER OF DEATHS FROM
DIPHTHERIA IN PHILADELPHIA, 1925-1947

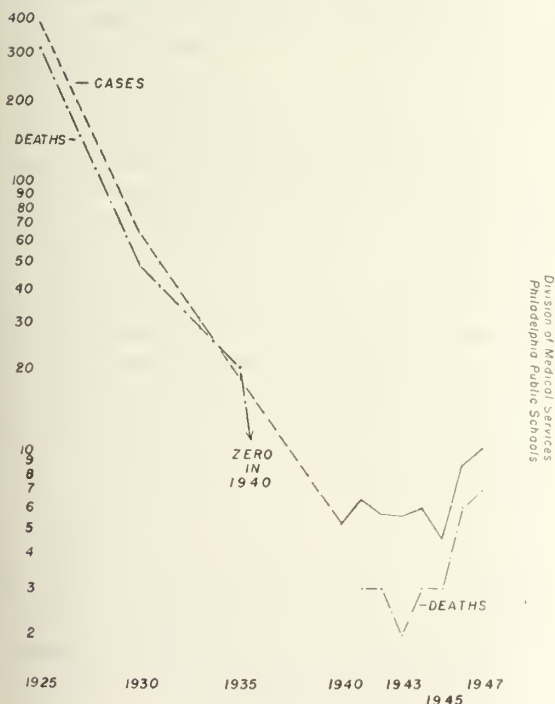


Fig. 5

school period. It is preferable to allow a month or two to elapse between injections of the diphtheria toxoid and the tetanus toxoid. Although tetanus is not the subject of this paper, a more extensive immunization program would reduce the incidence of this disease in civil practice as has been accomplished in warfare.

Second booster doses of both diphtheria toxoid and tetanus toxoid should be given approximately four years after the first booster doses to insure continued immunity.

Immunization against whooping cough is not recommended routinely in school age children. However, in the event of an outbreak of whooping cough in a school, pupils who have had a basic immunization against whooping cough in infancy should be given a booster dose of vaccine.

While general Schick-testing programs are not considered essential if the immunization program as outlined in this paper is carried out, sampling of significant numbers of pupils should be made in certain school districts from time to time for purposes of evaluating the program.

Summary

1. The increased incidence of diphtheria, especially among the older age group, in recent years suggested a need for study of control measures now being practiced.

2. Conferences were held to determine the methods of procedure. Two studies were recommended and conducted:

- a. A total of 1110 young children were Schick-tested by the Department of Health.

- b. A total of 5661 older children were Schick-tested by the Board of Education.

3. A program of immunization procedures was developed and approved by local and state health officials, school authorities, pediatricians, and organized medical groups.

4. The program was approved by the Secretary of Health for adoption throughout the State.

5. There is need for additional health education for both physicians and parents to emphasize the value of these new procedures and the reasons for the suggested changes.

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ABSTRACT OF DISCUSSION

ELI EICHELBERGER (York): Dr. Owen and his assistants are to be congratulated upon the collection and compilation of such carefully planned and controlled studies as just presented. These studies offer convincing proof of the inadequacy of diphtheria protection in a

very representative group of 5661 public school pupils. The results of such studies indicate a gradual loss of diphtheria immunity among pupils formerly immunized by the school physicians in accepted routine protective inoculations. I stress this point because it eliminates all doubt as to the authenticity of the dosage and time of the original inoculations given these pupils.

It is such findings as these that may help pediatricians, health officers, and physicians generally to formulate policies as to standard immunization procedures in the future. Such inoculations and booster doses would then offer more complete and lasting immunity in a diphtheria-susceptible age group of children. Questions that need to be answered are when and at what age is the most practical time to administer booster doses, and what preparation and what dosage are the most effective, and at the same time the least toxic. All these questions are pertinent, not only to school physicians but to all physicians who administer protective immunizations in their own practice.

The Health Department of the City of York has for years conducted the immunization program in the York city schools. An attempt has been made to answer the same questions that Dr. Owen and his staff have been tackling here in Philadelphia.

In 1947 it was decided to evaluate, if possible, the duration of immunity in a representative group of school children who had been artificially immunized some years previously. For this survey, Schick tests were offered to the junior and senior high school pupils. These pupils had been previously immunized to diphtheria either in pre-school years or in the school immunizing program conducted yearly. The group tested included the seventh, eighth, and ninth grades in the junior high schools and the tenth, eleventh, and twelfth grades in the senior high school, the age groups corresponding approximately to 12 to 14 years for the junior high schools and 15 to 18 years in the senior high school. In the group tested, an interval of five to twelve years had elapsed since the original immunization.

The results of this survey indicated that a relatively high percentage of pupils in the junior and senior high schools had lost their immunity to diphtheria. An average of 20 per cent were Schick-positive among 1250 junior high school pupils and 18 per cent of 1119 senior high school pupils tested. All pupils with a positive Schick reaction were given a booster dose of 0.5 ml. of alum-precipitated toxoid. No untoward reactions were encountered among 449 pupils given this stimulating dose. A few pupils had some soreness and redness at the site of injection for a day or so, but beyond this there was no other reaction. The results obtained in this group testing compare favorably with those reported in the medical literature and with the figures presented by Dr. Owen.

The accumulation of such statistics tends to confirm the belief that diphtheria immunity is not lifelong, and in order to adequately protect children as well as adults, booster doses of diphtheria immunizing agents must be employed at certain specific intervals. Certainly this procedure should be used immediately upon any outbreak of diphtheria in a community.

CLAUDE P. BROWN (Philadelphia): I think most of you know that I have been interested in producing diphtheria toxin since the days of the toxin-antitoxin mixture, so I hope you won't get the idea that I am sounding a sour note. It occurred to me that since typhoid vaccine in a tenth of a cc. dose given to anyone who has been immunized with the three doses develops sufficient

protection so that a large booster dose of typhoid vaccine is unnecessary, I wonder if individuals who receive a Schick test after immunization and are positive might not be stimulated so that subsequently, if given the Schick test again, they will have a negative reaction, i.e., the Schick test having acted as a booster dose.

Another thought occurs to me which may seem pretty remote and I would hesitate to say much about it unless some research was done, that is, if a person immunized against diphtheria acquired the organism with some local evidence of infection, might there not be sufficient absorption of the small amount of toxin produced early to act as a booster dose in itself?

In connection with Dr. Burdick's chart, I am wondering if these naval recruit records, if there are any (I don't remember seeing them), show whether these individuals had been immunized against diphtheria and were now positive to the Schick test, or whether they were just from the general population. It would be interesting to note, too, if they had been immunized and had received their typhoid vaccine previous to testing, because one would anticipate an anamnestic reaction, i.e., acting as a booster dose against diphtheria.

I think these are questions that might possibly be answered some time in the future.

A. PARKER HITCHENS (Philadelphia): Dr. Owen's paper is interesting to me chiefly because it points to a definite duty which every physician has, and certainly which every health department has.

Now I should like to take this discussion a little beyond diphtheria, if I am permitted, and consider the other infections for which we have really reliable immunizing agents.

We know the time at which babies seem to begin losing whatever maternal immunity they may have inherited. We also know that they have practically no maternal immunity to whooping cough. In a recent issue of the *Journal of the American Medical Association*, there was published a tabulation which shows that young children have a great deal of pertussis and a larger number of them die of pertussis than of scarlet fever and diphtheria and two or three other diseases put together.

A good many research pediatricians have started immunizing babies at the age of 3 months. So far I have been able to find no objection to that. We know that, in general, children do not become susceptible to diphtheria until they are around 6 months of age, and as far as tetanus is concerned, I have had no experience with that.

Children ought to be immunized against smallpox before the mother leaves the hospital, even though she is pushed out of the hospital the next morning, as seems to be the coming custom. Anyway, a baby can stand immunization against smallpox when it is very young, and at five-year intervals after that. On the other hand, the important thing for us to do as persons concerned with preventive medicine is to find the means by which babies will be immunized against pertussis at 3 months and against diphtheria at 6 months, with booster doses, if that is a nice word, at regular intervals thereafter.

Now, how can it be done? We are told that our hospitals need two million dollars to eradicate a deficit. How about spending one million dollars for the hospitals and one million dollars on a realistic immunization plan which embodies the knowledge we actually have? The only argument against it that I know of is lack of general public health education and, if I know anything, that is our job. We know what we want to

do. We know what we ought to do for each community. So the only other thing we need to know is how to do it.

THEODORE MELNICK (Philadelphia): I was a little annoyed by the fact that Dr. Owen, in recommending the immunization, omitted mentioning the value of the Schick test. His procedure may be indicated when thousands of individuals are immunized, but in private practice I don't think it is practical. The doctor must be prepared to tell the parent that the child is immunized, for should anything happen to that child a short time after the injections have been completed, what proof does the doctor have to show that that child has been completely protected?

The Schick test is a definite means of determining the immunization of an individual to diphtheria, therefore the doctor should resort to it at all times. The charts show that some individuals are immune for various periods, anywhere from a year or longer. Now,

how are we going to determine when an individual's immunization has ended? The same thing holds true in smallpox. We don't know when we should revaccinate.

A better program, I think, would consist of a regular shorter period of immunization, not the long one Dr. Owen recommends—from birth to puberty. I would recommend a booster shot every two years at least. In that way we would certainly immunize and protect more individuals than if we permit a longer period to elapse between booster doses.

DR. OWEN (Philadelphia): I can't recall exactly all those who had received toxoid but had not been Schick-tested.

Dr. Melnick's idea of Schick testing is good for family doctors anyway.

DR. MELNICK: That is right, and for the child.

DR. OWEN: We have no objection to the Schick test.

DO'S AND DON'TS

From many sources there has recently come to secretarial and editorial desks alike advice to practicing physicians on *how* and *how not* to react to the current politically inspired propaganda campaign for nationalized medicine. If you, Doctor, wish to *uphold President Truman* and his Director Ewing in their determined stand for their proposed radical change in the American form of sickness service, you should:

"Continue to sit and do nothing.

"Be apathetic and, like 5,000,000 registered Republican voters who failed to vote, do not bother to make your opinion known. If you think, as they did, that your opinion or your vote is not worth anything, the opposition will agree with you and act accordingly as they have.

"Tell everybody you see that the jig is up, and we might as well prepare for the inevitable.

"Refer to your medical leadership as a group of impotent, ineffective, and bumbling ignoramuses.

"Don't bother to tell your county medical society heads, your state society heads, or your national association heads what you want them to do. Expect them to find a way for you without your guidance.

"Scream about high medical society dues and forget that our friends in the trade unions demand many times what we pay; in other words, make the situation as difficult as possible, then grumble about it.

"Oppose any program developed by the majority of your colleagues because it demonstrates your superior wit and your general greatness.

"Remain superbly and learnedly dignified when Joe Doakes asks why you oppose state medicine. Brush him aside with any insult you can think of. Joe will like you for that.

"Don't bother to use the selling methods which actually bring messages before the public. Billboard advertising, newspaper advertising, national magazine advertising, radio advertising and, above all, continuous and daily radio spot programs over national hookups and all such like are too commercial, too troublesome, too expensive, and too undignified: don't use them."

If you follow this advice, my good colleague, soon

after January, in the year 1949, we will have exactly what we deserve, i.e., government control of medical practice.

BUT—

Your Representative and Senator in the Congress will do exactly what their constituents want them to do.

THAT IS YOUR CHALLENGE. To meet it do the following:

"Unite with the small committee of the top men from this A.M.A. to immediately collect funds to employ the finest national advertising agency in the country to put our historic message over in every village, town, and hamlet in the United States by every legitimate advertising method known.

"Unite with the voluntary insured medical service plan that is approved by your county and state medical society and preach its personalized high quality professional service to neighboring employers, employees, and their families alike."

SURGERY IN THE AGED

Operative surgery in patients beyond the age of seventy has been demonstrated in the experience of recent years to be relatively safe. The yearly increase in the elderly population in this country indicates that we may expect a larger requirement for surgery among the aged as time goes on. The recognized higher surgical mortality rates in these patients are constantly decreasing, and, at the same time, more extensive and formidable procedures are being successfully applied.

Diseases of the heart and blood vessels represent the principal causes of death among patients who succumb during the postoperative period for reasons not directly related to the operative work. Our efforts must be directed toward making surgery even safer for these patients by concentrating on increasing our accuracy in the application of the details of surgical care so that mortality rates reach the irreducible minimum possible with present knowledge.—C. STUART WELCH, M.D., in *New England Journal of Medicine*.

Office Management of the Patient with Diabetes Mellitus

LOUIS E. AUDET, M.D.
Williamsport, Pa.

THERE are well over 800,000 known cases of diabetes mellitus and 1,000,000 undiagnosed cases in the United States.

The office management of patients with uncomplicated diabetes mellitus has become a necessity because of a shortage of hospital beds. It is imperative that the doctor who assumes the responsibility of treating patients with diabetes possess knowledge of this disease and the proper treatment of it. He should have suitable laboratory equipment for the determination of blood sugar and a secretary or nurse who knows the fundamentals of diabetes. It is expecting too much to ask the patient to report to a distant laboratory for a blood sugar determination, then report back to your office on a subsequent date. The process becomes less complicated if laboratory procedures can be done during the initial office visit.

The treatment of a diabetic patient commences on the initial visit and this treatment requires time. The doctor should be prepared to spend at least three-quarters of an hour with the patient. A well taken history and physical examination are most essential. A urine examination and blood sugar determination are made. The patient is then enlightened about his condition, and in simple terms and language that he can understand he is told that he is suffering from a disturbance in his sugar metabolism which is partly due to a deficiency of insulin that is manufactured in the pancreas, and that by proper treatment and guidance he will live a normal, happy, and useful life. The procedures of treatment, which include diet, exercise, insulin and education, are outlined.

A patient well schooled in the fundamentals of this disease makes a good patient, and I do not feel that psychogenic trauma results from a careful explanation of the patient's illness.

The dietary treatment of diabetes today is quite simple. No longer is it necessary to weigh food. The more simplified and easy we can make our diets, the more they are apt to be followed.

A diet is prescribed which will allow a man or woman to carry on his daily activities without producing symptoms, and that will keep sugar absent from the urine and maintain a blood sugar that is within normal limits. We talk about a maintenance diet, that is, one which is adequate in carbohydrate, protein, fat, vitamins, and minerals and that one can eat and enjoy. It is well to compute this diet on the basis of the individual's activities, the exceptions being the obese patient who is placed on a strict reduction diet, and the child whose nutritional needs are different from those of the adult diabetic.

The patient is given a diet containing 150 to 200 grams of carbohydrate, 60 to 90 grams of protein, and 80 to 120 grams of fat. There is almost complete unanimity of opinion regarding the need of weight reduction for the obese diabetic patient, for it has been found that after weight reduction the patient will need less insulin, and, as a result, will have less strain on his cardiovascular system. Since insulin has a tendency to increase the appetite, it is not unusual for the obese patient to desire more food because of this increase of insulin; hence a gain in weight, rather than a decrease, usually follows.

When we start talking about grams and calories, I think that not only the patient but the doctor becomes confused. A simple diet prescription using household measures with a substitution sheet is all that is necessary.

If the patient has been on dietary treatment for a period of two weeks and his blood sugar estimations have not improved or approached normal limits and his urine still contains sugar, insulin is prescribed. Protamine zinc insulin is the insulin of choice, commencing with a small dose, say twenty units once a day, and increased two to four units every third or fourth day depending upon the percentage of glycosuria. When the urine specimens become green or blue, the insulin is no longer increased and the patient remains on this dosage for one week to ten days when a blood sugar determination is made. If the latter is found within normal limits, a reduction of insulin is ordered or an increase in diet.

Read before the Section on General Practice of Medicine at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 7, 1948.

It is not well to change both diet and insulin at the same time, as it makes for poor control. It is frequently said that so many units of insulin will aid in the metabolizing of so many grams of carbohydrates, which is not true, as there are other factors that operate in carbohydrate, protein, and fat metabolism.

If the fasting blood sugar is within normal limits, it is well to do blood sugar determinations in a subsequent examination after the noonday or evening meal, as it is not unusual to have a fasting venous blood sugar between 90 and 150 mg. per 100 cc. blood and a postprandial blood sugar of over 200 mg. per 100 cc. blood. In this particular instance, it is well to supplement the protamine insulin by administering small doses of regular insulin, say ten to twenty units, before breakfast or preceding the noonday meal. I have not found it feasible to mix insulins in the same syringe, as it only brings about more confusion for the patient because of certain technical difficulties.

On subsequent office visits the patient is weighed, urine and blood sugar determinations are made, and inquiries are made in reference to his diet. It is most important that more frequent blood sugar estimations be done, as many members of the profession rely entirely on the amount of sugar in the urine and it is not unusual for many diabetics to have sugar-free specimens and abnormally high blood sugars. This is explained on the basis of renal threshold, which varies in every diabetic patient. Hence, blood sugar determinations are most essential.

The doctor's nurse or secretary instructs the patient in reference to testing his urine by using Benedict's solution or the Clinitest method; the latter is simple and does not require heating. The patient is shown how to administer insulin and is told, if necessary, to report to the doctor's office every day until he has mastered the technique. When the latter is not feasible, some responsible member of the family or the community nurse can carry out this phase of the treatment.

The patient whose diabetes is not controlled on the above program needs frequent office observations either daily or weekly until his diabetes is under control, and then subsequent office visits every one or two months. A definite date for these later office visits is essential, and those who are delinquent in doing so are mailed a reminder. Every diabetic should test his urine daily at various intervals and a record should be kept, which is brought to the doctor on his next visit. A printed sheet of instructions is given to every patient outlining the procedure to be fol-

lowed in the care of the mouth and teeth, treatment of the feet, recognition of insulin reactions and their treatment, and how to prevent diabetic coma.

The large number of diabetics has made it mandatory for the doctor to manage these patients in his office, exercising all his skill and judgment in outlining a definite program of education, diet, insulin, and exercise, and have the patient report back at stated intervals to evaluate his status. There is definite evidence that diabetics who are well controlled over longer periods of time may be spared many of the complications that are frequently seen in poorly managed or uncontrolled diabetes mellitus.

ABSTRACT OF DISCUSSION

ALICE E. SHEPPARD (Pottstown): I think your colored chart is a magnificent idea, Dr. Audet.

What about a good book for diabetics instead of a printed sheet?

DR. AUDET: I don't know whether most of the doctors are aware of the American Diabetic Association's magazine called "The Forecast." This was originally sponsored by the Philadelphia Metabolic Association, but has now been turned over to the American Diabetic Association. It is a small magazine that comes out every two months, somewhat in the form of *Reader's Digest*. It is very informative, practical, and costs two dollars a year. There are questions and answers. It is a story on diabetes written for the diabetic patient, or for the lay group, and is very fascinating and worth while. It is published by the American Diabetic Association, whose headquarters are in Brooklyn, New York, 1 Nevins Street.

There are many primers for the diabetic patient, such as those by Dr. Joslin, Dr. Wilder, and Dr. Joseph T. Beardwood.

DR. SHEPPARD: Must a patient be advised not to smoke a cigaret before having a blood sugar determination?

DR. AUDET: I have had no experience with that particular question. After all, I don't think we should quibble about a blood sugar when we are talking about whether it is a difference of 50 or 25 milligrams. What we should be interested in is whether or not the patient has a blood sugar of 200, 300 or 400. I don't think 220 is any different from 240 or 250.

DR. SHEPPARD: If elderly patients seem to have occasional postprandial glycosuria with normal fasting blood sugar and a borderline glucose tolerance curve, do they need treatment as diabetics?

DR. AUDET: If an elderly patient seems to have occasional postprandial glycosuria with normal fasting blood sugar, I would like to know what that patient's blood sugar is after a meal. When we determine fasting blood sugars, we are really obtaining them under a somewhat abnormal condition. In other words, these patients don't eat from six to seven in the evening until eight or nine in the morning, and they have gone fourteen hours without food. I am more interested in determining a patient's blood sugar during the day when he eats breakfast, dinner, and supper. Blood sugars are far more important two or three hours after eating.

I am sure you are all aware of certain statements that have been made from various platforms and in some journals. There are physicians treating diabetics today who are not concerned about the amount of sugar in the urine or about how high the blood sugar goes as long as their patients feel well and do not have acetone bodies. To that, I am sure I do not subscribe, because I wonder where our diabetic children would be today had we ignored their glycosuria and their blood sugars.

Getting back to the question of the elderly patient who has a normal fasting blood sugar and a little spill of sugar in the urine after lunch, and a blood sugar of around 150 or 200 after lunch, I wouldn't be disturbed about that; in fact, I would let him go along that way.

We haven't time, but there is a lot to be said about the glucose tolerance curve. Most practitioners in the field of diabetes rarely make glucose tolerance tests. I don't think I have done one on a patient in the last five years. We don't see the necessity for it. There are many pitfalls. You must know what your patient has had a day or two before he has had the glucose tolerance test, and here you are pouring in a hundred grams of glucose, shocking his cells, placing a strain on his

pancreas, and when the glucose is taken, there is a question of absorption rate, and so on.

When I am in doubt as to whether a patient has diabetes or not, I have him get a big chocolate milk shake and a pint of ice cream and give him a large carbohydrate meal; in two hours I test his blood sugar, and if it is over 150, I consider him a diabetic, or at least a potential diabetic.

DR. SHEPPARD: What about the Joslin drop test for drop sugar?

DR. AUDET: I am not familiar with that test. We use the Folin and Wu method. As you know, there is the micro method. When you test micro blood sugars, remember that they are always 30 milligrams higher than the venous blood sugars, and there is a difference between capillary blood sugars and venous blood sugars. There are those who feel that we should use arterial blood rather than venous blood.

There is a method coming out very shortly, using a few drops of blood, that will enable one to determine a blood sugar within five minutes, and that will serve a very practical purpose. I am sure we will all do more blood sugar tests if we have something like that.

THANK YOU, GOVERNOR DUFF!

The medical profession in this state is deeply appreciative of Governor Duff's action in seeking medical advice in the preparation of his legislative program dealing with matters pertinent to public health, particularly mental health.

It is especially gratifying that the Governor saw fit to incorporate in his address to the Legislature a number of the recommendations made jointly by The Medical Society of the State of Pennsylvania, the Pennsylvania Psychiatric Society, and the Public Charities Association of Pennsylvania, which were submitted to the Governor by the presidents of the three associations in a personal interview January 4.

Included in the proposals were the elevation of the Secretary of Health and the transfer of the Bureau of Mental Health from the Department of Welfare to the Department of Health; appointment of a deputy to direct the Bureau of Mental Health, who shall be a Doctor of Medicine with experience in the field of psychiatry, at a salary of \$10,000 a year; and the early establishment of an eastern Pennsylvania Psychiatric Institute in Philadelphia, this to be closely integrated with the medical schools and to serve the whole state mental health system by limiting its in-patients to patients transferred from other mental hospitals.

In his message to the Legislature, Governor Duff made this latter suggestion one of his strongest and most urgent points, and there is every reason to hope that the Legislature will authorize the building of such an institute in the near future.

It was explained that the operation of the mental health system for the State, including hospital operation, clinics, mental health education; research and training, and preventive mental hygiene, would cost \$80,000,000 biennially, and that another \$80,000,000 will be needed for the construction of additional modern hospital facilities.

We urge every member of the county medical society to express his appreciation of the confidence Governor Duff displayed in the medical profession by communicating his endorsement of the Governor's program to his state legislators.—*Philadelphia Medicine*, Jan. 15, 1949.

MR. ROBERT

"The object of Rules of Order is to assist an assembly to accomplish in the best possible manner the work for which it was designed. To do this it is necessary to restrain the individual somewhat, as the right of an individual, in any community, to do what he pleases is incompatible with the interests of the whole . . . It is very material that order, decency, and regularity be preserved in a dignified public body." These words of General Henry Martyn Robert appear in the preface to Rules of Order, first copyrighted in 1876. Robert's manual has become recognized as the authority in parliamentary procedure. It is a compendium which, if given more attention by those who preside at the meetings of our medical societies, would not only be greatly helpful in facilitating the business of the meeting but would add a proper dignity to the proceedings. The suggestion has been made that all secretaries of such organizations should have a copy of Robert's Manual, to be loaned to the presiding officer on his election to office, hence this editorial brief. It may be interesting to know that the author of this valuable work was a graduate of West Point, served with distinction in the Civil War, and on his retirement from the Army was Brigadier General Chief of Engineers. General Robert died in 1923 at the age of 86.—Editorial, *Connecticut State Medical Journal*.

Schmincke's Tumor (Lympho-epithelioma)

Case Report

FRANK V. PICCIONE, M.D., and JULIUS FOLDES, M.D.
Hazleton, Pa.

SCHMINCKE'S tumor is a rare, malignant neoplasm the incidence of which is greatest in early adult life,¹ but it affects also middle-aged and old persons.²

The tumor arises in the pharyngeal region, usually from the pharyngeal, faucial, or lingual tonsils. The primary focus is usually small and insignificant in size. These tumors are not large, tend to yield small, infiltrating growths that are easily overlooked but which early invade the lymph nodes draining the affected area.

The first sign of the disease is generally a cervical adenopathy. A search for the original tumor is often unsuccessful for many months, so that a primary tumor of the nodes or bronchiogenic carcinoma is often suspected.³

The inspection may reveal a finely granular surface suggestive of erosion rather than frank ulceration. In rare cases the lesion extends around the pharyngeal ring and involves the mucous membrane of the base of the tongue, tonsils, and posterior pharynx.

The tumor consists of lymphoid cells intimately associated with epithelioid elements of an immature squamous or epidermoid type.²

The cases may be separated into two main groups.³ In the first group the tumor is frankly carcinomatous in type and is composed of strands of epithelial cells embedded in a stroma more or less rich in lymphocytes. The epithelial cells may be closely packed together or may form a rather loose reticulum heavily infiltrated by lymphocytes.

Such areas present pictures resembling those seen in the second group and form a link in the evidence for including both types with one main group.

In the second group the epithelial cells are more or less dissociated from one another and separated by a more or less dense lymphocytic infiltration which tends to isolate them from one another. This makes a tumor of this group more difficult to identify.

Regaud, Schmincke, and others⁴ accept the theory that the epithelium covering the lymphoid deposits of the nasopharynx is modified by a symbiosis with lymphocytes and that the tissue should be regarded as a specific tissue, lympho-epithelioma. Bones and visceral metastases (Derigs, Cutler, et al.⁴) present the same cell type including lymphocytic symbiosis or infiltration as does the primary tumor.

In 1904 Laval⁵ collected 27 cases. In 1916 Gatewood⁵ reported 26 additional cases. In 1922 New⁶ reported 79 cases. In 1929 Cutler⁵ presented a detailed review of 20 cases and stated that Ewing had encountered this condition 19 times (6.3 per cent) among 300 tumors of base of tongue, tonsils, and nasopharynx. In 1934 Cappell⁵ reported 12 cases. Ch'Eng,⁵ in 1935, reported 7 cases with involvement of the nervous system, and in 1938 Boyd and Goldbloom¹ reported a case of lympho-epithelioma with metastases complicated by tracheo-esophageal fistula.

Symptoms develop as a result of progression in the growth of the tumor. Neck glands are first involved and the enlargement is often the cause of the first complaint. Operations on the neck have been performed without discovery of the primary tumor.⁶ Cervical adenopathy in the adult is frequently malignant, usually of metastatic origin, and should make one suspicious of a primary lesion in the upper part of the respiratory tract.²

As the tumor grows, the back of the nasal cavity and the eustachian tubes become involved, thus causing symptoms of stuffiness of the nose, nasal obstruction, pain or sensation of fullness in the ear of the affected side. The tumor spreads not only through the lymph channels downward but also advances through the foramen lacerum, which lies in the roof of the nasopharynx, and extends upward through the base of the skull. The tumor invades the bone around the foramen, the floor of the middle fossa, and erosion results. The sixth nerve which runs over



Fig. 1. Note left-sided exophthalmos and widening of the bridge of the nose due to tumor infiltration.

the foramen lacerum is usually the first involved. The third, fourth, and fifth nerves lie close by and are the next involved, causing signs referable to ocular muscles as well as neuralgia and paresthesia of the fifth nerve. When the growth invades the orbit, it causes optic atrophy and blindness by pressing on the second nerve. The seventh and twelfth nerves are involved later. However, the seventh and eighth nerves are rarely affected.²

The symptoms may be grouped in the following order:^{2, 6}

Cervical adenopathy.

Pain in throat radiating to neck or head.

Nasal voice, nasal obstruction, epistaxis.

Sensation of fullness in the ear, earache, tinnitus, deafness.

Pain in the eyes, diplopia, ptosis, loss of vision.

Paresthesia of the face.

Hoarseness, aphonia, dysphagia.

Metastases to distal parts.

In all patients with any of the aforementioned symptoms the nasopharynx should be examined.⁶

Case Report

H. M., 42-year-old female, married, was admitted to the medical department of the Hazleton State Hospital (general hospital) on Nov. 11, 1947, because of intracranial tumor for which she had received roentgen therapy. The patient had been apparently well until the summer of 1946. At that time she noticed some difficulty in breathing through the nose and had a few nosebleeds. Later a headache developed which was more severe in the frontal region. In January, 1947, the left eye began protruding and the vision began to fail rather rapidly. About June the right eye was similarly affected. By fall (1947) the patient was completely blind and had marked nasal obstruction and dysphagia. The patient took very little nourishment and gradually lost weight.

The past history was irrelevant. The family history was not known. The patient was normally developed, well oriented, and cooperative. Because of the nasal obstruction, she breathed through the mouth and her

voice had a nasal twang. There was evidence of marked loss of weight. The skin was rather dry. The left side of the nose was swollen and the nose was deflected to the right. Bilateral exophthalmos, more pronounced in the left eye, was present. Fundi examination revealed bilateral optic atrophy. The left nasolabial fold was flattened. The tongue was dry, but no fibrillation, deviation, or atrophy was present. In both sides of the neck enlarged lymph nodes could be palpated. The thyroid was not enlarged. The lungs were clear. Except for a basal systolic murmur, the heart was normal. There was an element of clonus of the right rotula. The left foot showed positive Babinski and Oppenheim. The sensation of position was normal. Because of the poor general condition and "weakness" of the legs, the patient was bedfast. Pulse, respiration, temperature, and blood pressure were normal.

Laboratory reports:

Urine—a trace of albumin; a few, occasional large lumps of pus cells; occasional finely granular casts.

Blood—hemoglobin 74 per cent, red blood cells 4,890,000, white blood cells 9400, polymorphonuclears 89 per cent, lymphocytes 9 per cent, monocytes 2 per cent.

Kolmer and Kahn tests negative.

Sedimentation rate (Cutler's method)—5 mm. in five minutes.

Spinal fluid—normal pressure, colorless; cells, 10 lymphocytes per cc.; globulin, strongly positive; Kolmer, negative; colloidal gold curve, 0011244320.

X-ray of the skull showed a massive destruction of the middle fossa of the skull, the sphenoid sinus, the sphenoidal ridge, and all the posterior nasal structures.

Permission for biopsy of a cervical lymph node was denied by the relatives of the patient. The clinical impression was lympho-epithelioma (Schmincke's tumor).

The condition of the patient rapidly grew worse and she died on Dec. 16, 1947.

Postmortem findings and summary of the anatomical diagnosis (J. F.): malignant growth with infiltration of the nasal cavity, ethmoid and sphenoid sinuses, middle and frontal cerebral spaces of the cranium; malignant replacement of the chiasm of the optic nerve, pituitary, clinoid processes, middle ear, and retrobulbar area of eye; destruction of the bulbus olfactorius and portion of the tractus olfactorius; metastases present in the lungs and liver.



Fig. 2. The cribriform plate with the adjacent area beneath and the sella turcica with the clinoid processes are destroyed by the infiltrating tumor.

Cause of death: malignant tumor of the naso- and oropharynx, extension to the anterior and middle cervical spaces with metastases to the lymph nodes of the neck and metastases to the lungs and liver.

Microscopic examination: Naso-oro-pharyngeal tissue showed a tumor which grew in alveolar to concentric fashion but infiltrated also in single file, and irregularly, the surrounding structures. It consisted of hyperplastic epithelial cells, some of epidermoid type and others characterized by marked vesiculation and hyperchromatism. Double and triple nucleation was frequently seen in one cell which resembled a giant cell. Simple lymphocytic elements were intermixed with the tumor. One section of the brain which was continuous with the tumor showed infiltration of the brain by continuity.

Diagnosis: Lympho-epithelioma.

Discussion

Enlarged lymph nodes, unilateral or bilateral, are common symptoms of carcinoma of the nose, sinuses, mouth, or pharynx. With unilateral deafness or tinnitus and a feeling of fullness in the ear, the epipharynx should be examined even though the condition seems related to rhinosinusitis. Primary cancer of frontal or sphenoid sinus is an extremely rare condition.⁷ Intracranial chordomas, because of their position at the base of the brain, may simulate other tumors more commonly present in this region and carcinoma arising from the sphenoid sinus or in the nasopharynx with intracranial extension.⁸ Chordoma of basiocciput and basisphenoid may erode into the nasopharynx.⁹ In these cases nasal and extranasal (cranial) symptoms are present. Chordoma is a rather slow growth. The process may cover a period of many months or several years before the symptoms are pronounced enough for the patient to seek relief. However, the cranial type is the most rapidly fatal. Primary nasopharyngeal carcinomas are among the tumors to be differentiated.¹⁰

The symptoms of the case reported here, their development and sequence, particularly the early appearance of the nasal symptoms and cervical metastases, suggested the clinical diagnosis. Because of the wide dissemination, the adenopathy, and good response to radiation, this tumor may simulate lymphosarcoma more nearly than it does the group of epidermoid carcinomas. However, lymphosarcoma is often discovered after tonsillectomy, is more rapid in its course, tends to appear bilaterally, and soon produces constitutional symptoms.¹ This tumor, if untreated, is fatal in two or three years. Death often occurs from distant metastases.

Summary

Lympho-epithelioma (Schmincke's tumor) is a rare tumor arising in the pharyngeal region and consists of epithelial and lymphoid cells. Symptoms and diagnosis are discussed. The importance of nasopharyngeal examination in cervical adenopathy, nasal or aural symptoms, and the early treatment of lympho-epithelioma are emphasized. A case of lympho-epithelioma is reported.

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The forms for applying for space in the Scientific Exhibit of the 99th Annual Session which will be held at the Hotel William Penn, Pittsburgh, Sept. 26 to 29, 1949, may be secured from Elwyn L. Heller, M.D., Chairman, Committee on Scientific Exhibits, Presbyterian Hospital, Pittsburgh 13, Pa.

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OFFICE GYNECOLOGY

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THE subject of office gynecology can have a very broad scope, but in this paper we hope to confine it to a few common conditions and complaints which are most frequently encountered by the general practitioner.

Too often the busy doctor is apt to treat symptoms referable to the pelvic organs by giving a hurried prescription without examination or only a cursory glance at the perineum. It is the general practitioner or the family doctor who has the advantage and opportunity to pick up early cancer and to treat lesions which may in some instances be the precursors of malignancy. Most important then is the taking of sufficient time to secure a satisfactory history, then performing a pelvic examination with visualization of the external parts and of the cervix, and treating any abnormal conditions found.

Certainly the public, more than ever these days, with the present educational programs, and particularly the cancer-conscious female, realizes that physical examination is quite necessary for adequate diagnosis and treatment. The patient will think much more of the physician who examines her carefully than the one who prescribes empirically. How often it happens that the "menopausal patient" comes to the office with the story that she has been bleeding excessively, that her family doctor has prescribed hormones without examining her, saying that her condition is due to her age, and then when she is examined, she is found to have a cervical carcinoma.

What are some of the common gynecologic complaints which face the general practitioner? In my experience they are leukorrhea, low back pain, low abdominal pain, menorrhagia, metrorrhagia, and dysmenorrhea.

The most common complaint by far is leukorrhea or a non-sanguineous discharge associated with irritation, pruritus, or a disagreeable odor. It is impossible to give a detailed résumé of all the possible causes of leukorrhea, but an effort will be made to describe the most common conditions that are met. These are: cervicitis, result-

ing from laceration or infections following childbirth, or specific infection with gonorrhea, *Trichomonas* parasites, or *Monilia*; cervical polypi, and senile vaginitis. In the presence of any discharge occurring after the menopause, it is most important that malignancy be ruled out. This can be done by careful pelvic examination and visualization of the cervix.

Cervicitis due to gonorrheal infection can be diagnosed by taking smears or cultures from the cervix, urethra, and vulvar glands. Adequate penicillin or sulfonamide therapy will usually clear up this infection. The cervicitis following the lacerations and infections of childbirth with erosions or ectropion is best treated by cauterization of the cervix. Local treatment by tamponade, etc., is usually ineffective and continued applications of silver nitrate and other escharotics to the portio vaginalis may cause fibrosis and stenosis at the os. Cauterization of the cervix is generally a simple office procedure, but is frequently improperly performed. The treatment can be carried out with the ordinary small cautery outfit or electrosurgical machines without pain to the patient.

Radiating incisions are made with the cautery tip and carried deep enough to destroy the cystic and infected glands. Great care should be exercised to avoid cauterizing the endocervix too extensively or including too much of the circumference at one sitting, as this will often result in stenosis and in turn lead to dysmenorrhea and sterility. The more severe grades of cervicitis require deep cauterization or conization. Deep cauterization is a hospital procedure and requires anesthesia. Conization should not be performed as a routine office procedure because of the danger of hemorrhage afterwards, and great care should be exercised to prevent subsequent stenosis of the cervix; this is accomplished by cervical dilatation repeated frequently until healing is complete.

We have frequently noted marked atrophy of the pelvic organs with sterility and amenorrhea following too extensive cauterization of the cervix and cervical canal, as practiced and taught

Read before the Section on General Practice of Medicine at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 6, 1948.

by some gynecologists. Often cauterization is repeated with too short intervals between treatments. Six to eight weeks is required for the average cauterized wound to heal and the cauterization should not be repeated until the wound has healed. Many times subsequent inspection will show the cervix to be completely healed after this interval and further cauterization will be unnecessary, although the average case requires two or three treatments at two to three months' intervals. Do not cauterize a cervix in which there is the slightest indication of malignancy. A biopsy should be done when malignancy is suspected and should include a part of the endocervix, where cervical carcinoma usually has its origin. If you are quite suspicious of a lesion, send the patient to the hospital for biopsy, under the care of the surgeon who would treat her if carcinoma were found.

A good practice, if you have a positive cervical biopsy for carcinoma, is to send the pathologic slide and report to the surgeon who is to treat the patient. This saves further biopsy and a recently cauterized cervix is very difficult to evaluate as to malignancy.

A word at this time about the smear diagnosis for uterine cancer. I am sure that all of you present have been asked by patients if you can give them the new test that rules out cancer in the "female organ," since this test has been popularized by several current magazines. Pre-eminent in this field of diagnosis is the work of Papanicolaou who pioneered, developed, and refined this method of diagnosis. In his hands and those skilled in cytologic diagnosis, it is a very reliable method. However, caution should be exercised in accepting positive diagnoses of cancer by the smear method until the skill and experience of the laboratory have been proven. No surgical or radiotherapeutic measures should be instituted until a positive smear report has been verified by a positive biopsy or curettage.

A history of yellow, malodorous discharge with pruritus and irritation worse before and after menstruation makes one suspect the presence of a *Trichomonas vaginalis* infection. On inspection, the introitus is frequently reddened, and in the vagina one usually finds a reddened, strawberry-like, mucous membrane with a yellow frothy, malodorous discharge. The diagnosis is confirmed by placing a drop of physiologic saline solution on a coverslip, mixing it with some of the discharge, and examining it on a hanging drop slide. Under the low power lens of the microscope one finds *motile*, flagellate, pear-shaped parasites. The motion is sometimes sluggish and sometimes as active as that of

sperms. The source of this infection is not always clear. These organisms are known to infect the mouth, bladder, and intestinal tract; and in men, the prostate and seminal vesicles. If re-infection persists, these sources of possible contamination should be investigated. The parasite thrives when the normal bacterial flora of the vagina has been altered and when the pH is above five, which usually occurs before, during, and after the menses.

The basis of treatment is the re-establishment of the normal bacterial flora with the normal vaginal pH of four. The average case will clear up in two or three weeks with proper treatment, though many cases are persistent and recurrences frequent.

My best results have been obtained with the use of devegan and similar preparations such as floraquin, etc., using one tablet night and morning, or two tablets inserted at night high in the vagina without douches, and continuing the same through the menstrual periods for a period of three weeks. As recurrence is most common around the menstrual period, I have advised patients to use the medication five to seven days prior to the period, all through, and for five to seven days after each period for three months thereafter. An occasional patient will be sensitive to arsenical preparations; in fact, they state that the treatment causes much more pruritus and irritation than noted previously. In these cases, applications containing sulfa drugs have been found to be valuable, many of which are on the market. The drug is applied each night for three weeks without douches, again using the medication through the menstrual period. It is well to question patients concerning any sensitivity to sulfonamide preparations before prescribing this treatment, and to caution against its prolonged use.

A matter of great importance is to instruct the patient in cleansing the anus after defecation. She should be instructed to cleanse away from the vagina and toward the sacrum, and not toward the vagina, as reinfection may result if the causative organism comes from the rectum.

Monilia infection causes a white, curdy type of discharge with reddened mucous membrane and white fleck-like patches of exudate on the vaginal wall which bleed when the lesions are rubbed off. The patient complains of irritation and usually pruritus vulvae. The infection is quite common during pregnancy; however, lately we have been finding it more frequently in all age groups, and quite commonly after the menopause. The diagnosis in the more severe infections can be made by finding typical exudates on the walls of

the vagina; however, yeast-like organisms can be seen in hanging drop preparations if examined carefully, or they may be grown on culture. Treatment consists in painting the vagina with two per cent aqueous solution of gentian violet three or four times, five to seven days apart. Propionic acid preparations, such as propion gel dispensed with applicator, have been found useful as an adjunct in treatment. They can be applied at home by the patient, using an applicator of the medication each night. This condition is resistant and often requires prolonged treatment.

Cervical polypi frequently cause leukorrhea and at times bleeding. These can be removed in the office with the cautery, providing the base is not too broad or attached too high in the cervical canal. The base of the polyp should be cauterized. Most polypi are benign, but if there is any doubt, the specimen should be sent to the laboratory for microscopic examination. Polypi associated with pregnancy are often erroneously diagnosed as malignant. If a polyp is to be removed during pregnancy because of bleeding, great care should be taken to cauterize the pedicle, but not too high in the cervix. If asymptomatic, it is probably better not to remove it because of the possibility of precipitating a miscarriage or premature labor.

Postmenopausal dyspareunia, vaginal irritation, and discharge are common complaints, and in many instances are due to senile vaginitis. There are atrophic changes in the vulva and the vaginal mucosa appears thin; it is red with punctate hemorrhagic areas which often bleed slightly on trauma. There is loss of the normal elasticity of the parts, which are often fissured on stretching. Frequently, *Monilia* or *Trichomonas* infections are associated with the condition. Treatment should be directed toward eliminating any associated infection. Senile vaginitis responds well to the use of estrogenic vaginal suppositories. I prefer to use estrogens locally rather than orally, and a suppository of 500 rat units used every other night for several weeks usually gives relief; thereafter, a suppository only as needed.

Low back pain is a very common complaint in women, and many times it is hard to evaluate. Retrodisplacements of the uterus and a diseased cervix are infrequently the cause of backache. In such cases the backache is usually dull, low, mid-lumbosacral in location, and not usually related to effort. Replacement of the uterus to normal position with a properly fitting pessary will indicate whether the backache is due to retrodisplacement. A suspension operation is to be considered when the backache can be proven to be

definitely due to a retrodisplacement of the uterus. This operation, however, is too often performed when the etiology is dubious and frequently there is no relief of the backache. By far, the most frequent cause of backache is sacro-iliac disease. Other causes are arthritis, herniated disk, and postural defects. Pyelitis, ptosis, and renal lesions must be ruled out in lower dorsal and lumbar backache. Careful examination of the back will help to differentiate these conditions, with x-ray of the spine and sacro-iliac areas when needed. Many sacro-iliac conditions are relieved by a properly fitted corset and correction of postural defects.

Low abdominal pain, again like leukorrhea, has so many causes that we shall not attempt a discussion of the differential diagnosis in the short time allotted to this paper. The common causes to be ruled out are constipation, appendicitis, salpingitis, endometriosis, ectopic pregnancy, prolapse of the uterus, hernias, cysts, urologic conditions, and malignancy. Tenderness over the cecum and sigmoid is quite common in young, chronically constipated females. Right lower quadrant pain and tenderness with fever, leukocytosis, nausea and vomiting, and negative pelvic findings are suggestive of appendicitis. Lower abdominal pain without cause or a history of changing bowel habits would suggest possible carcinoma of the gastro-intestinal tract. Left-sided pain in older individuals may be due to diverticulitis, but a barium enema is necessary to differentiate it from malignancy. Salpingitis and endometriosis are often very difficult to differentiate and require an extremely careful pelvic examination. Tender, fixed, shot-like, nodules in the cul-de-sac suggest endometriosis; a larger, firm, fixed tender mass suggests adenomyoma.

The diagnosis of ectopic pregnancy requires an extremely careful history, and if the history is very suggestive, with typical symptoms, the pelvic examination should not be done in the office, but in the hospital, where immediate operation may be performed if rupture occurs. Prolapse of the uterus causes a bearing-down sensation in the lower part of the abdomen and is self-evident on examination. Small hernias are often missed by failing to examine the patient in an upright position. This is particularly true of small inguinal and femoral hernias.

Menorrhagia, metrorrhagia, and polymenorrhea are functional or organic pelvic abnormalities. Here we must rule out the whole gamut of gynecologic lesions. Any bleeding after the menopause should be considered as due to cancer until proved otherwise. Any irregular bleeding or change in the pattern of the menstrual cycle

should be carefully studied. This is particularly significant at the menopause; and where no cause can be found by careful pelvic examination and visualization of the cervix, a diagnostic dilatation and curettage should be done to rule out malignancy. Functional bleeding in young women requires careful evaluation of the endocrine system, which is not within the scope of this paper. However, all patients with such disturbances should have a basal metabolism test and adequate thyroid therapy if indicated, plus proper diet and the use of oral estrogen and progestin therapy if needed. I feel that light x-ray therapy to the pituitary and ovaries should be used as a last resort when medical therapy has failed.

Probably no symptoms are more overtreated in recent years than those of the menopause. Many women, even under the age of forty, having vague symptoms, often without hot flushes or symptoms suggesting the menopause, are receiving estrogens in some form. I believe we are forgetting in the practice of medicine that the menopause is a physiologic and not a pathologic state, and that most of the cases with menopausal symptoms can be relieved with the use of mild sedatives. Most patients have discussed their hot flushes, nervousness, and irritability over the bridge table or over the back fence and found that Mrs. Jones is taking "shots"; therefore, they believe that they require similar treatment. Those patients who do have exaggerated menopausal symptoms may be given therapy, but it should be on a graded dosage and gradually eliminated. We are seeing more and more cases of postmenopausal bleeding, the result of prolonged administration of estrogens, the bleeding occurring while the patients are still receiving estrogen therapy or after its withdrawal. As you are aware, these cases are extremely difficult to evaluate, and in most instances a diagnostic dilatation and curettage are necessary to rule out malignancy.

Patients precipitated into a surgical menopause need estrogenic therapy for a time, but even these many times do well with mild sedatives. Every drug company has multiple estrogenic preparations. It is well to select several effective preparations in varying strengths and prescribe them in gradually reducing dosage. My plan recently has been to prescribe a reliable estrogen equivalent to one milligram of stilbestrol and to give the patient one tablet daily for two weeks, then the same dosage every other day for the following two weeks, the fifth week not any, and then take the medication only as needed. At the same time, the patient is given small doses of phenobarbital three to four times daily.

Dysmenorrhea is a common complaint of young women. It is quite important in these cases to rule out first any physical defect. This can be done quite easily at the first visit by a careful pelvic examination, by rectum or vagina. In many instances, when the hymen is intact, a satisfactory pelvic examination may be made per vaginam with local anesthesia. The cervix may be visualized by using a small vaginal speculum. Repeated gentle cervical dilatation, using graduated Hegar dilators, helps these patients many times, providing no organic disease is found. A mild premenstrual sedative, together with capsules of aspirin, codeine, and atropine at onset of cramps, has been effective in relieving or partially relieving many cases of dysmenorrhea. Psychotherapy and elimination of the emotional factors are quite important.

In conclusion, then, I have briefly reviewed the most common conditions met in office gynecology, namely, leukorrhea, lower abdominal discomfort and back pain, menorrhagia, metrorrhagia, and dysmenorrhea. The diagnosis and treatment of these conditions in most cases is quite simple and requires only a careful brief history and adequate pelvic examination.

ABSTRACT OF DISCUSSION

QUESTION: Do you consider biopsy of the cervix a possible office procedure?

DR. CARLIN: As I said in the paper, if there is any suspicion of malignancy, the biopsy should be taken by the surgeon. It may be taken in the office, with a minimum of trauma to the cervix, using an electrosurgical unit with a cutting current or an ordinary punch biopsy, but we insist if the biopsy is taken elsewhere that the slide and the report be sent to the surgeon who will treat the patient. As you all are aware, a recently cauterized cervix is very difficult to evaluate as to whether or not there is neoplasm present.

QUESTION: Do you find that hot saline douches help or cure what appear to be swelling and tenderness in the adnexa where no tumor formation is present?

DR. CARLIN: If there is tenderness in the region of the adnexa, of course, you are always suspicious of salpingitis or of some type of infection or endometriosis. If there is elevation of temperature associated with it, I think that bed rest with the use of penicillin or sulfonamide therapy in the acute state is the treatment of choice. If there is low-grade pelvic discomfort, daily use of hot saline douches is beneficial. The most important thing in using douches is to instruct the patient to lie down in the bathtub so that the douche reaches the upper vagina. If you question your patients about taking douches, you will find that most of them sit up to take a douche and, therefore, it is not effective.

QUESTION: Why do you eliminate douches when you use devegan or floraquin?

DR. CARLIN: We have found over a long period of time that the elimination of douches gives much better results in the treatment of *Trichomonas* infections. If you examine these patients, you will find the vaginal

walls coated with the drug. These tablets are adjusted to give a pH of 4, and when the vaginal acidity is kept at 4, the infection tends to disappear; consequently, there is no point in inserting the drug and then washing it out a short period of time later. It is the loss of the normal pH which has allowed the *Trichomonas* parasites and other organisms to flourish in the vagina. Our results have been distinctly better in eliminating douches. Most important, also, is the continued application of the medication. I think that it is essential to give the patient practically one month's treatment, and then for the next three months have her use the medication before, during, and after the menstrual period. It is at these times that the *Trichomonas* infection recurs. *Trichomonas vaginalis* is the most common cause of leukorrhea which the general practitioner sees and often most difficult to cure.

A LOGICAL CONCLUSION

The following is from the English journal, *The Lancet*, for Oct. 2, 1948, from the section entitled "Letters to the Editor":

"Private Patients Not Admitted

"SIR—In your last issue you take exception to my letter to the *Times* of Sept. 15 in which I uphold the decision of the Minister of Health to exclude private patients from the new health centres because, in my opinion, this is bound to lead to either preferential, more considerate, or better treatment for them. You say—

'The truth seems to be that the great majority of patients remaining as private patients do so in order that they may suit their own convenience as to when, where, and how often, they consult their doctor.'

"But surely if private patients coming to the health centre are permitted to 'suit their convenience' as to when they see their doctor, whereas other patients, except emergencies, have to make appointments between certain hours, they are receiving preferential treatment, and here of course I am using the term treatment to imply service and not medical treatment for disease.

"It is quite permissible to argue that to admit private patients to health centres might have compensating advantages to the doctor or even to the service as a whole by saving the doctor's time, but to deny that it would involve two standards is absurd.

"London, S.W.1.

SOMERVILLE HASTINGS."

Isn't it interesting to see a bureaucratic system indicting itself? Somerville Hastings expresses himself in a naive fashion regarding the preferential service to private patients, not realizing apparently that he has put his finger on the secret force responsible for the superior results achieved in the private practice of medicine. His complaint has a distinct spoiled-child, or possibly dog-in-the-manger flavor.

This proponent of state medicine admits his fear of competition when he brazenly supports the proposition by saying "to deny that it would involve two standards

QUESTION: How frequently should the cervical canal be dilated following conization in order to prevent stenosis?

DR. CARLIN: That is a very good question. It depends upon the individual case, but routinely the cervix should be dilated once weekly for eight weeks. After that it depends on how much you had to dilate the patient at her last visit. I think that the cervix should be dilated up to at least a No. 10 Hegar dilator at each visit. The patient should not be allowed to go too long without dilatation, or there will be stenosis and difficulty in dilating the canal. I would say the frequency of dilatation depends upon the amount of stenosis found at the last visit. It is important to keep the cervical canal patent at least two months following conization or cauterization of the canal.

is absurd." In other words, the people of Britain now live, sick or well, under a double standard as far as medical care is concerned. Let us hope the U. S. A. does not follow this path.—*Journal of the Indiana State Medical Association*, January, 1949.

KICKBACKS KICK BACK

Blinded, no doubt, by the bright sunshine of the brilliant land in which they practice their art, an impressive number of the physicians of Los Angeles County seem unable to have read with understanding the Principles of Medical Ethics of the American Medical Association. Ironically, this visual incapacity has had to do with the receiving of rebates or "kickbacks" on eyeglass prescriptions from the local purveyors of these optical adjuncts.

For eight years efforts from within the medical profession were of no avail in putting to an end this lucrative by-product of a professional activity otherwise not without honor. Eventually, however, the Los Angeles Better Business Bureau, aided by the *Reader's Digest* and the backing of the Los Angeles Radiological Society, succeeded in achieving a degree of publicity that, while it reflected no credit on a considerable number of physicians who perhaps had not heard of the Hippocratic Oath, nevertheless waked the "organized profession" into action.

Let us hope that clean glasses will aid in a clearer view of all manner of rebates, kickbacks, and other fee-splitting devices.—*The New England Journal of Medicine*, July 15, 1948.

LEST YOU FORGET

The spring sessions of the Graduate Education Institute begin the first week of April in each of the ten centers.

Mark your calendars now so that you will not miss the opening session.

THE PENNSYLVANIA MEDICAL JOURNAL

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EDITORIALS

PREDOMINANT FALLACY TENDS TO BECOME TRADITION

The leading newspapers of an eastern Pennsylvania county recently gave full publicity to a statement to the effect that 70 per cent of 24 to 25-year-old men of that county called up by the Selective Service (Draft) Boards for physical examination in October, 1948, were found to be unfit for military service.

A committee of the medical society of the county recently completed its investigations and since have publicly declared the following facts and findings:

1. Inquiry of the four local Service Boards, and confirmed by questioning ten of the first group of seventeen to be examined by Service Boards, disclosed that the entire group of seventeen had been physically examined and refused (4F) during World War II.

2. The present Selective Service Board had no official information as to the prior classification of this group of seventeen.

3. At the present time the physical examination given by the Selective Service is more thorough and stricter than that given during World War II, and further study of appropriate Army regulations indicates that requirements for induction at the present time are more stringent.

4. Study of the statistics, available to anyone, concerning the causes of the rejections as physically unfit by World War II Selective Service

Boards proved that the vast majority of defects were non-remedial and non-preventable.

5. Under present Selective Service procedure no effort is made whereby any follow-up study or treatment is encouraged except in the case of venereal disease.

6. The local news articles above referred to stated that the local percentage of such rejection is a little lower than the national average, which for the 24 to 25-year-old groups is 72 per cent.

In this writer's judgment the above reliable and readily documented findings serve admirably and reflect heavily against the governmental processes that (1) permit as well as persist in the accumulation and circulation of fallacious draft board statistics, and (2) fail to return to the care of a physician such rejected draftees whose physical handicaps may be amenable to amelioration or restoration.

The hopes which members of the medical profession of America have nurtured that the earlier dishonestly collected and widely publicized data on draft board rejections had been neutralized in the minds of the people by honest interpretations are again dashed by the experience above related.

Our only hope now is to continue to combat fallacy with truth, as did the Lancaster County Medical Society, and to strive for the adoption of the administrative methods of private enterprise in the functioning of Selective Service Boards at county, state, and national levels.

OF MICE AND MEN

The attitude of defeatism current among a few members of the medical profession when the question of government control of medicine is broached is a surprising demonstration of individual professional cowardice. Medicine of all professions is accustomed to winning losing battles. Doctors of medicine never retreat in the face of odds. If we believe our viewpoint is correct and represents the best interest of the public and our patients, only the field of unrelenting battle is open to us.

We, better than any other group in society, can interpret and assay the moral and intellectual professional decay which has occurred where government has assumed direction of medical practice. We know how specious are the arguments of those who rely solely on criticism of the weaknesses of our present system and refuse constantly to face the world-wide proven failure of their panacea—government medicine.

In late weeks we have seen a marked awakening of intelligent public opinion to the implications of the Ewing Plan. Leaders of press, church, labor, and politics have issued forthright indictments of the proposed program. Witness the recent public releases from such independent leaders as Dorothy Thompson, George Sokolsky, John L. Lewis, Harold Stassen, Senator Vandenberg, Fulton Lewis, and a multitude of others. There has also been noticeable news editorial support from far and near by writers who have critically questioned Mr. Ewing's plans and on occasions devastatingly analyzed Mr. Ewing's proposals. The country seems to be slowly awakening to the implications of this drive by entrenched bureaucrats to fasten upon the American people a system which has proven unsatisfactory for the health of the people wherever it has been tried. Its great success has been as a measure to destroy freedom of action by the individual and to aid in grinding individual human rights under the totalitarian heel.

Never has there been a clearer call to any group than the call which today comes to men of medicine to expose the fallacies of an exploded ideology and to battle for human freedom. Our professional brethren from other lands, who are pleading with us to preserve the ideals of the profession, know too well the sad collapse that follows government invasion of medical practice.

To retire in the face of misinformed opposition would be the act of cravens—to desert in time of stress would be gross disloyalty to the age-old tradition of our profession and to its humanitarian ideals. We have but one course that is

worthy of men of character and that is to give without stint of our substance and ourselves. We must preserve our patients' welfare, the right of our profession to progress, and the freedom which our forefathers bought so dearly and our fathers cherished so sincerely.

H. K. P.

CARCINOMA OF THE LUNG

The American people are becoming increasingly interested in the cancer problem. The widespread dissemination of knowledge concerning malignancy and its proper treatment has led them to expect that each individual with cancer should receive the very best medical care. In this respect, the desires of the public and the aims of the medical profession coincide. Indeed, it is the purpose of this and all similar medical journals to convey knowledge to the medical profession toward that end. •

Cancer of the lung affords an excellent example of recent medical progress in the field of malignancy, for the first successful pneumonectomy was performed only fifteen years ago. At first a high mortality attended this operation, but with the technical advances which have occurred in thoracic surgery the mortality in most large clinics is now in the neighborhood of 10 per cent or below.

The five-year cures following pneumonectomy for carcinoma have been only 5 to 8 per cent of all cases diagnosed. However, this represents 40 to 50 per cent of all patients coming to operation before the malignancy has spread beyond the lung. The implication of this is self-evident—that, unless a true cancericidal agent is discovered, our only hope of raising the five-year cure rate in patients with cancer of the lung is by earlier diagnosis of the disease. At the present time approximately 75 per cent of the patients with carcinoma of the lung are inoperable by the time the diagnosis is made. If real advances are to be made, we must get these patients to the thoracic surgeon earlier.

There have been many improvements in the diagnosis of carcinoma of the lung. The roentgenologist has become more conversant with the early manifestations of the disease and is utilizing new techniques to aid him in diagnosis. He no longer considers a single x-ray exposure an adequate examination of the lungs. Bronchoscopic biopsy and the aspiration of secretions for cytologic study now offer a positive diagnosis in

a high percentage of cases. When a positive diagnosis cannot be made of a mass lesion, exploratory thoracotomy can now be safely done.

As with all carcinoma, the early diagnosis of that in the lung lies with the practitioner of medicine. He must have a high index of suspicion for, until he thinks of carcinoma of the lung, he is not apt to diagnose it. National campaigns are now underway to educate the layman to visit his physician at the first appearance of symptoms, and many people are now having routine medical checkups at regular intervals. The practitioner of medicine must do his part by not

neglecting clues which are presented to him when a cure is still possible. In a recent series of cases of carcinoma of the lung, 40 per cent of the patients first presented symptoms suggestive of atypical pneumonia. The physician must, therefore, think of carcinoma in all such patients and not wait until the patient has had repeated attacks of "atypical pneumonia," and finally comes to "look like he has cancer." He must consider an unexplained cough or an unexplained shadow in the lung upon x-ray as being due to cancer unless proved otherwise.

JULIAN JOHNSON, M.D.

WHY SMEAR THE DOCTORS?

Federal Security Administrator Oscar R. Ewing, a smart and aggressive public servant, has two projects currently nearest his heart.

One of these is the extension and expansion of the Social Security old age provisions so as to increase pensions substantially and take in millions of persons not now covered. On that, we're with the Security Administrator, as we've remarked before.

The other pet Ewing plan calls for adoption of an elaborate system of compulsory health insurance for, as we understand it, all Americans. Compulsory health insurance is what its friends call it. Those opposed use the term socialized medicine, or state medicine.

At this stage of the medical argument, we feel more against Mr. Ewing than for him.

One big reason why we're so dubious is the Ewing manner of opening the campaign to persuade Congress to adopt his health project.

In a recent speech in New York, for example, Mr. Ewing, instead of explaining the plan calmly, saw fit to cut loose with a salvo of abuse of the leaders of the American Medical Association. These gentlemen intend to assess the nation's doctors \$25 a head in order to raise a \$3,500,000 fund with which to fight the Ewing proposals.

They have a perfect right to do that, so far as we can see, only provided they comply with laws on registering lobbyists in Washington. If the doctors haven't such a right, then neither have the big labor organizations a right to raise money to push their chiefs' ideas, or the dregs to build big kitties to peddle prohibition. We don't hear any protests from Administration circles about these labor and dry funds.

To Mr. Ewing, however, the doctors' defense chest is a slush fund "to finance the greatest lobby in history for a last-ditch stand," and the doctors collecting the money are "the reactionary elements of the medical profession." Also, "the hour of these gentlemen is past," and they feel "the inevitable breathing hard on their necks."

That is smear language, name-calling, an effort to line up public opinion against the opponent before he has had a chance to open his mouth in his own behalf.

It is not fair play. We think it is bad tactics. We feel sure it cannot contribute to an intelligent solution

of the problem of extending adequate medical care to the whole U. S. population.

There is no argument on the fact that many Americans now do not get such care, either because they can't pay for it or because there are not enough doctors. Plenty of others, too, depend on rabbits' feet or quacks or witches for their medical help, and plenty more are afraid to consult doctors to find out what ails them for fear the news will scare them to death.

It seems to us that the socialized medicine debate will be much more intelligent and constructive if those on both sides will contribute light instead of heat. Mr. Ewing's output up to now has been chiefly heat.

We'd like some hardpan, factual information, for instance, on such questions as these:

If, under the proposed system, a patient can choose his own doctor, what happens when some popular physician is swamped with customers and an unpopular one in the same community finds time hanging heavy on his hands?

How are hypochondriacs (people who think they're sick most of the time but aren't) to be kept from overloading the setup? Same as to chisellers, malingerers, and people who would just love to move into hospitals for good long rests if the Government would pay the bills.

Suppose doctors here and there sabotage the plan by prescribing unnecessary and expensive medicines, or unneeded spectacles, false teeth, trusses, etc.

These and many other surprises are cropping up in England, where the Labor Government has recently installed a state medicine system. Costs are ballooning above original estimates, while Health Minister Aneurin Bevan screams alibis and oaths.

It would be helpful, we feel, if Mr. Ewing and his compulsory health insurance friends would let the public know, in plain English, what if any precautions are taken in their plans against some sad and very costly repetitions of the British mishaps.

After all, this public health problem is a serious one, and the main object is to get it solved correctly the first time. Smearing the American medical profession—which incidentally leads the world in skill, techniques, and scientific alertness—can hardly help toward that end.—Reprinted by courtesy of the *Daily News*, New York's Picture Newspaper.

Deaths from Selected Causes in Pennsylvania, August, 1948

County	All Causes, Excluding Stillbirths	Still- births	Infant Deaths	Maternal Deaths	Cancer	Heart Disease	Intra- cranial Lesions of Vascular Origin	Nephritis	Pneu- monia	Tuber- culosis
Adams	23	0	1	0	3	9	0	3	0	0
Allegheny *	1143	82	93	2	185	361	75	63	29	18
Armstrong	42	2	2	0	6	21	3	2	0	0
Beaver	106	13	8	2	13	31	6	9	2	2
Bedford	28	0	0	0	4	4	3	4	1	1
Berks *	216	11	7	0	28	76	18	11	4	8
Blair *	135	8	8	1	19	46	13	8	2	1
Bradford	58	2	1	0	6	27	2	3	2	1
Bucks	86	2	5	0	13	30	11	5	2	1
Butler *	73	5	2	0	5	27	7	7	1	1
Cambria *	136	7	11	0	15	43	13	7	5	2
Cameron	3	0	0	0	0	3	0	0	0	0
Carbon	43	1	2	0	6	10	3	2	0	1
Centre	37	6	2	0	5	14	6	3	0	0
Chester *	91	7	5	0	14	36	5	3	2	0
Clarion	21	1	2	0	3	8	4	2	1	0
Clearfield	53	1	2	1	8	22	3	4	0	0
Clinton	21	1	3	0	3	7	3	1	1	1
Columbia	45	2	1	0	14	15	2	2	0	1
Crawford	64	3	2	0	10	33	6	1	0	0
Cumberland *	53	3	5	0	12	17	7	3	0	0
Dauphin *	155	13	17	0	26	54	12	3	3	2
Delaware	252	9	22	1	40	78	19	18	4	7
Elk	20	4	0	1	6	6	0	0	0	1
Erie	165	13	12	0	30	52	14	10	3	2
Fayette	130	15	11	0	13	41	11	12	4	1
Forest	3	0	1	0	0	2	0	0	0	0
Franklin *	47	5	4	0	7	16	6	4	1	1
Fulton	4	0	0	0	1	1	0	1	0	0
Greene	27	2	0	0	2	15	1	4	0	0
Huntingdon	37	4	6	0	2	10	2	3	0	0
Indiana	36	2	4	0	3	10	1	2	1	0
Jefferson	39	3	2	0	5	11	6	4	0	1
Juniata	7	0	0	0	1	3	1	1	0	0
Lackawanna	230	16	10	0	45	79	9	18	5	5
Lancaster	166	8	9	2	28	51	10	12	3	2
Lawrence	73	4	4	0	9	26	9	5	0	0
Lebanon *	54	3	3	0	6	20	2	5	2	0
Lehigh *	181	6	7	1	33	60	8	16	4	4
Luzerne	352	21	18	0	42	110	16	30	11	13
Lycoming	97	8	3	0	15	30	10	6	1	2
McKean	48	1	4	0	6	14	4	1	0	0
Mercer	75	6	2	0	7	24	7	10	1	0
Mifflin	38	3	4	0	1	13	3	3	0	0
Monroe	34	1	4	0	7	10	2	1	0	0
Montgomery *	212	11	11	0	26	83	20	5	1	3
Montour *	20	1	6	0	5	4	1	0	2	1
Northampton	120	9	10	0	23	48	7	5	2	1
Northumberland	87	3	5	0	14	32	3	5	1	3
Perry	18	0	0	0	2	7	3	1	0	0
Philadelphia *	1857	34	84	3	309	655	154	103	40	70
Pike	2	0	0	0	1	0	0	0	0	0
Potter	6	0	0	0	1	3	0	0	0	0
Schuylkill	196	9	9	0	27	71	12	8	4	1
Snyder *	13	0	0	0	2	4	2	1	0	0
Somerset *	45	8	4	0	2	19	5	1	1	0
Sullivan	1	0	0	0	0	0	0	1	0	0
Susquehanna	18	0	1	0	2	6	2	0	0	0
Tioga	39	2	0	0	6	16	8	0	1	0
Union	21	0	3	0	5	6	3	0	0	1
Venango *	72	4	6	0	14	22	9	1	0	1
Warren *	31	6	2	0	5	8	3	1	0	0
Washington	145	7	7	0	19	51	12	11	4	5
Wayne *	29	0	1	0	4	10	2	4	1	0
Westmoreland *	182	15	5	0	26	67	23	5	4	1
Wyoming	11	0	0	0	2	5	2	1	0	0
York	131	8	9	0	22	37	15	10	3	1
State and Federal institutions	262	1	0	0	29	71	12	15	18	61
State totals	8265	422	472	14	1253	2801	641	480	177	228

* Exclusive of deaths in State and Federal institutions except general hospitals.

CHARTER, CONSTITUTION AND BY-LAWS OF THE MEDICAL SOCIETY
OF THE STATE OF PENNSYLVANIA
(Society Organized 1848)

AS REVISED BY THE 1948 HOUSE OF DELEGATES

CHARTER

To the Honorable, the Judges of the Court of Common Pleas of Philadelphia County, Pennsylvania:

In compliance with the requirements of an Act of the General Assembly of the Commonwealth of Pennsylvania, entitled "An Act to Provide for the Incorporation and Regulation of Certain Corporations," approved the twenty-ninth day of April, A.D., 1874, and the supplements thereto, the undersigned, all of whom are citizens of Pennsylvania, having associated themselves together with others hereinafter named, for the purpose hereinafter specified, and desiring that they may be incorporated according to law, do hereby certify:

First. The name of the proposed Corporation is The Medical Society of the State of Pennsylvania.

Second. The said Corporation is formed for the purpose of organizing the medical profession in the State of Pennsylvania, and advancing medical science.

Third. The business of the said Corporation is to be transacted in the City of Philadelphia.

Fourth. Said Corporation is to exist perpetually.

Fifth. The names and residences of the corporators are as follows: Charles W. Dulles, M.D., Philadelphia; John H. Packard, M.D., Philadelphia; John B. Roberts, M.D., Philadelphia; J. B. Murdock, M.D., Pittsburgh; Alexander Craig, M.D., Columbia; William B. Atkinson, M.D., Philadelphia; Horatio C. Wood, M.D., Philadelphia; John T. Carpenter, M.D., Pottsville; E. A. Wood, M.D., Pittsburgh; A. M. Miller, M.D., Bird-in-Hand; W. T. Bishop, M.D., Harrisburg; Traill Green, M.D., Easton; S. S. Schultz, M.D., Danville; and John Curwen, M.D., Warren, all of the State of Pennsylvania.

Sixth. The number of Trustees of said Corporation is fixed at nine, and the names and residences of those who are chosen as Trustees are as follows: H. C. Wood, M.D., Philadelphia; John T. Carpenter, M.D., Pottsville; E. A. Wood, M.D., Pittsburgh; A. M. Miller, M.D., Bird-in-Hand; W. T. Bishop, M.D., Harrisburg; Traill Green, M.D., Easton; S. S. Schultz, M.D., Danville; John H. Packard, M.D., Philadelphia; and John Curwen, M.D., Warren.

Seventh. At the next annual election for Trustees of the Corporation three Trustees shall be elected to serve for the term of one year, three others to serve for the term of two years, and three others to serve for the term of three years; and thereafter, annually, three Trustees shall be elected to serve for the term of three years, in the place of those whose terms expire.

Witness our hands and seals this twenty-sixth day of November, A.D., 1890.

Charles W. Dulles, [Seal.]

John H. Packard, [Seal.]

John B. Roberts, [Seal.]

H. C. Wood, [Seal.]

W. B. Atkinson. [Seal.]

(Section 7 of Chapter IX of the By-laws deals with conformation to certain requirements of this Charter.)

Commonwealth of Pennsylvania, County of Philadelphia, ss:

Before me, the subscriber, Recorder of Deeds of said County, personally appeared, Charles W. Dulles, John H. Packard, and John B. Roberts, three of the subscribers to the above and foregoing Certificate of Incorporation of The Medical Society of the State of Pennsylvania, and in due form of law acknowledged the same to be their act and deed.

Witness my hand and official seal, this twenty-sixth day of November, A.D., 1890.

[Seal.]

JOS. K. FLETCHER,
Deputy Recorder.

County of Philadelphia, ss:

Filed in the office of the Prothonotary of the Court of Common Pleas, in and for said County, this twenty-sixth day of November, A.D., 1890.

JAS. W. FLETCHER, *Deputy Prothonotary.*

DECREE

In the Court of Common Pleas, No. 4, for Philadelphia County:

In the matter of the incorporation of the "Medical Society of the State of Pennsylvania."

And, now, to wit, this twentieth day of December, A.D., 1890, the within Certificate of Incorporation having been on file in the office of the Prothonotary of the said Court since the twenty-sixth day of November, A.D., 1890, the day on which publication of notice of intended application was first made, as appears from the entry thereon, and due proof of said publication having been presented to me, I do hereby certify that I have perused and examined said instrument, and find the same to be in proper form and within the purposes named in the first class of Corporations specified in Section 2 of the Act of April 29, 1874, and that said purposes are lawful and not injurious to the community. It is therefore ordered and decreed that the said charter be approved and is hereby approved, and upon the recording of the said charter and its endorsements, and this decree, in the office of the Recorder of Deeds in and for said County, which is now hereby directed, the subscribers thereto and their associates shall henceforth be a Corporation for the purposes and upon the terms and under the name therein stated.

[Seal.] M. RUSSELL THAYER, *President Judge.*

Recorded in the office for Recording of Deeds in and for the City and County of Philadelphia, in Charter Book No. 16, page 507, etc.

Witness my hand and seal of office this twentieth day of December, A.D., 1890.

[Seal.]

GEO. G. PIERIE, *Recorder of Deeds.*

CONSTITUTION

ARTICLE I.—NAME

The name and title of this organization is The Medical Society of the State of Pennsylvania.

ARTICLE II.—PURPOSES OF THIS SOCIETY

The purposes of this Society shall be to federate the medical profession of the Commonwealth of Pennsylvania; to unite with similar state medical societies to form the American Medical Association; to extend medical knowledge and to advance medical science; to elevate and maintain the standards of medical education; to advocate and support the enactment of such legislation as will accrue to the health and well-being of the public; to enlighten and direct public opinion in regard to health and hygiene.

ARTICLE III.—COMPONENT SOCIETIES

Component societies shall be those county medical societies whose several constitutions and by-laws have been approved by this Society, and such approval shall continue unless further amendments to the county society constitutions and by-laws should conflict with provisions of the Constitution and By-laws of this Society.

ARTICLE IV.—MEMBERSHIP

SECTION 1.—The active members of this Society shall be citizens of the United States licensed to practice medicine in the Commonwealth of Pennsylvania, members in good standing in the component county medical societies, and whose annual assessments in this Society have been paid.

SECTION 2.—Upon certification in due form to the office of the Secretary-Treasurer and election by the Board of Trustees and Councilors, a member of this Society who has been a member for a continuous term of fifteen years immediately preceding, who is not less than sixty-five years of age, on request of his component county medical society, may be made an associate member provided he holds like membership in his component society as shall relieve him from the payment of annual assessment in his component society. An active member of this Society who is prevented from the practice of medicine by reason of illness or disability may, on annual certification by the component county medical society, be elected to associate membership by the Board of Trustees and Councilors in regular meeting. A component county society shall not be required to pay any annual assessment for an associate member. Associate members shall be privileged to participate in the scientific discussions of this Society; they shall receive the *JOURNAL* of The Medical Society of the State of Pennsylvania; they shall be eligible to the benefits of the Medical Benevolence Fund, but they shall not be entitled to the benefits of the Medical Defense Fund.

SECTION 3.—Affiliate members may be elected by the Board of Trustees and Councilors upon recommendation of the component society of the county in which they are located. They shall be chosen from those doctors of medicine who are citizens of the United States engaged in Pennsylvania in teaching, public health, research work, or holding positions in the Federal Service, or serving hospital residencies. They shall be doctors of medicine not holding license to practice in Pennsylvania and such membership shall end with termination of such status within Pennsylvania. Affiliate members shall have all the rights and privileges of active members

except the right to vote, to hold office, and to benefits of the Medical Defense and Benevolence Funds. The annual assessment of affiliate members shall be one-half the annual assessment of active members.

SECTION 4.—Any doctor of medicine not a resident of this state but a member of his own state or territorial medical association may be elected an honorary member of this Society by the House of Delegates by a three-fourths vote at any annual session. Not more than two may be thus elected in any one year.

SECTION 5.—Members whose annual assessments are received by the Secretary-Treasurer of this Society on or before March 1 shall be entitled to all the privileges of this Society for the current year. One whose assessment is received after March 1 shall not be entitled to any benefit from the Medical Defense Fund from January 1 to the date of the receipt by the Secretary-Treasurer of this Society of his name and assessment. The assessment of new members, elected and reported between July 1 and November 1, shall be one-half the annual assessment. Assessments received for new members elected and reported in November or December shall be the full annual assessment, which shall cover the assessment for the following calendar year.

SECTION 6.—Each member in attendance at the annual session of this Society shall enter his name on a registration blank, indicating the component county medical society of which he is a member. When his right to membership has been verified by the official Roster of this Society, he shall have a right to all the privileges of membership at that session. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section.

SECTION 7.—Any person who is under sentence of suspension or expulsion from a component county medical society, or whose name has been dropped from its roll of members, or whose license to practice medicine has been revoked, shall not be entitled to any of the rights or benefits of this Society, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.

Any member who has been convicted by a court of an offense making liable the revocation of his medical license may be dropped from the roll of members of this Society by action of the Board of Trustees and Councilors (acting as judicial council) even though such possible revocation has not yet been accomplished.

SECTION 8.—Delegates to this Society from any state society entitled to representation in the American Medical Association shall, by presenting certificates of delegation duly signed, be entitled to seats and to participate only in the scientific activities of this Society.

SECTION 9.—Any doctor of medicine of reputable standing, not a resident of Pennsylvania, but a member of his own state or territorial medical association, after an introduction by a member present, may by vote of a general meeting or of a section be accorded the privilege of participating in the scientific discussions.

ARTICLE V.—HOUSE OF DELEGATES

The House of Delegates shall be the legislative and policy-making body of this Society and shall be composed of: (1) delegates elected by the component county medical society in the proportion of one delegate for every 100 or fraction thereof of its active members, as of June 1 preceding the annual session, and who

shall be certified to the office of the Secretary-Treasurer of this Society by June 1; (2) the secretaries of the component county medical societies; (3) ex-officio, the President, the President-elect, and the Vice-presidents of this Society, the trustees and councilors, Secretary-Treasurer, Assistant Secretary-Treasurer, ex-presidents of this Society, and the presidents of the component county medical societies, but without the right to vote. In the absence of its secretary, the president of that component county medical society may be seated with the right to vote. The county medical society when electing delegates shall also elect two alternates-at-large for each delegate, who shall also be certified to the office of the Secretary-Treasurer of this Society by June 1.

If any component county medical society is without representation at any session of the House of Delegates, then the members registered in attendance from that county may select from their number one delegate who shall be the representative of that county and who shall serve in the place of an accredited delegate. If but one member is registered, he shall be seated as a representative of that county. When any delegate is once seated, no change may be made in his status during the session. No individual member shall be entitled to more than one vote. The voting membership shall be the delegates duly seated, alternates duly seated as delegates, and the secretaries of the component county medical societies in attendance or their presidents acting as their alternates.

No individual occupying an ex-officio membership in the House of Delegates shall be seated as a delegate with vote, except that, when an ex-president of this Society, who is not at the time a trustee and councilor or other officer, is a regular delegate of his county medical society duly elected to represent it in the House of Delegates, he shall be received as an accredited member of the House of Delegates, and shall have all the privileges of an accredited member during the term for which he was elected.

ARTICLE VI.—SECTIONS

The House of Delegates may provide for a division of the scientific work of this Society into appropriate sections.

ARTICLE VII.—SESSIONS AND MEETINGS

SECTION 1.—This Society shall convene in annual session at such place as may be determined by the House of Delegates, at such time as may be determined by the Board of Trustees and Councilors, and each session shall continue for three days, or longer if, required by the business of the Society. In case of strikes, governmental regulations, or unavoidable catastrophes, the Board of Trustees and Councilors shall have the power to cancel or change the date or the place of meeting of the annual session of The Medical Society of the State of Pennsylvania.

SECTION 2.—Special meetings, either of this Society or of the House of Delegates, shall be called by the President on petition of forty delegates or two hundred members, or by nine members of the Board of Trustees and Councilors.

ARTICLE VIII.—OFFICERS

SECTION 1.—The officers of this Society shall be a president, a president-elect, four vice-presidents, a secretary-treasurer, an assistant secretary-treasurer, a

speaker and a vice-speaker of the House of Delegates, trustees, who are also councilors (one from each councilor district who must be in the active practice of medicine), and as many district censors as there are component county medical societies.

SECTION 2.—The officers, except the trustees and councilors, shall be elected annually by the House of Delegates to serve for one year, or until their successors are elected and installed.

SECTION 3.—A full complement of the Board of Trustees and Councilors shall be maintained by election each year in the House of Delegates, each trustee and councilor to serve for a period of five years. No trustee and councilor shall be eligible to succeed himself after he has served two consecutive terms. Each councilor district shall be entitled to one trustee and councilor. A trustee and councilor must be a member of one of the component societies of the councilor district which he represents.

SECTION 4.—In the event of a vacancy in the Board of Trustees and Councilors, the Board shall fill the vacancy within ninety days by the appointment of a member from that councilor district, such appointee to serve until the next regular meeting of the House of Delegates.

At the next meeting of the House of Delegates, the remainder of the unexpired term created by the vacancy shall be filled by election. This shortened period in office shall constitute a term within the meaning of Article VIII, Section 3.

ARTICLE IX.—FUNDS

SECTION 1.—Funds shall be raised by annual assessment payable by each active and each affiliate member of the several component county medical societies. The amount of the annual assessment is to be fixed by the House of Delegates annually. Funds may also be raised by voluntary contributions and in any other legal manner approved by the House of Delegates. The House of Delegates may recommend the appropriation of funds to defray the expenses of this Society for publications and for such other purposes as will further the interests of this Society.

SECTION 2.—Each year, out of the funds of this Society, the trustees and councilors may appropriate a sum not to exceed \$1.00 for each active member, to be set aside by the Secretary-Treasurer as a special fund to be known as the Medical Defense Fund. This fund shall be kept separate from other moneys and may be invested by the Secretary-Treasurer under the direction of the Board of Trustees and Councilors and shall be used only for the legitimate expenses of members threatened with or prosecuted for alleged malpractice; provided, however, that no member of this Society shall be entitled to the benefits of this fund who was not in resident practice in the State of Pennsylvania when the alleged act of malpractice was committed.

SECTION 3.—Each year, out of the funds of this Society, the trustees and councilors shall appropriate a sum not to exceed 15 per cent of the annual dues for each active member, to be set aside by the Secretary-Treasurer as a special fund to be known as the Medical Benevolence Fund. This fund shall be kept separate from other moneys and may be invested by the Secretary-Treasurer under the direction of the Board of Trustees and Councilors, and shall be used (a) for the

relief of pecuniary distress of sick or aged members or the parents, widows, widowers, or children of deceased members, and (b) for the relief of pecuniary distress of members resulting from catastrophic natural emergencies.

SECTION 4.—The Endowment Fund (established as an Endowment Fund of this Society in 1917) may be sustained and maintained by any surplus revenues, gifts, and interest from investments which the Board of Trustees and Councilors shall in its discretion set aside for that purpose. The Endowment Fund and its accumulations shall be used by order of the House of Delegates in annual meeting assembled for any purpose devoted to instructional and educational purposes that may be reflected in improved service to humanity under medical auspices.

SECTION 5.—Each year out of the funds of this Society, the trustees and councilors with the approval of the House of Delegates may appropriate a sum not to exceed \$2.00 for each active member to be set aside by the Secretary-Treasurer as a special fund to be known as an Educational Fund. This fund shall be kept separate from other funds and may be invested by the Secretary-Treasurer under the direction of the Board of Trustees and Councilors, and shall be used to assist in the underwriting of the expenses of continuing the education in high school, college, or medical school of the children of members of this Society if and when said training is about to be discontinued for lack of family financial support following the death, or incapacitating illness, or injury of the physician parent member of this Society.

ARTICLE X.—SEAL

This Society shall have a corporate seal which shall contain the monogram "A.M.A." and "1847" within a circle on a keystone, at the sides of which shall appear: "Organized 1848: Chartered 1890," and the whole surrounded by a double circle containing the words, "Medical Society of the State of Pennsylvania."

ARTICLE XI.—AMENDMENTS

Proposals for amendments or alterations to this Constitution may be offered at any annual session or during the interim, provided such proposal or proposals be signed by fifteen active members of this Society. If offered during the interim, such proposals must be sent to the Secretary-Treasurer of this Society at least four months before the next annual session. All proposals for amendments or alterations must appear either in the published minutes of the preceding annual session or must be published in the JOURNAL of this Society at least three months before the next annual session; and all such proposals for amendments or alterations must appear in the official call for the next annual session. If these conditions have been fulfilled, then the House of Delegates may adopt such proposals by a two-thirds vote of the delegates present at the next annual session.

BY-LAWS

CHAPTER I.—MEETINGS

SECTION 1.—At the annual session there shall be three types of meetings: (1) general meetings, (2) scientific assemblies, and (3) scientific sections.

SECTION 2.—The general meeting shall be presided over by the President, or a vice-president, or a delegated chairman. All registered members and friends

may attend. The program may include: (1) introduction of invited special guests, (2) report of Committee on Necrology, (3) reports of Committees on Scientific Work and Exhibits, (4) an address by the incoming president, and (5) appropriate entertainment.

SECTION 3.—The Scientific Assembly shall be presided over by the Chairman of the Committee on Scientific Work, or Chairman of the Committee on Scientific Exhibits, or a delegated substitute. Registered members and friends may attend. Discussion shall be limited to registered members.

SECTION 4.—Scientific sections shall be divided into two general groups: (1) Medicine, and (2) Surgery.

SECTION 5.—The scientific assembly or either of the sections in session may recommend to the House of Delegates the appointment of commissions for scientific investigations of special interest and importance to the profession and the public.

CHAPTER II.—HOUSE OF DELEGATES

SECTION 1.—The House of Delegates shall meet on the morning of the day before that fixed as the first day of the annual session. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the scientific programs. The order of business shall be arranged as a separate section of the program.

SECTION 2.—Each delegate, before being seated, shall deposit with the Committee on Credentials a certificate signed by the President and Secretary under seal of the component county medical society, stating that he has been legally and regularly designated as a delegate to this Society.

SECTION 3.—Forty delegates shall constitute a quorum.

SECTION 4.—The House of Delegates shall receive reports of officers, committees, and commissions authorized by the House of Delegates at each annual session. All reports of committees and commissions not previously published shall be limited to ten minutes in verbal presentation before the House of Delegates. Any report of greater length shall be printed or mimeographed and a copy furnished each delegate. The pertinent or argumentative features of a report shall then be presented in the allotted ten-minute period.

In unusual cases this rule may be suspended by a two-thirds vote of the House of Delegates, each exception to this rule to be voted upon separately.

SECTION 5.—It shall consider and advise as to the interests of the public, wherein it is dependent upon the profession, and shall use its influence to secure proper medical and public health legislation and to diffuse popular information of an educational nature in relation thereto.

SECTION 6.—It shall make careful inquiry into the condition of the profession in each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such component county medical societies as already exist, and for organizing the profession in counties where societies do not exist. It shall specially and systematically endeavor to promote friendly intercourse among physicians of the same locality, and shall continue these efforts until every legally qualified physician in every county of the State who is reputable has been brought under organized medical society influence.

SECTION 7.—It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body, these delegates so elected to assume office on January 1 following their election. The Board of Trustees and Councilors are authorized to reimburse delegates to the American Medical Association for travel expense and maintenance while in attendance at the sessions of the American Medical Association.

SECTION 8.—The House of Delegates shall meet in open session to which any person may be admitted, except as it shall move into closed session restricted to members of this Society and attaches of this Society and component county medical societies, and except as it shall move into executive session restricted to members of the House of Delegates.

CHAPTER III.—COMMITTEES OF THE HOUSE OF DELEGATES

SECTION 1.—The reference committees of the House of Delegates shall be as follows, the appointments to be made annually by the President-elect prior to July 1 from the members already reported as members of the House of Delegates for the coming session of this Society:

A Committee on Credentials.

A Reference Committee on Reports of Officers.

A Reference Committee on Reports of Standing Committees.

A Reference Committee on Reports of Commissions.

A Reference Committee on Scientific Business.

A Reference Committee on New Business.

A Reference Committee on Hospital Relations.

A Reference Committee on Amendments to the Constitution and By-laws.

SECTION 2.—The Committee on Credentials of the House of Delegates shall consist of three members of the House of Delegates for the coming session of this Society, to which shall be referred all questions regarding the registration and credentials of the delegates.

SECTION 3.—The Reference Committee on Reports of Officers shall consist of five members of the House, and to it shall be submitted all reports of officers.

SECTION 4.—The Reference Committee on Reports of Standing Committees shall consist of five members of the House, and to it shall be submitted reports of all committees not otherwise specifically referred to other committees.

SECTION 5.—The Reference Committee on Reports of Commissions shall consist of five members of the House, and to it shall be submitted reports of all commissions not otherwise specifically referred elsewhere.

SECTION 6.—The Reference Committee on Scientific Business shall consist of five members of the House, and to it shall be referred all new business of a scientific nature, not otherwise specifically referred to other committees before action may be taken by the House.

SECTION 7.—The Reference Committee on New Business shall consist of five members of the House, and to it shall be referred resolutions introducing ordinary new business, not specifically referred to other committees, before action may be taken by the House.

SECTION 8.—The Reference Committee on Hospital Relations shall consist of seven members of the House,

and to it shall be referred all matters pertaining to the relationship between the profession and hospital administration.

SECTION 9.—The Reference Committee on Amendments to the Constitution and By-laws shall consist of five members of the House, and the President, Secretary-Treasurer, and Speaker of the House of Delegates as ex-officio members. To it shall be referred all proposals for additions, revisions, and modifications concerning the Constitution and By-laws.

SECTION 10.—The proceedings of the House of Delegates at the annual meeting, or any special meeting, shall be published in this Society's publication, in the first possible issue following said meeting of the House of Delegates.

CHAPTER IV.—COUNCILOR DISTRICTS

SECTION 1.—The State of Pennsylvania shall be divided into twelve councilor districts, and each district shall be entitled to one councilor. The councilor districts shall be composed of the following counties:

First Councilor District—Philadelphia County.

Second Councilor District—Berks, Bucks, Chester, Delaware, Lehigh, and Montgomery Counties.

Third Councilor District—Carbon, Lackawanna, Monroe, Northampton, Pike, and Wayne Counties.

Fourth Councilor District—Columbia, Montour, Northumberland, Schuylkill, and Snyder Counties.

Fifth Councilor District—Adams, Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, Perry, and York Counties.

Sixth Councilor District—Blair, Centre, Clearfield, Huntingdon, Juniata, and Mifflin Counties.

Seventh Councilor District—Cameron, Clinton, Elk, Lycoming, Potter, Tioga, and Union Counties.

Eighth Councilor District—Crawford, Erie, Forest, Mercer, McKean, and Warren Counties.

Ninth Councilor District—Armstrong, Butler, Clarion, Indiana, Jefferson, and Venango Counties.

Tenth Councilor District—Allegheny, Beaver, Lawrence, and Westmoreland Counties.

Eleventh Councilor District—Bedford, Cambria, Fayette, Greene, Somerset, and Washington Counties.

Twelfth Councilor District—Bradford, Luzerne, Sullivan, Susquehanna, and Wyoming Counties.

SECTION 2.—Each councilor district shall have a separate board of censors. The board shall be formed by the House of Delegates of this Society electing one censor from each component county medical society in the councilor district. Each component county medical society is requested to present to the House of Delegates for its consideration the name of a suitable member for district censor.

SECTION 3.—The district censors of each councilor district shall sit under the chairmanship of the councilor of the district who shall not have the right to vote. They shall consider every case of appeal from the decision of a component county medical society by a member who has been censored, suspended, or expelled, provided that the appeal is made within three months after the censure, suspension, or expulsion. They shall report in writing their decision thereon to the county medical society, and also to the trustees and councilors of this Society. They shall consider and dispose of all questions affecting the principles of medical ethics that may be referred to them, either by a component county medical society or by this Society. The

decision of the censors in every case must be signed by a majority of the board. Any appeal or judicial question arising in a district comprised of less than three county societies shall be referred directly to the judicial council of this Society.

A. In instances wherein the censors or judicial board of a component society suppress without a proper hearing, or deny appeal from board decision on charges of unethical conduct formally brought against a member of this Society, the complainant may bring such alleged conduct or such decision, through the Board of Trustees and Councilors of this Society, to the consideration of a grievance committee composed of the district censors of the complainant's councilor district. The findings of the grievance committee shall be reported to the Board of Trustees and Councilors, seated as a Judicial Council, for disposition.

B. In hearing appeals the district censors may admit oral or written evidence as in their judgment will best and most fairly present and record the facts.

After giving at least thirty days' notice to the appealing member and his component county society, the Board of Trustees and Councilors sitting as a Judicial Council shall hold a hearing on the appeal. The Board shall review the record of the original proceedings and may obtain additional evidence. Its decision shall be final except that within the next ninety days a further appeal may be made to the Judicial Council of the American Medical Association.

SECTION 4.—Each councilor district shall hold one or more district meetings each year for the purpose of increasing acquaintanceship, good fellowship, and organization among the physicians of the district. All physicians residing in the district who are eligible to membership in a component county medical society shall be invited to the meetings.

CHAPTER V.—ELECTION OF OFFICERS

SECTION 1.—All elections shall be by ballot of the House of Delegates and a majority of votes cast shall be necessary to elect.

SECTION 2.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the morning of the second day of the annual session. This order of business may be postponed to a definite time and place by a two-thirds vote of those present. The Speaker of the House of Delegates shall appoint three members as tellers, who shall count the ballots under the supervision of the Secretary-Treasurer. At the election of officers of this Society, such election shall be preceded by roll call of the members of the House of Delegates under the supervision of the Secretary-Treasurer.

SECTION 3.—Any person known to have solicited votes for himself, or sought after, any office within the gift of this Society shall be ineligible for any office for two years.

SECTION 4.—The chairmen and secretaries of sections provided for by these By-laws or future action of the House of Delegates shall be elected by the sections at executive meetings held on the second day of the annual session.

SECTION 5.—INSTALLATION OF OFFICERS.—The officers of this Society, except the President, shall assume their duties at the close of the last meeting of the annual session at which they are elected.

SECTION 6.—INSTALLATION OF THE PRESIDENT.—The President-elect shall be installed as President at the first general session of the next annual meeting following that at which he was elected. In the event that circumstances beyond the control of this Society prevent the holding of the regular meeting of this Society or of its House of Delegates, he shall assume the office of President at the previously announced time for the annual meeting of the Society.

SECTION 7.—No member of this Society shall be elected by the House of Delegates to serve simultaneously in more than one office, as specified in the Constitution, Article VIII, Section 1.

CHAPTER VI.—DUTIES OF OFFICERS

SECTION 1.—The President shall preside at all general meetings of this Society. At the first general meeting of the annual session following his election he shall deliver an address on such matters as he may deem of importance to this Society. He may at any time make suggestions in writing to the House of Delegates or to any committee or commission and shall close his term with a report to the House of Delegates. He shall be ex-officio a member of the Board of Trustees and Councilors, without the right to vote. He shall be ex-officio a member of all committees and commissions, without the right to vote.

SECTION 2.—The President-elect shall appoint the reference committees of the House of Delegates prior to July 1. He shall as far as possible select his committee appointees, with the exception of those that must be approved by the Board of Trustees and Councilors, at least thirty days in advance of the next annual session in order that meetings of such committees may be planned to be held during the annual session. He should attend all meetings of the Board of Trustees and Councilors during his term of office as President-elect and shall assist the President in the performance of his duties. In the event of his death, removal, refusal to serve, or for any other cause a vacancy exists, his successor shall be elected by the House of Delegates as a special order of business on the morning of the first day of the annual session next succeeding such vacancy.

SECTION 3.—The Vice-presidents shall assist the President and President-elect in the performance of their duties. In case of the death, resignation, or removal of the President, the vacancy shall be filled by the ranking Vice-president.

SECTION 4.—The Secretary-Treasurer shall attend the general meetings of this Society, the meetings of the House of Delegates and of the Board of Trustees and Councilors. He shall have no vote in the Board of Trustees and Councilors nor in the House of Delegates. He shall keep the minutes of their respective proceedings in separate record books. He shall be custodian of all record books and papers belonging to this Society. He shall receive and receipt for the annual assessments from the component county medical societies. He shall provide for the registration of the members and the delegates at the annual session. He shall aid the trustees and councilors in the organization and improvement of component county medical societies, and in the extension of the influence and usefulness of this Society. He shall conduct the official correspondence, notifying members of meetings, officers of their election, and committees of their appointment and duties. He shall em-

ploy such assistance as may be ordered by the trustees and councilors, and shall make an annual report to the House of Delegates. He shall supply each component county medical society with the necessary receipts and blanks for making its report. Acting with the Committee on Scientific Work, he shall prepare and issue all programs.

SECTION 5.—The Assistant Secretary-Treasurer shall act as an aid to the Secretary-Treasurer, especially during annual sessions, and may take his place when necessary as a temporary secretary. In case of vacancy in the office of the Secretary-Treasurer on account of death or otherwise, the vacancy shall be filled by the Assistant Secretary-Treasurer until the next annual session of the House of Delegates.

SECTION 6.—The Secretary-Treasurer shall hold all funds of this Society together with bequests and donations and deposit the same in such banks or trust companies as may be designated as depositories by the Board of Trustees and Councilors. He shall pay money out of the treasury only on written orders signed by the President and countersigned by the Chairman of the Finance Committee of the Board of Trustees and Councilors. He shall render annually to this Society a full account of the state of funds. He shall give bond of a surety company, in an appropriate amount, for the faithful performance of his duties.

SECTION 7.—At the first meeting of the Board of Trustees and Councilors after the annual session of this Society, it shall organize by electing a chairman. The Board of Trustees and Councilors shall have charge of the financial affairs of this Society, including the right to borrow money, and shall have charge of all properties including the authority to purchase, sell, lease away or otherwise dispose of any real estate. It shall recommend to the House of Delegates the amount of the annual assessment. It shall be the duty of the Board of Trustees and Councilors to provide for and superintend the publication of a medical journal and of all proceedings, transactions, and memoirs of this Society. It shall have full discretionary power to omit from the medical journal, in part or in whole, any paper or advertisement that may be referred to it for publication. It shall appoint an Editor of the JOURNAL and such assistants as may be necessary, and shall determine the salaries and the terms and conditions of their appointment.

It shall exercise general supervision over the conduct of all committees and commissions in the interval between sessions.

It shall be empowered to appoint an Executive Secretary, who shall perform such executive duties as the Board may designate, and who shall receive such salary and serve for such period and under such conditions as the Board may determine.

It shall be empowered to employ such administrative representative or representatives for the Society as shall be needed to conduct the work outlined by the Committee on Public Relations, or any other constituted or appointed committee.

These representatives' activities shall be only of an executive nature, since all policies of this Society shall originate within the House of Delegates, the Board of Trustees and Councilors, or within appointed or constituted committees. The term of employment of such representatives shall not exceed one year; the salary and conditions of their employment shall be determined by the Board of Trustees and Councilors.

a. The chairman shall appoint a finance committee of three members of the Board.

b. The chairman shall appoint a committee of three members of the Board to supervise the publication of a medical journal.

SECTION 8.—The Board of Trustees and Councilors shall have full control of all arrangements for the annual session. It may employ a Convention Manager, who shall carry out all the business details incident to the annual session of this Society. He shall provide suitable accommodations for the meeting places of this Society, Board of Trustees and Councilors, and the House of Delegates and their respective committees. He shall report an outline of the arrangements to the Secretary-Treasurer for publication in the program and in the medical journal, and make such additional announcements during the session as occasion may require. He shall render to the Board of Trustees and Councilors a full itemized account of all receipts and expenditures on account of the annual session, and he shall, from time to time, remit moneys received to the Secretary-Treasurer. All items of expense in connection with the annual session shall be paid out of the treasury on written orders signed by the President and approved by the chairman of the Finance Committee of the Board of Trustees and Councilors, excepting such small items as may be paid from a "Revolving Petty Cash Fund," which may be provided for this purpose. He shall receive a salary to be fixed annually by the Board of Trustees and Councilors. He shall give a bond of a surety company in the sum of \$1,000 for the faithful performance of his duties.

The Board of Trustees and Councilors may, at their discretion, combine any of these designated positions in a manner which they may deem for the best interest of this Society.

All resolutions or recommendations of the House of Delegates pertaining to the expenditure of money must be approved by the Board of Trustees and Councilors before the same shall become effective. During the annual session of this Society, the Board shall hold meetings as often as may be deemed necessary and all matters referred to it by the House of Delegates shall be reported on within twenty-four hours if so requested by the House of Delegates. The Board of Trustees and Councilors shall have the accounts of the Secretary-Treasurer and the officers of the JOURNAL audited annually or oftener if deemed desirable and shall make an annual report on the same to the House of Delegates. This report shall specify the character and cost of all publications of this Society during the year and the amount of all properties belonging to this Society.

The Board of Trustees and Councilors shall designate the salary of the Secretary-Treasurer.

Regular meetings of the Board of Trustees and Councilors shall be held immediately after the conclusion of the annual meeting of the House of Delegates, and at least quarterly thereafter. Special meetings of the Board may be called at any time by the chairman or by three members of the Board. Seven members of the Board shall constitute a quorum. During the intervals between the sessions of the House of Delegates, the Board of Trustees and Councilors shall supervise the action of committees and commissions constituted by the action of the House of Delegates.

SECTION 9.—BOARD OF TRUSTEES AND COUNCILORS.—Each councilor shall be judicial representative of this Society for his district consisting of certain counties.

He shall visit the component societies in his district at least once a year and make a report of such visit at the next meeting of the Board of Trustees and Councilors. It shall be his function to help organize component county medical societies where none exist; to inquire into the condition of the profession, and to improve and increase the zeal of component county medical societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district at the annual session of the House of Delegates. Members of the Board of Trustees and Councilors shall be reimbursed for their travel expenses in attendance at Board meetings, and for any official business of this Society.

SECTION 10.—The Board of Trustees and Councilors shall be the Judicial Council of this Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component county medical societies, or to the Society. All questions of an ethical nature brought before the House of Delegates or the General Meeting shall be referred to the Council without discussion. It shall decide all questions of discipline affecting the conduct of members or component county medical societies, on which an appeal is taken from the decision of the Board of Censors, as provided in Chapter IV, Section 3a, of these By-laws. Its decision in all such matters shall be final, unless appealed to the Judicial Council of the American Medical Association.

SECTION 11.—In sparsely settled sections it shall have authority to organize the Doctors of Medicine of two or more counties into a society. Such societies, when organized and after their constitution and by-laws have been approved by this Society, shall be entitled to all rights and privileges provided for component county medical societies.

SECTION 12.—The Board of Trustees and Councilors shall select a member of the bar of Pennsylvania as legal counsel of this Society, and is empowered to pay such counsel an annual retaining fee. To the legal counsel shall be submitted all suits for alleged malpractice brought against members of this Society and he shall be asked to endorse local counsel suggested by the trustee and councilor to defend such suits. To him also shall all proposed appeals to higher courts be submitted. The proper fees for defending members of this Society in suits for alleged malpractice shall be paid out of the Medical Defense Fund, provided that the member has placed his case in the hands of this Society in accordance with these By-laws.

a. A member sued or threatened with suit for alleged malpractice should at once fill out the application blank, which can be secured from the office of the Secretary-Treasurer of this Society. The Society will not undertake the defense of any member unless his application is made within seven days after service of summons.

b. Legal procedure requires that an appearance be made in court usually within fifteen days after service of summons. If deemed expedient by the Trustee and Councilor, he may, having ascertained from the Secretary-Treasurer of this Society that the member making application was in good standing at the time of the alleged malpractice, retain an approved attorney to make appearance in court in response to service of summons. The Society will not be responsible for attorney's fees incurred in behalf of any applicant, the defense of whom has not been approved by the Trustee and Councilor for the District.

c. Before other assistance than the service specifically provided for in paragraph "b" of this Section may be given, the application must be endorsed by unanimous vote of all the censors of his county medical society present at a special meeting called for the consideration of the applicant's standing in his society. It should be understood that the endorsement of the censors of a county medical society carries with it not only moral support but their active participation in the conduct of the trial in any way they may best assist, and all without thought of pecuniary return.

d. Immediately after the application has received the endorsement of the censors of the county medical society, it shall be mailed to the Trustee and Councilor for the District.

e. After the application has received the endorsement of the county medical society censors and the Trustee and Councilor for the District, the management of the member's defense will rest with the Committee of Counsel—the Trustee and Councilor for the District, the President, the Secretary-Treasurer of this Society, and the necessary attorney or attorneys.

f. The Trustee and Councilor for the District or the Secretary-Treasurer of the State Society, or both, shall then arrange and conduct a conference with the legal representatives and other parties concerned, having in view the thorough discussion of all circumstances pertaining to the threatened suit and the possibility of its withdrawal. The Trustee and Councilor or Secretary-Treasurer, or both, upon approval by the Board of Trustees and Councilors shall be paid for their time expended in this particular service and be refunded their legitimate expenses.

g. The applicant shall sign a contract vesting in the Committee of Counsel sole authority to conduct the defense of his suit, and he shall agree to make no compromise or settlement of the case without the written consent of the Trustee and Councilor of his District.

h. The State Society will not undertake the defense of any member who, after investigation by the censors and Trustee and Councilor for the District, is believed guilty of criminal abortion, feticide, homicide, or any criminal act, or who has not conformed to the recognized ethical laws in regard to these cases. It will only defend suit brought in the course of legitimate professional work.

i. The State Society will not pay any expenses for serving subpoenas nor the expenses of witnesses residing within the county, nor will it pay judgment or fine awarded or imposed by the jury or court.

SECTION 13.—The actions taken by the Board of Trustees and Councilors shall be published in this Society's publication in the first issue possible following the said meeting of the Board of Trustees and Councilors.

CHAPTER VII.—COMMISSIONS AND COMMITTEES

SECTION 1a.—A Commission shall be defined as a group under a chairman, authorized by the House of Delegates and appointed by the President, to undertake scientific investigations and promote the instruction of the profession and the public regarding the subject matter identifying their commission. Such a commission shall be automatically discharged unless annually continued by the House of Delegates. Continued membership on a commission shall be contingent upon faithful performance of duty and attendance at a majority of called meetings. Commissions shall submit annually a written report to the House of Delegates to be delivered.

ered to the office of the Secretary-Treasurer before July 1.

b.—A Standing Committee shall be defined as a group under a chairman, authorized by these By-laws or by the House of Delegates and appointed annually by the President-elect at least thirty days prior to his installation as president, except as further provided for by these By-laws. They shall be responsible for other activities of the Society in the interim between annual sessions not specifically delegated to the Board of Trustees and Councilors. They shall submit annually a written report to the House of Delegates to be delivered to the office of the Secretary-Treasurer before July 1.

c.—A Special Committee shall be defined as a group under a chairman authorized by the House of Delegates, or the Board of Trustees and Councilors, in the interim between sessions of the House of Delegates, for the purpose of expediting any other business of the Society. The membership of these committees will be appointed by the President and the committee report will be given to the House of Delegates by submitting annually a written report to the office of the Secretary-Treasurer prior to July 1.

SECTION 2 a.—STANDING COMMITTEES—membership to be appointed by the President, except as hereinafter provided by these By-laws:

Committee on Scientific Work.

Committee on Scientific Exhibits.

Committee to Nominate Delegates and Alternates to the House of Delegates of the American Medical Association.

Committee on Archives.

Committee on Medical Benevolence.

Committee on Educational Fund.

Committee on Necrology.

Advisory Committee to Woman's Auxiliary.

Committee on Hospital Relations.

Committee on Military Affairs.

Committee on Psychiatric Services to Criminal Courts.

Committee on Rural Medical Service.

Committee on Telephone Directory.

Committee on Workmen's Compensation Laws.

b.—STANDING COMMITTEES—membership to be appointed by the President and approved by the Board of Trustees and Councilors:

Committee on Medical Economics.

Committee on Public Health Legislation.

Committee on Public Relations.

SECTION 3.—It shall be the function of the President to name the chairman of any commission or committee, except as hereinafter provided by these By-laws. In case a vacancy occurs, the committee shall elect one of its own members as chairman until the next meeting of the House of Delegates. No member of this Society shall serve as an appointed member simultaneously on more than two commissions or standing committees.

SECTION 4.—The Committee on Scientific Work shall consist of the President, Secretary-Treasurer, Editor, Convention Manager, Chairmen and Secretaries of the Sections, Chairman of the Finance Committee of the Board of Trustees and Councilors, Chairman of the Committee on Scientific Work, and Chairman of the Scientific Exhibit Committee. It shall determine the character and scope of the scientific proceedings of this Society for each session, subject to the instructions of the House of Delegates. At least ninety days previous to

each annual session it shall prepare a program to be issued by the office of the Secretary-Treasurer, announcing the order in which papers and discussions shall be presented.

SECTION 5.—The Committee on Scientific Exhibits shall consist of a chairman appointed by the President and four additional members appointed by the chairman. It shall be their function to cooperate with the Committee on Scientific Work and the Convention Manager to develop for the next annual session instructive and educational exhibits of progress in the science of medicine.

SECTION 6.—The Committee to Nominate Delegates and Alternates to the House of Delegates of the American Medical Association shall consist of five members.

It shall be the duty of the committee, after careful consideration, to submit to the House of Delegates a list of nominees for delegates and alternates to the House of Delegates of the American Medical Association. These nominations shall not preclude nominations from the floor of the House of Delegates. To conform to the requirements of the House of Delegates of the American Medical Association, each nominee must have been a Fellow in the American Medical Association for at least two years prior to his nomination.

SECTION 7.—The Committee on Archives shall consist of three members. They shall have charge of, and be custodians of, the records of this Society, written property, the Secretary-Treasurer's books not in use, records of conventions, and all written records pertaining to this Society and its functions.

SECTION 8.—The Committee on Medical Benevolence shall consist of the Secretary-Treasurer and three members to be selected annually by the Trustees and Councilors, at least one of whom shall be a Trustee and Councilor. This committee shall select its own chairman, secretary, and treasurer, and shall have absolute and confidential jurisdiction over the distribution of such part of the Medical Benevolence Fund as may be placed in its hands. No money shall be paid from its treasury except on warrant signed by the chairman and secretary of the committee, and an annual audit of its accounts shall be made by a committee of the Trustees and Councilors, the names of the beneficiaries being omitted. All beneficiaries shall be designated by number, and after each annual audit all communications tending to show the personality of the same shall be destroyed. This committee may solicit subscriptions, donations, and legacies to be added to the principal of the Medical Benevolence Fund. It may also receive subscriptions to be used for the relief of members in distress from the effects of any special catastrophe. It may also draw upon its treasury for the relief of members in distress from the effects of a special catastrophe of nature, giving due consideration to equitable recommendations from the president and the secretary of the distressed member's component county medical society and from the district councilor concerned.

SECTION 9.—The Committee on Educational Fund shall consist of the Secretary-Treasurer and three members to be selected annually by the Trustees and Councilors, at least one of whom shall be a Trustee and Councilor. This committee shall select its own chairman, secretary, and treasurer, and shall have jurisdiction over the distribution of such part of the Educational Fund as may be placed in its hands. No money shall be paid from its treasury except on warrant signed by the chairman and secretary of the committee, and an

annual audit of its accounts shall be made by a committee of the Trustees and Councilors. When considering requests for educational assistance, this committee shall consult members of the component society of the county from which the request is received and shall consult also teachers and pertinent school records in their efforts to determine (1) the need for financial assistance and (2) the qualifications for the absorption of higher education of those for whom assistance is sought. This committee may solicit donations, legacies, and repayments to be added to the Educational Fund. All expense for the administration of this Fund shall be met from the Society's general checking account.

SECTION 10.—The Committee on Necrology shall consist of the Secretary-Treasurer of this Society and four members. They shall prepare and present a report at the opening general meeting of each annual session of this Society, and shall publish in the annual Membership List the names of members deceased from July 1 to July 1.

SECTION 11.—The Advisory Committee to the Woman's Auxiliary shall consist of three members. They shall act in an advisory capacity to the Woman's Auxiliary, and shall hold meetings whenever it is necessary to furnish advice to the Woman's Auxiliary on any debatable question regarding the change in their constitution or other functions.

SECTION 12.—The Committee on Hospital Relations shall consist of seven members and it shall be its duty to confer with any recognized organization of hospitals or hospital management. It shall also concern itself with legislation affecting hospitals and the medical profession, and it shall at all times labor to improve relations between the medical profession and the hospitals in Pennsylvania. It shall strive to elevate the standards of all hospitals in Pennsylvania in conformity with the Principles of Ethics and Rules of Standardization of the American Medical Association.

SECTION 13.—The Committee on Military Affairs shall consist of five members, with at least one member from each branch of the three medical reserve units of the Armed Forces. They shall concern themselves with the existence of reserve units of the Armed Forces in Pennsylvania, and shall serve as a liaison agent between this Society and the Office of the Secretary of Defense or subordinate officials. They shall inform themselves and our members of pertinent knowledge concerning all phases of military medicine.

SECTION 14.—The Committee on Psychiatric Services to Criminal Courts shall consist of five members and it shall confer with and advise courts and local Pennsylvania Bar Associations regarding the relation of psychiatry to the practices and operation of criminal courts.

SECTION 15.—The Committee on Rural Medical Service shall consist of five members whose duty it shall be to make a study of current needs for improved medical facilities in rural areas.

SECTION 16.—The Committee on Telephone Directory shall consist of three members whose function it shall be to cooperate with the several telephone companies operating in Pennsylvania, to secure completely accurate listing of all subscribers affiliated with the healing arts in conformity with the Principles of Ethics of the American Medical Association.

SECTION 17.—The Committee on Workmen's Compensation Laws shall consist of five members whose

function it shall be to keep under constant review workmen's compensation laws; to cultivate cooperation between employer and employee while striving to improve the medical services to the workmen and the position of the Doctor of Medicine in the provisions of the Act.

SECTION 18.—The Committee on Medical Economics shall consist of seven members to be appointed by the President, contingent upon approval by the Board of Trustees and Councilors. This committee shall consider all questions dealing with proposals for the expansion of health and medical service in Pennsylvania by State or Federal bureaus or by lay organizations as they may be referred to the committee by the House of Delegates or the Board of Trustees and Councilors. It is a fact-finding body and shall report annually to the House of Delegates. Its chairman shall attend or be represented at regular meetings of the Board of Trustees and Councilors.

SECTION 19.—The Committee on Public Health Legislation shall consist of a representative from each councilor district, a chairman, and the President and the Secretary-Treasurer. These appointments shall be subject to and contingent upon the approval of the Board of Trustees and Councilors. This committee shall represent the Society in securing legislation in the interest of public health and scientific medicine. It shall act under the direction of the House of Delegates, and in the interim between the meetings of the House of Delegates it is authorized to undertake such activities as in its judgment will further the purpose it represents.

SECTION 20.—The Committee on Public Relations shall consist of nine members appointed by the President, three of whom are appointed annually to serve for three years, and ex-officio the President, the President-elect, the Chairman of the Board of Trustees and Councilors, the Chairman of the Finance Committee of the Board of Trustees and Councilors, and the Secretary-Treasurer. These appointments shall be subject to and contingent upon the approval of the Board of Trustees and Councilors. It shall conduct and direct campaigns of public education in matters of public health and hygiene. It shall assist the component societies in the conduct of similar campaigns and shall act as a source of information to individuals, press correspondents, or civic or state bodies, who seek enlightenment on matters of public health, medical legislation, or scientific medicine. The President may appoint committees to deal with special problems which may arise, such committees to work in conjunction with the Public Relations Committee.

CHAPTER VIII.—COUNTY SOCIETIES

SECTION 1.—All county societies now in affiliation with this Society are component county medical societies. Those which may hereafter be organized in this state, which shall have adopted principles of organization not in conflict with this Constitution or these By-laws, shall, on approval of the censors of the district, become component parts of this Society. Only one component medical society from any one county shall be affiliated with this Society.

SECTION 2.—Remembering that the component county medical society is the only portal to this Society and the American Medical Association, in considering the qualifications of applicants for active membership, using due diligence so that only reputable Doctors of Medicine licensed in Pennsylvania, citizens of the United States, may be admitted to membership, each

component county medical society shall make formal inquiry regarding such applicants to the Biographic Department of the American Medical Association.

SECTION 3.—Any Doctor of Medicine who may feel aggrieved by the action of a component county medical society in refusing him membership shall have the right to appeal to the censors of the councilor district for their decision.

SECTION 4.—When a member in good standing in any component county medical society moves to another county in this State, he shall, on request, be recommended by his society for transfer to the component county medical society into whose jurisdiction he moves, for election without the delay attendant upon ordinary applications for membership.

SECTION 5.—Any Doctor of Medicine living near a county line may hold his membership in the county society most convenient for him to attend, on permission of the councilor of his district, but no Doctor of Medicine shall at the same time hold membership in more than one component county medical society.

SECTION 6.—Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral, and material condition of every Doctor of Medicine in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every qualified Doctor of Medicine in the county.

SECTION 7.—At some meeting prior to June 1, each component county medical society shall elect a delegate and two alternates-at-large to represent it in the House of Delegates of this Society, in the proportion of one delegate and two alternates to each one hundred of its members and for each fraction thereof in good standing on June 1 preceding the session.

SECTION 8.—The secretary of each component county medical society shall keep a roster of its members in which shall be shown the full name, address, college and date of graduation, date of registration or license to practice in the State, and such other information as may be deemed necessary. In keeping such a roster, the secretary shall note any change in the personnel of the profession by death or by removal to or from the county; and in the event of the death of a member he shall fill out in duplicate the blanks supplied by the State Society, keep one on file as a permanent record of the county society, and promptly forward the other to the office of the State Society Secretary-Treasurer for permanent filing in the archives of the State Society.

SECTION 9.—The secretary of each component county medical society shall remit to the office of the Secretary-Treasurer of this Society, promptly upon receipt, the amount of the annual assessment of the members of his society, together with a copy of the receipt given to the members of his society. He shall promptly notify the office of the Secretary-Treasurer of this Society of any change of address of the members of his society, and of losses in membership, giving the cause, such as death (with date), resignation, transfer, removal (with present address), or expulsion. He shall upon request furnish the office of the Secretary-Treasurer of this Society with a list of the officers and members of his county medical society, and shall report new members as soon as they are qualified as members of his society, remitting at the same time the amount of the member's annual assessment.

SECTION 10.—Each component county medical society shall notify the office of the Secretary-Treasurer of this Society of any new by-laws or rules that have been adopted, and furnish for publication in the JOURNAL of the State Society brief notes of its deceased members. Each component county medical society shall designate one of its members to act as reporter for the JOURNAL, who shall furnish such reports of the meetings of his society and such professional news as may be thought desirable for publication.

CHAPTER IX.—MISCELLANEOUS

SECTION 1.—No address or paper before this Society, except those of the President and invited guests, shall occupy more than fifteen minutes in its delivery. In the discussion of any papers, no member shall speak longer than five minutes, except by unanimous consent.

SECTION 2.—All papers read before this Society or the sections shall become the property of this Society. Each paper shall be deposited with the section secretary when read.

SECTION 3.—The deliberations of this Society shall be governed by parliamentary usage, as contained in Robert's Rules of Order Revised when not in conflict with this Constitution or these By-laws.

SECTION 4.—The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relation to each other and to the public, and to this end each member shall conduct himself so as not to defeat or tend to defeat the purposes for which the Society is organized and is operating.

SECTION 5.—At each annual session, a public reception shall be provided as part of the program in honor of the President of the Society. This function shall be under the direction of the Secretary-Treasurer and the Convention Manager, and shall be paid for by this Society.

SECTION 6.—Any vacancy occurring in an appointive office shall be filled at once by appointment by the President for the unexpired term, except as otherwise provided for by these By-laws.

Any vacancy occurring in an elective office during the interim of the annual sessions shall be filled by the Board of Trustees and Councilors until the next regular session of the House of Delegates, unless otherwise provided by these By-laws.

SECTION 7.—It shall be required that The Medical Society of the State of Pennsylvania shall keep on file at all times at the offices of the Philadelphia County Medical Society a complete published list of membership of The Medical Society of the State of Pennsylvania and the annual report of this Society, including an unabridged copy of the minutes of the meetings of the Board of Trustees and Councilors, with the full financial report.

SECTION 8.—If anything in these revisions is contrary to any previous articles or chapters, then such previous articles or chapters shall be considered null and void.

CHAPTER X.—AMENDMENTS

These By-laws may be amended at any annual session by three-fourths vote of the House of Delegates after lying over one day. If there be less than three-fourths favorable vote, the amendment shall lie over for one year and take the course of amendments to the Constitution.

Public Relations

Dissatisfaction Breeds Discontent

No sound public relations program can be promoted by solely proposing opposition. We cannot improve the medical profession's position in the eyes of the public if we confine our activities only to hostile opposition to compulsory sickness insurance.

The satisfied customer does not insist on new unproven products from unreliable sources so long as the desired product maintains its high standards of performance and service. Likewise, the satisfied patient does not insist on new unproven systems of medical care so long as the present system maintains its high standards of efficiency and satisfactory service.

Apparently then, in view of the existing support of compulsory sickness insurance, we have a sizable number of dissatisfied customers.

Now we have something fundamental upon which to establish the foundation of our public relations program. How shall we proceed? First, it becomes our public relations responsibility to search out the underlying causes of dissatisfaction, since it is these causes which have prompted the demand for this change in our present system of medical care.

What are these underlying causes of dissatisfaction which have influenced a sizable number of American citizens into thinking that a government-controlled system would better serve the American people than our present free-enterprise system?

1. The increasing cost of medical care.
2. The inability to get medical care in an emergency.
3. The unequal distribution of medical care.
4. The quality and quantity of medical care.
5. The unethical practice of rebates and kickbacks.

Whether the medical profession is ready to admit that these causes of dissatisfaction are justified makes little difference. If they are figments of the hypochondriac's imagination, they still are real to him and damaging to the profession. The bogeyman is unreal to adults, but to the child his grinning face leaps out of the dark to disrupt the nervous system so that irreparable damage may be done if the child is not consoled and quieted.

Consolation or quieting are not in our program. These causes of dissatisfaction—real or imaginary—must be corrected if real; if imaginary, clarified. Our failure from a public relations standpoint is that we have not let the public know what we are doing to correct the real shortcomings of our present system. It is always a much sounder public relations policy to admit wherein we have erred and to keep the public informed of our corrective measures rather than to attempt to justify or alibi our deficiencies.

Therefore, in our educational program designed to combat compulsory sickness insurance, we must incorporate positive corrective measures in conjunction with an intensified effort to improve and progress in the field of medical science, to the end that dissatisfaction with our present system of medical care will be reduced to a minimum. Then and only then can we expect the bureaucratic proponents of government-controlled sickness insurance to admit defeat.

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*

8104 Jenkins Arcade

Pittsburgh 22, Pa.

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State From What It Is to What It Ought to Be.

FALLACY EXPOSED

The following resolution was mailed to the officers and members of the Board of Trustees and Councilors of The Medical Society of the State of Pennsylvania on Jan. 19, 1949:

WHEREAS, The *Lancaster Intelligencer-Journal* and the *Lancaster New Era*, newspapers published daily in Lancaster, Pa., on Tuesday, Nov. 9, 1948, both published articles in which it was stated that "70 per cent of the 24 to 25-year-olds called up for physical examination in October from Lancaster City and County were found to be unfit for military service," and

WHEREAS, No information is given as to the physical classification these individuals were given by the Selective Service during World War II, and

WHEREAS, Both newspapers ascribed the source of this information to Selective Service officials, although the latter have denied giving any such information to the newspapers, and

WHEREAS, Inquiry by a representative of this committee of the Lancaster City and County Medical Society at the three local Selective Service Boards, and confirmed by personal questioning of ten of the first group of seventeen to be examined by Selective Service, disclosed that all seventeen in this group had been classified as 4F by the Selective Service of World War II and the present Board had no official information of this prior classification prior to calling up this group of seventeen, and

WHEREAS, Statistics available to anyone concerning the causes of rejection as physically unfit by World War II Selective Service proved that the vast majority of defects were non-remedial and non-preventable, and

WHEREAS, Questioning of the above ten individuals called for physical examination disclosed that at the present time the physical examination given by the Selective Service is more thorough and stricter than that given during World War II and further study of appropriate Army Regulations indicates that requirements for induction at the present time are more stringent than during World War II, and

WHEREAS, Under present Selective Service procedure no effort is made whereby any follow-up study or treatment is encouraged except in the case of venereal disease so that remedial defects can be brought to the attention of the rejectee or his physician and such defects receive the attention they deserve, and finally

WHEREAS, The local news articles referred to state that the local percentage is a little lower than the national average, which for the 24 to 25-year-old group is 72 per cent; therefore be it

Resolved, That the two Lancaster newspapers be requested to prominently publish this resolution so that the facts mentioned above may be brought to the attention of the citizens of Lancaster County, and be it further

Resolved, That a copy of this resolution be forwarded to the Board of Trustees of The Medical Society of the State of Pennsylvania with the suggestion that some effort be made to counteract similar publicity known to have appeared elsewhere in the State of Pennsylvania, and be it further

Resolved, That a copy of this resolution be forwarded to the Board of Trustees of the American Medical Association with the suggestion that effort be made to work out at the national level with the Selective Service some procedure whereby an individual rejected by the Selective Service Board will be personally notified by the Board as to the cause of his rejection and advised to seek medical care and that, on his signed permission, his family physician be permitted to receive the findings of the Medical Examining Board of the Selective Service.

PRESIDENT ENGEL'S TEN-POINT PLAN

The triumphant story of President Gilson Colby Engel's Ten-Point Plan, already familiar to many JOURNAL readers as the focus point for a Federal legislative counterplan to legislation earlier introduced in favor of compulsory sickness insurance, will appear in complete form in the March issue of THE PENNSYLVANIA MEDICAL JOURNAL. We are, however, exercising an editorial prerogative by forcing into page proof (received February 17) of the February JOURNAL a bit of the considerable exciting news received February 17 from Dr. Engel, who is absent in Florida on a well-earned vacation. We quote:

"I approved yesterday (February 15) the printer's proof of the first portion of the bill being drawn by U. S. Senator Lister Hill of Alabama, which deals with the care of the medically indigent through the insured service of Blue Cross and Blue Shield. As written, it is specif-

ically stated that the government will have no direct authority over any hospitalization or non-profit voluntary insured medical service plan. The portion now being drawn is in relation to education of student nurses and selected medical students. This Federal fund is to be distributed through a state health education authority with no direct Federal control over funds.

"This bill, I expect, will be ready for introduction by the first part of March. The sentiment in Washington and over the country is snowballing in favor of it and it has the blessing of the A.M.A."

1949 SCIENTIFIC EXHIBIT APPLICATIONS AVAILABLE

The forms for applying for space in the Scientific Exhibit of the 99th Annual Session which will be held at the Hotel William Penn, Pittsburgh, Sept. 26 to 29, 1949, may be secured from Elwyn L. Heller, M.D., Chairman, Committee on Scientific Exhibits, Presbyterian Hospital, Pittsburgh 13, Pa.

Completed application forms must be returned to the committee by May 1 to receive consideration.

BUCKS COUNTY MEDICAL SOCIETY CELEBRATES CENTENARY

The Doylestown Armory, home of Bucks County's famous Company D, 11th Regiment of the Pennsylvania National Guard, was the scene recently of the celebration of the one hundredth year of the Bucks County Medical Society.

The traditions of medicine through the centuries and the historical importance of the Bucks County Society in Colonial and Constitutional America in the founder's county and the Commonwealth of Pennsylvania were embodied in the person of the guest of honor, Dr. John Beans Carrell, of Hatboro, 98-year grand old man of Pennsylvania medicine.

The Armory auditorium was filled with about 350 members of the society, wives and guests. Dr. Carrell related the establishment of the Bucks County Society, its growth and accomplishments. His long life, Dr. Carrell declared, is due to three rules of life. They are to be temperate in personal habits and in thought, word and deed.

Clyde R. Flory, M.D., of Sellersville, announced the publication of a beautiful book of the society's undertakings and the biographical record of each member.

The centennial committee chairman was Dr. Flory. Allen H. Moore, M.D., Doylestown, and Raymond D. Tice, M.D., Quakertown, who were

supported by an excellent reception and decoration committee, planned most effectively.

The program opened with the official welcome by the president of the Bucks County Medical Society, Michael Peters, M.D., of Telford, and ended with fifty minutes of humor by Edmund H. Harding, of Washington, N. C.

Dr. Peters, in his official welcome, called attention to the fact that the Bucks County Medical Society is the third oldest in the Commonwealth of Pennsylvania.

Dr. Carrell, the dean of the medical profession in Bucks County, was given an enthusiastic ovation as he was introduced. He is the founder of the practice of writing the well-known "R.N." after the names of registered nurses. He has also appealed to physicians to write "M.D." after their names and eliminate the "Dr." before their names.

Dr. Carrell, who is a famous genealogist, an author of history books and medical papers, also served as editor of the *Bucks County Medical Monthly* for twenty years. He gave the accolade to Allen H. Moore, M.D., of Doylestown, the present editor of the *Monthly*, for the remarkable work he is doing. "In my opinion Dr. Moore, as editor of our *Monthly*, has the best editorial technique of any county society periodical in Pennsylvania," said Dr. Carrell.

County medical society presidents present were William J. Goetz (Berks), William A. Limberger (Chester), John H. Hennemuth (Lehigh), Stephen J. Deichelman (Montgomery), and Theodore R. Fetter (Philadelphia). Deans of medical schools in attendance were John McK. Mitchell (University of Pennsylvania), William Harvey Perkins (Jefferson), William N. Parkinson (Temple University), Charles L. Brown (Hahnemann), and William S. McElroy (University of Pittsburgh). Others there were John J. Sweeney, Second District councilor, and Edgar S. Buyers, a vice-president of the State Medical Society; Andrew Godfrey, a veteran of fifty years in the practice of medicine; Mrs. Paul C. Craig, president of the State Auxiliary; and Mrs. Elmer Bausch, Second District councilor of the Auxiliary.

The profession of dentistry was represented by Dr. G. Edward Swartley, of Souderton, president of the Bucks-Montgomery Dental Society. Dr. Ivor Griffith, president of the Philadelphia College of Pharmacy, was a guest, as was Norman H. Shull, of Bristol, representing the Bucks County Pharmaceutical Association.

The newspaper profession was well represented.

Bucks County officials introduced included President Judge Hiram H. Keller of the Bucks County courts, District Attorney Edward G. Biester, and State Senator Edward B. Watson.

The Rev. John R. Hart, rector of George Washington Memorial Chapel at Valley Forge, gave the invocation. Music was furnished by the Wavrek Symphonic Orchestra of Allentown.

The official greetings of the Commonwealth of Pennsylvania were extended by Maj. Gen. Daniel B. Strickler, of Harrisburg, lieutenant governor of the State.

Gilson Colby Engel, M.D., of Philadelphia, president of the State Medical Society, declared: "We are proud of the Bucks County Medical Society as a unit of the State Society."

Elmer Hess, M.D., of Erie, immediate past president of the State Medical Society, and Walter F. Donaldson, M.D., of Pittsburgh, secretary-treasurer of the State Society, were introduced.

Francis F. Borzell, M.D., of Philadelphia, a native of Doylestown, and speaker of the House of Delegates of the American Medical Association, brought the official greetings of the A.M.A. to the Bucks County group and to Dr. Carrell.

THE 1949 HONOR ROLL

In accordance with the Constitution of The Medical Society of the State of Pennsylvania as revised by the 1948 House of Delegates, *State Society dues now become delinquent after March 1, instead of March 31, as heretofore.*

On Jan. 28, 1949, the dues of 3259 members had been received in the office of the secretary-treasurer of the State Society.

County societies which are credited with having more than 50 per cent of their members' dues paid on the above date are as follows:

County Society	No. of Members	Per Cent Paid
Allegheny	1704	75
Berks	267	75
Bucks	93	74
Butler	70	59
Clarion	25	90
Clearfield	54	52
Clinton	28	78
Columbia	47	80
Cumberland	49	57
Dauphin	261	62
Delaware	291	65
Franklin	77	71
Indiana	46	56
Juniata	8	88
Lawrence	83	59

County Society	No. of Members	Per Cent Paid
Montgomery	335	81
Montour	39	69
Northampton	206	75
Westmoreland	212	51
Wyoming	12	100
York	173	77

CONGRATULATORY MESSAGE ON ROYAL BIRTH

Her Royal Highness The Princess Elizabeth
Duchess of Edinburgh
Buckingham Palace
London, England

Your Royal Highness:

On behalf of The Medical Society of the State of Pennsylvania, I wish to extend to you and Prince Philip our hearty congratulations on the birth of your son.

I am sure that his birth has brought happiness to the peoples of the world and may God's blessing rest upon you all.

With every good wish for health, happiness and longevity, I am

Sincerely yours,
GILSON COLBY ENGEL, M.D.,
President.

Nov. 15, 1948



BUCKINGHAM PALACE
18th November, 1948.

My Dear President

I am desired by Their Royal Highnesses The Princess Elizabeth and The Duke of Edinburgh to thank you most sincerely for your very kind message on the birth of Their Royal Highnesses' child.

Yours sincerely
[Signature]
COMPTROLLER.

EXCERPTS FROM MINUTES OF COMMISSION ON DIABETES MEETING

A luncheon and business meeting of the Commission on Diabetes of The Medical Society of the State of Pennsylvania was held Wednesday, Jan. 5, 1949, at the University Club, Pittsburgh.

Members of the commission present were: Drs. George F. Stoney, chairman, C. C. Campman, Thaddeus Danowski, W. Wallace Dyer, L. Dale Johnson, J. West Mitchell, Campbell Moses, Jr., Paul F. Polentz, Charles R. Reiners, and Harry B. Thomas. Mr. Robert L. Richards, staff secretary to committees, was also present.

Following a luncheon at 12:30 p.m., Dr. Stoney opened the business meeting at 1:45 p.m. He expressed his appreciation to the members of the commission for the success of the 1948 program and, particularly, to Dr. W. Wallace Dyer for his efforts in regard to the exhibit at the Centennial Celebration convention.

It was moved, appropriately seconded, and unanimously carried that the minutes of the meeting of Oct. 4, 1948, be approved as distributed.

County Society Programs on Diabetes

Dr. Stoney requested the secretary to read communications received from the Northampton and Lancaster County Medical Societies in regard to county society programs on diabetes. Both letters stated that, in recent meetings, Dr. W. Wallace Dyer had addressed these societies on the subject of diabetes.

Dr. Stoney then informed the commission that he had received three requests for speakers for other county society programs. One was received from the Lawrence County Medical Society, in which they suggested that four particular phases of diabetes be discussed, for their meeting on March 3 in New Castle.

Following appropriate discussion, Dr. J. West Mitchell was appointed to speak on the subject "Management of Diabetic Coma," and he was requested to contact the chairman of the program committee of Lawrence County Medical Society in this regard.

The second request for a speaker was received from the Columbia County Medical Society and the subject suggested was "The Management of Juvenile Diabetes," to be presented on July 1 at the Hotel Berwick, Berwick.

Following appropriate discussion, Dr. Paul F. Polentz was appointed to speak before the Columbia County Medical Society and requested to contact Dr. Joseph V. M. Ross, program committee chairman, in this regard.

The third request for a speaker was received from the Jefferson County Medical Society. The subject requested was "The Modern Treatment of Diabetes," to be presented at the county society meeting in DuBois on January 13.

The chairman was designated to secure a speaker and make the necessary arrangements with Dr. C. Wearne Beals, chairman of the program committee of the Jefferson County Medical Society.

SECRETARY'S NOTE: Since the date of the meeting, two additional requests have been received: one from Luzerne County Medical Society for a speaker on "Diagnosis and Treatment of Diabetes," for February 2, and the other from the Greene County Medical Society for a speaker on the same subject for February 11.

The chairman has accepted the responsibility for securing speakers to fulfill these requests.

Painting—"Diabetes, Then and Now"

Dr. Stoney submitted a letter received by Dr. Dyer from Dr. Joyce Sheridan, president of the Philadelphia Metabolic Association. The letter was unsolicited by Dr. Dyer and contained an estimate on the cost of producing lithographed copies of the painting "Diabetes, Then and Now." It was the thought of Dr. Sheridan that physician members of the A.D.A. might like a copy of the painting for their office walls, if it were procurable at a reasonable cost. The prices for a 20 x 40 inch size contained in the letter were the following:

500 copies, approximately	\$2,643
1000 copies, approximately	2,734
2000 copies, approximately	2,863

It was the opinion of the members of the commission that it would be impossible to provide lithographed copies of the painting and that such a project would not be considered at this time.

Dr. Dyer reported that he has prepared a slide of the painting in black and white, and that copies may be made for teaching use. He also stated that the painting has been insured for the sum of \$600, and he wished to receive the advice of the commission as to the preparation of a packing case.

It was moved, appropriately seconded, and unanimously approved that Dr. Dyer be authorized to expend the necessary funds for a packing case and that he be refunded the money for the \$600 insurance by the commission.

Dr. Dyer also reported that a legend is being prepared for the painting to explain the figures displayed thereon, and that, thus far, the painting has been displayed at Gimbel's Department Store in Philadelphia, the Philadelphia Metabolic Association, and has been used in the teaching of medical students and nurses at the University of Pennsylvania.

Dr. Thomas suggested that the painting be displayed in other department store windows in urban centers as part of the drive to uncover the one million unknown diabetics in the United States. However, following discussion, it was the consensus that the original painting should not be distributed to department stores.

It was moved, appropriately seconded, and unanimously approved that Dr. W. Wallace Dyer be appointed the official custodian of the painting and that all correspondence in regard to the display of same be directed to him.

Dr. Mitchell quoted Secretary Walter F. Donaldson of the MSSP, who suggested that the location of the picture and its availability be advertised to the membership.

It was then suggested that this information be inserted in THE PENNSYLVANIA MEDICAL JOURNAL and included in announcements to county medical societies for insertion in their publications.

Camp for Diabetic Children

Dr. Stoney requested Dr. Dyer to report on the Philadelphia Camp for Diabetic Children.

Dr. Dyer reported that plans for enlargement were under way and that last year approximately 25 boys and 30 girls attended the camp for a period of three weeks each. He also stated that many requests were

turned down and, therefore, the need for a larger camp and more funds is rather urgent.

The question was raised as to what the Commission on Diabetes might be able to do to encourage the use of the camp's facilities. Dr. Dyer suggested that he have Dr. Joyce Sheridan, president of the Philadelphia Metabolic Association, write to the members of the commission, stating the dates on which the camp will be available to their patients, thereby encouraging the use of present facilities by the doctors throughout the State.

Articles for Publication in Journal

Dr. Stoney suggested that several articles for publication in THE PENNSYLVANIA MEDICAL JOURNAL be prepared by members of the commission. Dr. Thomas suggested a dry clinic publication, that is, case reports with specific emphasis on one phase of the problem in each case.

Following appropriate discussion as to what should be included in such reports, it was moved, appropriately seconded, and unanimously carried that a committee be appointed by the chairman for the preparation of approximately six case reports and that they be fully prepared and submitted to the editor of THE PENNSYLVANIA MEDICAL JOURNAL with the request that he publish one each month.

Dr. Stoney appointed Dr. Dyer as chairman of the committee, and Drs. Danowski and Thomas as members to assist Dr. Dyer in the preparation of the case reports.

SECRETARY'S NOTE: In the discussion it was emphasized that no one case report be more than 1000 words so that one page in THE PENNSYLVANIA MEDICAL JOURNAL will be sufficient printing space.

Scientific Paper

As discussed at the October 4 meeting, it was the consensus that the commission request that a paper on diabetes be presented in the scientific program of the 1949 convention.

The secretary was directed to contact the chairman of the Scientific Works Committee and make known the desire of the commission to present a paper on diabetes, or preferably, a panel discussion on several phases of the problem, such as insulin dosage, surgical management, coma, etc.

Scientific Exhibit

The presentation of a scientific exhibit at the 1949 convention was then discussed, and it was decided that Dr. Mitchell should be responsible for its preparation.

It was suggested that a laboratory setup be prepared for the taking of blood sugars for doctors and their wives who may be present at the meeting, and that a request for space equivalent to two booths (18 feet) be submitted to the Committee on Scientific Exhibits, one section of the booth to be set off for the display of the painting "Diabetes, Then and Now," and the other section to be used for the blood sugar testing laboratory. Included with the exhibit would be a demonstration setup necessary for the office of a general practitioner in the routine care of diabetic patients.

It was moved, appropriately seconded, and unanimously carried that the commission set aside the amount of \$500 for the preparation of the scientific exhibit booths.

Progress Report

It was moved, appropriately seconded, and unanimously approved that the chairman submit a progress report to the Board of Trustees at the March meeting and that he at the same time present the commission's request for the funds necessary for the 1949 exhibit.

Next Meeting

It was decided that the next meeting of the commission should be held in Philadelphia in the spring of 1949, with the hope that it may be combined with a medical meeting of some interest to the members of the commission. The exact date of the meeting will be decided by the chairman, in conjunction with Dr. Dyer, and the members of the commission will be appropriately notified.

The meeting adjourned at 4:30 p.m.

GEORGE F. STONEY, M.D., *Chairman*,
ROBERT L. RICHARDS, *Staff Secretary*.

CHANGES IN MEMBERSHIP OF COUNTY SOCIETIES

New (54) and Reinstated (5) Members

ALLEGHENY COUNTY: James V. H. Ballantyne, Jr., Charles N. Chasler, William R. Clarkson, Walter F. Edmundson, Paul V. Hutchinson, Harry R. Zeller, and Robert F. Kleinschmidt, Pittsburgh.

BERKS COUNTY: Elizabeth H. B. Benford and Emerson E. Hoppes, Reading; Maurice R. Schmoyer, Jr., Kutztown.

BRADFORD COUNTY: Alan S. Rubenstein, LeRaysville.

BUCKS COUNTY: Harvey D. Groff, Quakertown.

DELAWARE COUNTY: Delbert C. Smith, Ridley Park.

INDIANA COUNTY: Ross S. Rumbaugh, Ernest.

LACKAWANNA COUNTY: Eugene J. Agnone, Scranton.

MONTGOMERY COUNTY: Jesse J. Cancelmo, Jr., Rosemont; William W. Young, Wynnwood.

NORTHAMPTON COUNTY: Willis E. Manges, Easton; Warren A. Miller, Bethlehem.

PHILADELPHIA COUNTY: William J. Carey, Noel J. Cortes, John J. Domanski, Israel Finestone, George E. Fissell, John J. Kennedy, E. Paul Kitchin, Harry J. Knowles, Martin R. Krausz, Earl A. Loomis, Jr., Robert J. McNeill, Jr., Russell K. Mattern, Thomas F. Maley, Elliott F. Maguire, Milton C. Maloney, Melvin M. Meyers, John L. Redman, Armand Rosenbaum, Herbert Salis, Anthony T. Scavo, James Ayers Snyder, Richard M. Steinhilber, Zachary Schlaff, Thomas E. Shoemaker, 2d, John D. Turchi, Leroy L. Walker, Jr., and W. G. Wosnack, Philadelphia; Margaret Castex Sturgis, Wynnwood; A. Valdes-Dapena and Marie Valdes-Dapena, Havertown. (Reinstated) Roycroft C. Jones and Michael P. Mandarino, Jr., Philadelphia.

SCHUYLKILL COUNTY: Charles W. Delp, St. Clair; W. R. Bohenblust, New Ringgold. (R) William F. Leigh, Pottsville.

SUSQUEHANNA COUNTY: (R) George W. Norris, Dimock.

WASHINGTON COUNTY: John H. Hoon, Monongahela. (R) Fernand N. Parent, Charleroi.

YORK COUNTY: Samuel C. Cissel, III, and Harold Fisher, York.

Resignations (10), Transfers (6), Deaths (19)

ALLEGHENY COUNTY: *Resignations*—Daniel E. Di Iaconi, Detroit, Mich.; Everett D. Hockenberry, Coral Gables, Fla. *Deaths*—Francis J. Madden, Duquesne (Univ. Pgh. '95), December 15, aged 78; Voigt Mooney, Pittsburgh (Univ. Pgh. '20), December 28, aged 54; Daniel E. Sable, Pittsburgh (Univ. Pgh. '07), December 11, aged 64; Thomas Turnbull, Jr., Cassanova, Va. (Univ. Pa. '87), December 23, aged 83.

BEAVER COUNTY: *Death*—Edward C. Straessley, Beaver Falls (Univ. Md. '12), December 7, aged 59.

BUTLER COUNTY: *Transfer*—Frank E. Sherman, Pittsburgh, to Allegheny County Society. *Death*—Wes-ton W. Lasher, Saxonburg (Univ. Pgh. '93), Decem-ber 12, aged 77.

CRAWFORD COUNTY: *Death*—George T. Waggoner, Conneaut Lake (Univ. Mich. '23), August 2, aged 50.

HUNTINGDON COUNTY: *Death*—I. Swartz Plymire, Petersburg (Jeff. Med. Coll. '04), December 8, aged 75.

INDIANA COUNTY: *Death*—Elmer E. Onstott, Salts-burg (Univ. Ill. '89), December 2, aged 87.

JEFFERSON COUNTY: *Deaths*—Russell C. Gourley, Punxsutawney (Univ. Pgh. '94), November 17, aged 78; Frank A. Pugliese, Punxsutawncy (Temple Univ. '35), November 17, aged 40.

LACKAWANNA COUNTY: *Resignation*—Roy T. Agos-tini, Cincinnati, Ohio.

LANCASTER COUNTY: *Transfers*—John H. Mentzer, Harrisburg, to Dauphin County Society; Edward S. Crosland, Royersford, to Montgomery County Society.

LUZERNE COUNTY: *Resignation*—Leon W. Dierolf, Dallas, Texas.

MERCER COUNTY: *Death*—Montrose B. Magoffin, Mercer (Univ. Pa. '12), recently, aged 62.

MONTGOMERY COUNTY: *Transfer*—Delbert C. Smith, Ridley Park, to Delaware County Society. *Resignation*—Peter J. Labowski, Colorado Springs, Colo.

MONTGOMERY COUNTY: *Resignation*—Charles L. Zim-merman, Danville.

NORTHAMPTON COUNTY: *Death*—Harvey O. Rohr-bach, Daniclsville (Ill. Mcd. Coll. '02), December 10, aged 78.

NORTHUMBERLAND COUNTY: *Transfer*—Henry T. Simmonds, Harrisburg, to Dauphin County Society.

PHILADELPHIA COUNTY: *Transfer*—Philip G. Kitch-en, Pocono Lake, to Monroe County Society. *Resigna-tions*—John W. Nicholson III, Rochester, Minn.; Wil-fred Y. Hanaoka, Los Angeles, Calif. *Deaths*—Paul E. Loudenslager, Haddonfield, N. J. (Univ. Pa. '22), December 7, aged 56; George B. Miller, Philadelphia (Univ. Pa. '85), December 6, aged 84; Wm. Burrill Odenatt, Philadelphia (Med.-Chi. Coll. '97), December 3, aged 72.

SCHUYLKILL COUNTY: *Death*—Theodore C. Fegley, Tremont (Univ. Pa. '99), November 17, aged 72.

WARREN COUNTY: *Death*—Erwin S. Briggs, War-ren (Jeff. Med. Coll. '06), July 1, aged 71.

WESTMORELAND COUNTY: *Death*—William C. Toll, Monessen (Univ. Toronto '05), November 19, aged 69.

YORK COUNTY: *Resignations*—Joseph M. James, Butler; Cletus E. McGuigan, York.

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since November 30. Figures in first col-umn indicate county society numbers; second column, State Society numbers.

Dec. 2	Lancaster	1-3	27-29	\$45.00
	Allegheny	1, 4-714	30-741	10,680.00
	Montgomery	18-74,		
		76-174	742-897	2,340.00
7	Northampton	3	898	15.00
	Dauphin	1	899	15.00
10	Bucks	1-28	900-927	420.00
13	York	3-34	928-959	480.00
	Washington	1-3	960-962	45.00
	Montgomery	175-196	963-984	330.00
14	Washington	148	10495	15.00
	Delaware	1-64	985-1048	960.00
15	Bradford	49	10496	15.00
16	Bucks	29-36	1049-1056	120.00
	Philadelphia	1-9	1057-1065	135.00
	Philadelphia	3171-3181	10497-10507	82.50
20	Northampton	4	1066	15.00
	Berks	2-3	1067-1068	30.00
	York	35-78	1069-1112	660.00
	Indiana	45	10508	15.00
21	Delaware	65-93	1113-1141	435.00
22	Bucks	38-45	1142-1149	120.00
23	York	79-86	1150-1157	120.00
27	Susquehanna	19	10509	15.00
	Wyoming	1-12	1158-1169	180.00
	Allegheny	2, 715-950	1170-1406	3,550.00
29	Warren	1-9	1407-1415	135.00
	Bucks	46-51	1416-1421	90.00

HAVE YOU USED THE PACKAGE LIBRARY SERVICE?

Have you taken advantage of the facilities offered by the package library of The Medical Society of the State of Pennsylvania? Over 97,000 reprints are now filed in the library for your use.

Prior to 1944 the average yearly number of requests was approximately 350. However, from 1944 to 1948 inclusive, there has been a continuous increase in usage. There were 899 requests filled during 1947, an increase of 196 requests over the total for 1946. During 1948 there were 1192 requests.

A package of reprints will be sent immediately for a loan period of two weeks to any member of the State Society. There is a charge of 25

cents for each subject requested to cover postage and part of the expense of collecting the material. Send requests to the Librarian, 230 State St., Harrisburg, Pa.

Subjects requested between December 1 and December 31 were:

Paget's disease	Theophorin
Treatment of cancer	Iontophoresis
Blindness	Diaphragmatic hernia
Glaucoma	Anxiety in children
Strabismus	Rutin
Cataract	Histoplasmosis
Conservation of vision	Anuria
Periarteritis nodosa	Medical education
History of urology	Progress in medicine
Diabetes	Rheumatic fever (2)
Hearing aids	Cancer clinics
Nasal cytology	Aortic aneurysm
Poliomyelitis	The brain
Medical economics	Drugs
Migraine	Clinical pathology
Rh factor (2)	Essential hypertension
Hypoparathyroidism	Tumors of the kidney
Medical licensure	Treatment of migraine
Industrial dermatosis	Diabetes
Pneumothorax	Blood banks
Barbiturate poisoning	Premature infants
Peptic ulcer	Chronic shock
Rh factor and hapten	Eye surgery
Cholangiography	Ulcerative colitis
Paravertebral block	Bursitis
Sacro-iliac joint	Neurodermatoses
Emphysema	Animal experimentation
Vivisection	
Hypertensive heart disease	
Physiology of the thyroid gland	
Socialized medicine (4)	
Carcinoma of the male urethra	
Treatment for intestinal parasites	
Controlling air-borne infection (2)	
X-ray therapy of Marie-Strümpell disease	
Sulfonamides in the prevention of rheumatic fever	
Gold therapy in arthritis	
Neurocirculatory asthenia	
Sympathectomy for essential hypertension	
Erythroblastosis fetalis	
Vitamin E in treatment of heart disease (2)	
Schools of nursing in Pennsylvania	
Actinomycosis of the kidney	
Penicillin and streptomycin allergy	
Aerosol penicillin in chronic sinusitis	
Association of American Physicians and Surgeons	
Methods of oxygen therapy	
Antireticular cytotoxic serum	
Kuntscher intramedullary nails	
Incidence of diabetes in Pennsylvania	
Rice treatment of hypertension	
Treatment of dermatoses	
Desmoid tumors of the stomach	

VETERAN'S LOAN REPAID

Secretary-Treasurer,
Medical Society of the State of Pennsylvania.

I believe that it is approximately three years since the Veterans Loan Fund MSSP kindly loaned me five hundred dollars on my return from military service.

With my check for \$500 enclosed, please accept my thanks for this loan, which came at a most opportune time.

Very truly yours,

_____, M.D.

Nov. 1, 1948

SUBSCRIPTION FEES PASS \$3,000,000 IN PENNSYLVANIA "DOCTORS' PLAN"

Annual subscription fees in force in Pennsylvania's Blue Shield topped \$3,000,000 for the first time last November.

Subscription fees in force on last November 30 totaled \$3,003,097 as compared to \$1,061,519 on the corresponding date in 1947. The increase amounted to \$1,941,578 during the twelve months, or 182.9 per cent.

During the same twelve-month period the number of MSAP's Blue Shield subscribers increased from 126,972 to 324,718, an enrollment gain of 155.7 per cent. This and other consistently large gains all during 1948 indicate the growing acceptance of "the doctors' plan" of voluntary prepaid medical care by employed men and women throughout Pennsylvania.

During the first eleven months of 1948 the number of physicians' services paid by MSAP increased 141.6 per cent over the same period in 1947. The number of services paid was 20,128 as compared to 8332 during the corresponding period in 1947, an increase of 11,796.

Between Jan. 1 and Nov. 30, 1948, the cost of physicians' services incurred by MSAP totaled \$1,297,554, an increase of 140.9 per cent over the same period in 1947. This item totaled \$538,700 for the first eleven months of 1947.

MATERNAL DEATHS BY COUNTIES

On page 564, this issue, will be found a listing of "Deaths from selected Causes in Pennsylvania, September, 1948." The column "Maternal Deaths" totals 14, divided by counties as follows: Allegheny, Delaware, Lackawanna, and Philadelphia, 2 each; Beaver, Cambria, Chester, Crawford, Dauphin, and Lebanon, 1 each. It is hoped that the causes for these deaths were determined and discussed by members of the medical societies in the counties where such deaths occurred.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the co-operation of the Pennsylvania Tuberculosis Society
and The Medical Society of the State of Pennsylvania

UNTIL army maneuvers exposed many thousands to the disease, coccidioidomycosis was confined chiefly to a few scattered areas in the southwestern part of the United States. Infected individuals are now widely disseminated and the fact that the pulmonary lesions resemble those of tuberculosis, with which it may be coexistent, increases the difficulty of recognition.

COEXISTING PULMONARY COCCIDIOIDOMYCOSIS AND TUBERCULOSIS

The following is a case report in which caseous pneumonic tuberculosis with cavitation developed in a patient with a coccidioidal cavity in the opposite lung. Had the previous medical history not been known, the finding of tubercle bacilli in the sputum together with the x-ray picture would have led to a diagnosis of bilateral cavity tuberculosis, and the coccidioidomycosis would have been overlooked.

This case raises the question whether it would not be wise to do routine examinations for both *Coccidioides immitis* and tubercle bacilli in all cases of pulmonary disease with cavitation. This suggestion is in line with the conclusions reached by other investigators.

Case Report

F., a 24-year-old Negro, was admitted to the hospital in December, 1945. Pulmonary tuberculosis had been diagnosed on routine x-ray examination at a separation center that showed infiltration in both apexes and in the right third anterior interspace.

During the war the patient had taken part in desert maneuvers in southern California from June to December, 1943, but had had no respiratory illnesses. The past medical history was noncontributory. The family history was negative for tuberculosis.

On admission the only complaint was intermittent, slight pain in the left side of the chest for the preceding few months. Physical examination revealed a well-developed man who did not appear ill. There was no dyspnea or cyano-

sis, and examination of the heart and lungs was negative. X-ray examination showed minimal infiltration in both apexes. Planigrams showed a small thin-walled cavity just above the right clavicle.

Significant laboratory findings were as follows: A tuberculin skin test using purified protein derivative was negative in the first strength and weakly positive in the second strength. A coccidioidin skin test in a 1:1000 dilution was negative on two occasions. Sputum concentrates, examination of the gastric contents, one sputum culture, and one guinea-pig inoculation were negative for tubercle bacilli. One 72-hour concentrate was negative for fungi. The sedimentation rate was 8 mm. in one hour. Urinalysis showed a trace of albumin. Blood counts were within normal limits.

The patient left the hospital against advice in March, and the discharge diagnosis was chronic pulmonary tuberculosis, moderately advanced.

The patient returned to the hospital on June 13 with the chief complaint of bilateral chest pain and a slightly productive cough. Physical examination and x-ray films of the chest showed no essential change since the previous admission. There was the same isolated, thin-walled cavity in the right apex and a small area of infiltration in the left apex.

A coccidioidin skin test was positive on July 2 in a 1:1000 dilution and positive on July 5 in a 1:100 dilution. Sputum studies for acid-fast bacilli, including seven direct smears, five concentrates, and three gastric lavages, were neg-

BRONCHIAL ASTHMA

"Aminophyllin has in recent years taken a definite place in the armamentarium of asthmatic medication. Physiologically it acts by relaxing the bronchial muscles. It is also extremely valuable in relieving patients of an adrenalin fastness and is less contraindicated in cases with cardiac disorders or hypertension."¹

By relaxing the bronchial musculature, improving ventilation, increasing vital capacity and promptly reducing both intrathecal and venous pressures,

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AMINOPHYLLIN *

exerts a favorable influence on the rate and volume of respiration in bronchial asthma as well as in paroxysmal dyspnea and Cheyne-Stokes respiration.

ORAL . . . PARENTERAL . . . RECTAL
DOSAGE FORMS



*Searle Aminophyllin contains at least 80% of anhydrous theophylline. G. D. Searle & Co., Chicago 80, Illinois.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

1. Mountain, G. E.: Bronchial Asthma, J. Iowa M. Soc. 35:324 (Aug.) 1915.

ative. On July 15 the sputum was found to contain spherules of *Coccidioides immitis* on direct smear, and this was confirmed by culture on July 20. Serologic tests for active coccidioidomycosis were performed. The complement-fixation test was four plus in 1:2 and 1:4 dilutions. The precipitin tests were all negative. It was concluded that the findings indicated a coccidioidal infection. His symptoms subsided and he was discharged on February 19, 1947. He returned seven months later because of weight loss and hemoptysis. X-ray showed cavitation in both upper lobes. Sputum examination showed acid-fast bacilli on both smear and culture. Serologic tests for coccidioidal infection were repeated at this time. The complement-fixation test was four plus in dilutions of 1:2, 1:4, and 1:8 and two plus in a dilution of 1:16. The precipitin tests were negative in all dilutions. These results were interpreted as not being high enough to indicate a coccidioidal dissemination. *C. immitis* was again found in the sputum on smear and culture.

The patient left the hospital against advice on November 1, before streptomycin therapy could be instituted.

Summary

A case is presented in which coccidioidal cavitation was observed for fifteen months in a patient who subsequently developed a caseous cavity tuberculosis in the opposite lung, with a positive sputum test for tubercle bacilli.

That tuberculosis and coccidioidomycosis may both cause pulmonary cavitation is now a well-known fact. Since the diseases may coexist in the same patient, it is advisable to check routinely for both tubercle bacilli and *Coccidioides immitis* in all patients with pulmonary cavitation.

Coexisting Pulmonary Coccidioidomycosis and Tuberculosis, Lieut. Robert S. Study (M.C.), U.S.N.R., and Philip Morgenstern, M.D., New England Journal of Medicine, June 10, 1948.

THIRTEENTH ANNUAL POSTGRADUATE INSTITUTE OF

THE PHILADELPHIA COUNTY MEDICAL SOCIETY

BELLEVUE-STRATFORD HOTEL, PHILADELPHIA

April 5, 6, 7, and 8, 1949

Symposia on Modern Methods of Diagnosis and Treatment

Subjects to Be Presented

Diseases of the Circulatory System
Common Conditions of the Oral Cavity
Diabetes
Anterior Poliomyelitis
Blood Dyscrasias
Diseases of the Kidney

Pain
Industrial Medical and Surgical Problems
Common Obstetric Problems
Problems of Infancy and Childhood
Eye, Ear, Nose and Throat
Gastro-intestinal Problems

Vaginal Discharge—Causes and Treatment

Four Full Days of Lectures Two Special Evening Sessions Technical Exhibits

Registration Fee—\$5.00 for Entire Course

GILSON COLBY ENGEL, M.D., Director

301 South 21st Street

Philadelphia 3, Pa.



Old Age NEED NOT MEAN *Chronic Illness*

Clinical studies ^{1,2,3} demonstrate that the results of inadequate dietaries are insidiously cumulative and may not become evident for many years. Many of the afflictions of old age are now attributed to lifelong faulty dietaries and no longer need be the inevitable accompaniment of advanced years.

In advanced age the wisdom of dietaries high in vitamins, minerals, and protein, low in fat, and moderate in carbohydrate, is pointedly emphasized in reported clinical studies. Liberal amounts of vitamin B complex and of calcium, in particular, are important for increasing

the appetite and for supporting the calcium integrity of the skeletal structure.

Ovaltine in milk, a delicious *multiple* dietary supplement, is highly useful in the management of aged patients. Its multiple vitamins, its important minerals, and its biologically complete protein are the very nutrients required for effecting full adequacy of even seriously faulty diets. The refreshing tastefulness and easy digestibility are welcomed by the aged.

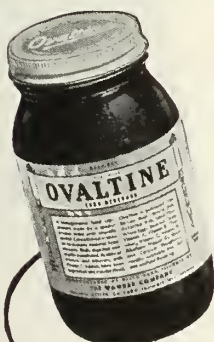
The rich dietary contribution made by three daily glassfuls of Ovaltine in milk, is outlined in detail in the table.

¹ Boss, E.P.: The Physiologic and Clinical Phenomena of Aging, New Orleans M. & S. J. 97:64 (Aug.) 1944.

² Spies, T.D., and Collins, H.S.: Observation on Aging in Nutritionally Deficient Persons, J. Gerontol. 1:33 (Jan.) 1946.

³ Stieglitz, E.J.: Therapy of the Aged, M. Ann. District of Columbia 17:197 (Apr.) 1948.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.



Ovaltine

Three servings daily of Ovaltine, each made of
1/2 oz. of Ovaltine and 8 oz. of whole milk, * provide:

CALORIES	676	VITAMIN A	3000 I.U.
PROTEIN	32 Gm.	VITAMIN B ₁	1.16 mg.
FAT	32 Gm.	RIBOFLAVIN	2.0 mg.
CARBOHYDRATE	65 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12 mg.	COPPER	0.5 mg.

*Based on average reported values for milk.

TWO ADDED SUGARS

Cows' milk contains about 4.6 per cent carbohydrate

MORE EASILY DIGESTED PROTEINS

The protein content of Baker's is made more and less allergenic by the manufacturing process ing to the boiling point

AN ADJUSTED FAT

Although the fat of cows' milk is usually readily digested, it contains more of the esters of fatty acids than is contained in the fat of human milk. Therefore, these

FORTIFIED AT 7 STRATEGIC POINTS

Starting with tuberculin-tested cows' milk, the formula, Baker's Modified Milk

A COMPLETE MILK DIET

Baker's Modified Milk contains the essentials which

ADEQUATE SUPPLY OF PROTEINS

To compensate for the lower biological value of cow's milk protein as a tissue builder in infants, Baker's Modified Milk, when diluted to normal strength, provides total protein (including added gelatin) in approximately 60 per cent greater amount than in human milk

FORTIFIED VITAMIN CONTENT

The vitamin potencies of Baker's Modified Milk when diluted to normal strength, ready for feeding, have been determined by actual tests

SIMILAR TO HUMAN MILK

Baker's Modified Milk gains acceptance by the infant only to the extent that it is well tolerated

THE MINERAL CONTENT

Baker's Modified Milk all of the mineral salts are present in amounts slightly in excess of those found in human milk. Calcium, phosphorus, iron, and

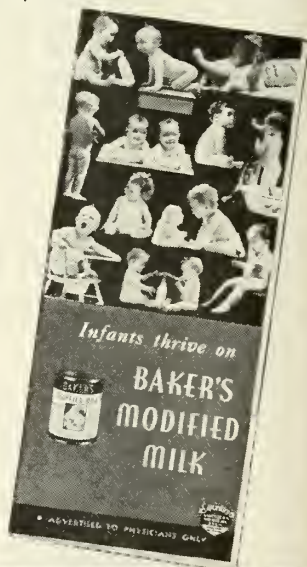
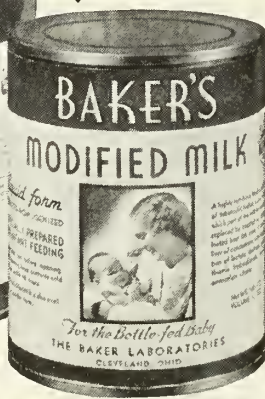
Developed to Meet the Needs of the Physician in Infant Feeding



← POWDER

↓ LIQUID

Start with either and change from one to the other, to meet individual requirements.



A copy of this informative folder which completely describes Baker's Modified Milk, with feeding directions, will be mailed on request.

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Division Offices: San Francisco, Los Angeles, Denver, Seattle and Greensboro, N. C.



THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

547 Water Street

Indiana, Pa.

PRESIDENT'S MESSAGE



The Auxiliary section this month contains material on two phases of our program—conferences and talks for lay groups. Included is the report of the National Conference of State Presidents by Mrs. Drury Hinton.

The third Pennsylvania Conference is to be held in Harrisburg, March 17-18, 1949. The members of the State Executive Board will be a part of this meeting, but it is essentially a workshop for the county presidents and presidents-elect. Begun during the term of Mrs. Jay G. Linn as president, conferences have fully proved their usefulness to county officers. No ideas discussed by this representative state group can be carried out without the help of Auxiliary members in every county.

The purpose of the conference is *orientation*—to learn how our activities should be developed, *inspiration* and *training* for the work to be done, *comparison* of the techniques used in different counties, and *coordination* of activities which we carry out on a state-wide basis.

We hope that those who attend will take back concrete ideas to incorporate into their county programs and a realization of the potentialities of Auxiliary work. Each member shares this conference indirectly as her county president reports on the conference details and then plans to carry out some of the program within her county.

One thing to be stressed at this 1949 conference is the need for study groups to learn about medical legislation before Congress and the State Legislature, and to be conversant with the issues so that in each county there will be women prepared to speak before lay groups, with the permission of the county medical society, of course.

Such a study group was held in Berks County Auxiliary several years ago when a number of women read the then current Wagner-Murray-Dingell Bill and other pertinent literature. Recently a member of that group prepared an article to give before a club of women executives

in the community. It is published here as an example of what an alert, interested Auxiliary member can say to a lay audience. It was well received and was a distinct community service. We hope to hear about more talks of this type as the year progresses.

(MRS. PAUL C.) CATHARINE PALMER CRAIG,
President.

REPORT OF 1948 A.M.A. CONFERENCE OF STATE AUXILIARY PRESIDENTS

The fifth annual Conference of State Presidents and Presidents-elect and the National Committee Chairmen of Standing Committees of the Woman's Auxiliary to the American Medical Association was held at the Hotel Sherman, Chicago, Nov. 4 and 5, 1948. To those of us who were privileged to attend, the gathering of representatives from thirty states and the Territory of Hawaii (our newest Auxiliary unit organized last June) was most awe-inspiring. Seventeen states sent both presidents and presidents-elect, fourteen sent one representative; and some ten or twelve officers and chairmen of the National Board made up the rest of the group.

Following as it did this year the fateful election day of 1948, with all the implications which the medical world knew must attend the results of said election, the conference was even more interesting and important than must have been anticipated. The messages of the fine speakers who addressed us left no doubt in our minds as to the significance of our place as an Auxiliary to the American Medical Association. So much was offered us on all phases of Auxiliary projects that space here will permit only a brief summary of all that transpired. I am sure that others, like myself, felt that much time was needed to absorb all the important facts which we heard and wished to remember.

Presiding over the conference was the president-elect of the National Auxiliary, Mrs. David B. Allman, of New Jersey. Mrs. Allman ex-



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pressed the hope that we would plan, work, and fight together for the success of the Auxiliary, and reminded us that an informed auxiliary is a good auxiliary. Thus she set the theme of the conference—education—first of ourselves, and then of others.

Mrs. Luther H. Kice, national president of the Auxiliary, greeted the assembled conference, expressing pleasure at the fine attendance and stressing the importance of our work. "Now, more than ever before," she said, "the Auxiliary must work for better health to combat the propaganda that is being spread by those who would tear down the American way of medical care." She urged us to fight false theories with known facts—again stressing education of ourselves first—and to know the difference between voluntary health insurance and compulsory health plans so that we can interpret these facts to the laity.

National committee chairmen brought recommendations for state programs and how best to use the material offered by each committee. Among the outstanding suggestions were the following:

To work closely with the medical society on both state and county levels.

To consult with standing committees in order to keep informed on trends in legislation.

To stress the value of *Hygeia* as an excellent form of public relations.

To advertise the Auxiliary as a unit interested in public health.

To point out the need in our everyday contacts with the laity for interpreting the medical profession to the public.

To form study groups of women with various lengths of experience in Auxiliary work to serve with public relations chairmen.

To interest ourselves in programs coordinating medical societies and the community health agencies, and to encourage Health Days or institutes, both rural and urban, for the laity and featuring members of the county medical society.

State presidents gave highlights of their outstanding auxiliary programs, and it was most interesting to hear of the many fine ways that service is rendered to the medical profession over the entire nation. Some mention of these might inspire our state and county chairmen with new ideas for extending the work in Pennsylvania: radio programs featuring the doctors' wives; development of state auxiliary newsletters; "movies" on sex education, nursing, animal experimentation, etc., in the schools and clubs; study groups on medical service plans, civic re-

(Turn to page 540.)

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sponsibilities, etc.; *Hygeia* sent to legislators; workshops and schools of instruction for auxiliary officers; loan funds for both nurses and medical students; benevolence funds such as our own plan in Pennsylvania; representation on school boards and in various civic organizations; establishment of museums and prenatal clinics; surveys of school health problems; and many other fine projects.

More and more reports were made of aid from medical societies to auxiliaries, both financial and material. Many states reported the auxiliaries being represented by women on the committees and subcommittees of the medical societies in the states. One state invites the president, president-elect, and public relations chairman to sit in on all medical society board meetings.

Excellent speakers, during both the meetings and the luncheons of the two-day conference, provided us with much food for thought.

Mr. William Doscher, assistant director of public relations for the A.M.A., spoke of the value of Auxiliary public relations in combating pernicious political medicine. He urged us to know and define the public relations issues of our own state society and to relate our programs to them. He stressed recognition of our responsibilities as an auxiliary in selling ourselves to

the public. We must stress the service angle of auxiliary work and the interest of the profession in public health; we must avoid purely social groups, as they are poor public relations in the communities.

Fred V. Hein, Ph.D., consultant on physical fitness for the A.M.A., gave the public relations angle of the programs of school health throughout the nation, showing how all health agencies are cooperating in the interest of health and its relation to education. He told of the value of the health committees of local medical societies appointed to act as advisers to the educational authorities. He said that auxiliary members, acting with the approval of their advisory committee, can further the work of the various phases of the school health program by serving on a school health council.

Frank G. Dickinson, Ph.D., director of the Bureau of Medical Research of the A.M.A., urged (1) the use of the "oblique attack—not a frontal approach" in our dealings with the laity; (2) in discussing medical problems, nothing can be gained by argument but much can be accomplished by suggestion.

Highlights of Dr. Dickinson's work in the field of medical research were most revealing and the following items are from recent surveys: (1) "Accident prevention has not kept pace with



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medical progress—accidents are the number one enemy of the American public today and cause more deaths than any medical failure.” (2) “Doctors cannot prevent death—everyone must die—but they can and have modified the causes of death and the age at which death occurs. In the last one hundred years the life expectancy of the American people has risen from forty to sixty-seven years, showing the increase in the quality of medical care now being provided.” (3) “The cost of living has risen twice as fast as the cost of medical care—the quality of medical care has risen by leaps and bounds.”

Mr. Thomas A. Hendricks, secretary of the Council on Medical Service of the A.M.A., told of the findings of the Hoover Commission and the report of this body which will be submitted to the 81st Congress with recommendations for the elimination of some government health agencies and the consolidation of others.

Mr. Arthur Conrad, assistant administrator of the National Physicians Committee for the Extension of Medical Service, who provided one of the most interesting and arresting programs at our own state convention in October, pointed out more strongly than ever the menace of the forces behind the drive for socialized medicine. And it must be said that the reaction to his words was

the same as here in Pennsylvania—complete silence as he presented thoughts uppermost in all our minds on that day following election 1948. He placed the medical profession at the crossroads and said there could be no compromise with the forces advocating political medicine.

Louis H. Bauer, M.D., vice-chairman of the Board of Trustees of the A.M.A., told of his experiences abroad with the World Medical Association, the interest displayed by doctors from countries where communism and socialized medicine prevail, and the great need for support of the World Medical Association by American medicine if the world is to have better health for all people.

All programs pointed to the furthering of one great ideal—service to the people of our communities through the interpretation to our neighbors of the ideals and objectives of the doctors. Public relations is our job—it is US. Thus the spirit of the conference was summed up for us in one phrase, “Health is everybody’s business just as peace is everybody’s problem,” and we departed from Chicago with greater determination to serve our Auxiliary to the fullest of our abilities.

(MRS. DRURY) ELIZABETH MACILROY HINTON,
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IS MR. EWING'S PLAN PRACTICAL?

Several years ago a group of women, desiring not to take the word of the grapevine, read the Wagner-Murray-Dingell Bill rather minutely. As a result there were many questions in our minds which we attempted to clear up at a later date when one of us had an opportunity to speak personally with Senator Murray. Much to our surprise the sponsor of this bill in Congress was not sufficiently familiar with the details of the proposed legislation to answer the majority of these questions. He stated that many people had collaborated in the writing of this bill, and I felt personally that it left much to be desired.

Recently a National Health Plan based on compulsory insurance has been proposed by Mr. Oscar Ewing, Federal Security Administrator. I have read this plan carefully trying to be completely impartial and have concluded that the principle of better health for everybody is an ideal to which all of us wholeheartedly subscribe.

Current Federal Legislation Discussed

Briefly, the plan provides for medical care for everyone, everywhere in the United States. Medical care embraces the care of the physician, the dentist, the nurse, hospitalization, drugs, preventive medicine, immunization, and mental care. Under this plan hospitals would be erected in areas needing them and medical education would be provided in order to increase the number of physicians necessary to carry out such a program. The cost of such a program would be borne by each wage earner and his employer through taxation by the government.

These funds would be administered by the Federal Government to the state and eventually to a local level. There would of necessity be federal administrators, state administrators, regional and local directors, plus secretaries, inspectors, and investigators. The system of paying the physician, the dentist, and probably the nurse, would be chosen by the local or regional board. Hospitals would be granted money by the government to support such a program. In Mr. Ewing's report the hospitals would retain local management and the people would have free choice of physicians. Such a program sounds ideal.

Time will not permit discussing here the innumerable ramifications of such a program, but there are a few things I should like you to think about before endorsing such a scheme. To me there are many aspects that might be questionable, but assuming that all these could be improved, I should just like to enlarge on two,

which I believe are the most important ones: (1) the cost of such a régime; (2) the quality of medical care we would have under such a régime.

I am quoting from the report of the Brookings Institution, an impartial, unbiased, non-political research business enterprise: "In most income classes medical care amounts roughly to 4.0 to 4.5 per cent. On the average it does not equal expenditures for automobile purchase and operation or alcoholic beverages. . . . In both 1935-36 and 1941 the available figures show for all income classes with total incomes of \$1,500 a year or over that savings exceeded expenditures for medical care. In the light of these facts, it seems necessary to conclude that the average lack of medical care among consumers with total incomes of around \$2,000 or over at the 1941 price levels is due more to failure to give medical care a high priority than to lack of resources to pay for it. . . . Changes in state and national income-tax laws with respect to reductions for the cost of medical care would permit material increases in expenditures for medical care." (page 37)

The cost now is estimated to be about 3 per cent of each earned income up to \$4,800 yearly, with the employer paying half and the wage earner half. If you are self-employed, you would pay the entire 3 per cent. The employer or industrialist would not be able to absorb the tax himself on thousands of employees, so he would be forced to pass on the cost of the program to you, the purchaser, by placing a higher price on his commodity. For a wage earner making \$4,800, the sum of \$144 yearly would be paid for him and his entire family to receive complete medical care and hospitalization. Whether dental and nursing care would be supplied in this 3 per cent is not clear. Mr. Ewing speaks of a probable 1 per cent being added for dental care. No mention is made of taxations on incomes over \$5,000; Mr. Ewing says medical service for everyone everywhere, so we must assume that incomes over \$5,000 would be taxed proportionately. Should you fall in this category and wish to seek a personal physician's advice, you would be paying twice. This, of course, applies to any income, but I choose the figure of \$5,000 because I believe that no one with a smaller income could afford to be taxed and pay also. Let me remind you that this 3 per cent would be in addition to Social Security and Old Age Pensions assessments already enforced by deductions from one's "take home" pay.

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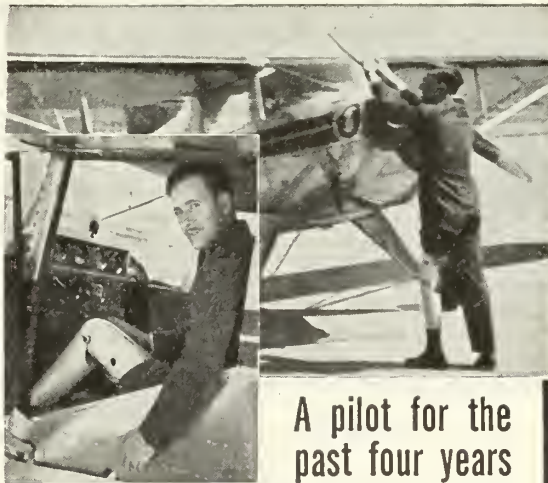
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The American Committee on the Cost of Medical Care finds that the reason it is so expensive today is because of the development of laboratory facilities and refinements in diagnostic accuracy in American medicine. There can be no doubt that adding administrative costs will

(Turn to page 546.)

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Hoover Commission Indicts Federal Extravagance

I suggest that you read Oscar Ewing's National Health Plan, the report of the Brookings Institution which is opposed to embarking on this program at the present time, and above all the more recent report of the Hoover Commission which contrasts the difference between the cost of civilian administration as opposed to the much higher cost of government administration.

As to the quality of medical care, it has been the experience of other countries operating under this system that malingering has increased the load of unnecessary calls on the physician. Secondly, the amount of paper work required to establish proof of medical service in other countries has constituted a major demand on the physician's time. It has also been the experience in other countries with this system that the expense

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of its operation has necessitated a limit on the type of drugs the physician may prescribe. Thus it no longer becomes a question of which drug is best for the patient, but rather which low-cost drug can be substituted. There are many instances where substitution of less expensive drugs is not justifiable if the best interests of the patient are the prime objective.

Furthermore, the practitioner knows that his actions may be questioned by a government inspector under this system. He must substitute his interpretation of insurance rules and regulations for his own professional judgment.

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icine is no exception, as borne out by the tremendous advances which have been made in American medicine over the last quarter century. If you believe that the proposed system would hamper free competitive progress, to which every physician should be entitled, because it introduces not only limitations but politics into the practice of medicine, you will think twice before favoring such a legislative program.

In summary then, with regard to advancement of the nation's health through compulsory insurance, we must not overlook the experiences of other countries where the quality of medical care has been lowered because of the stifling of medical initiative. We must not overlook the impending high cost of medical care pyramided by the tremendous administrative cost of a compulsory insurance system. Mr. Ewing's plan has not become law. When it is reduced to legislative form, let us examine the bill carefully before we decide whether the compulsory system can accomplish as much advancement as a voluntary one based either on more income tax reductions for medical care or voluntary insurance plans such as Blue Cross and Blue Shield, the latter being a plan sponsored by The Medical Society of the State of Pennsylvania for paying the doctor.

(MRS. FRED B.) MARIE R. NUGENT,
Member of Study Group,
Woman's Auxiliary to the Berks
County Medical Society.

N. B. Since this was written, the current bills have been published. National health insurance bills S. 5 and H.R. 783 are identical with S. 1320 of the 80th Congress, with the exception of the change in dates.

C. P. C.

INTRODUCING THE BOARD MEMBERS Councilors

First District: Mrs. Francis F. Borzell was formerly chairman of necrology for the State Auxiliary. She has held many chairmanships in the Philadelphia County Auxiliary and was president in 1941-42. She is active in the Frankford Woman's Club and Emergency Aid, Seashore Home for Crippled Children, and Hannah Penn Republican Club of Philadelphia. Dr. Borzell is the eminent speaker of the House of Delegates of the A.M.A.

Second District: Mrs. Elmer H. Bausch is a past president of Lehigh County Auxiliary and a past vice-president of the State Auxiliary. She is a registered nurse and has done hospital supervisory work. Mrs. Bausch is a past president of the Junior Auxiliary of the Allentown Hospital, at present president of the

Muhlenberg Auxiliary, and an active member of the Allentown Garden Club. Dr. and Mrs. Bausch have three sons, twenty-four, nineteen, and seventeen.

Third District: Miss Mary H. Stites, president of Northampton County Auxiliary 1943-44, has taught in Bushkill Township and did secretarial work for several years during the war. She is active in the Nazareth Woman's Club, D.A.R., Moravian Historical Society, and various alumnae associations.

Fourth District: Mrs. William J. Jacoby, a member of the Northumberland County Auxiliary, formerly served as operating room supervisor for Ashland State Hospital. Since 1938 she has been on the Executive Board of the Harrisburg Diocesan Council of Catholic Women. She is active as chairman of the community nurse project of Mt. Carmel Woman's Club. Dr. and Mrs. Jacoby have a married daughter and a son, a junior at Jefferson Medical College.

Fifth District: Mrs. John M. Ranck is a past president of the Lancaster County Auxiliary. Before her marriage, she did general work in a bank in New Holland. She is very active in Leola in church and Sunday School, Missionary Society, Girl Scouts, the Woman's Club, Historical Society, and Hospital Auxiliary. She is a director of the Upper Leacock School Board. She has had many entries in local farm shows and won twelve prizes in 1947 and 1948. The Rancks have one son 10 years of age.

Sixth District: Mrs. Ralston O. Gettemy was a li-

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brarian at Indiana State Teachers College and an elementary teacher in Altoona. She is a member of the executive boards of the Altoona Council of Church Women and Family Service Bureau, mission superintendent of the Blair County Sunday School Association, and a member of the Altoona Welfare Federation. Dr. and Mrs. Gettemy have one son and two daughters. She was chosen as Mother of the Year in 1947, to address Westminster College students on Parents' Day.

Seventh District: Mrs. Harry W. Buzzerd is an enthusiastic member of the Lycoming-Union Auxiliary, having served on various committees. She is a member of the St. Mark's Lutheran Church in Williamsport and the Eastern Star. She assists her husband almost full time at the office. Harry, Jr., is aged six.

Eighth District: Mrs. Mary Harker Jones, a member of the Mercer County Auxiliary, formerly worked in a bank in Pemberton, N. J. For nineteen years she has been executive secretary of the Council of Christian Education in Mercer County, and for the past five years a member of the Unified Staff of Pennsylvania and the International Advisory Board. She has directed the junior work in the First Presbyterian Church of Sharon for twenty-nine years.

Ninth District: Mrs. F. Earle Magee, Sr., a past president and active member of the Venango County Auxiliary, is also a past president of the Pennsylvania Federation of Woman's Clubs and a member of the board of the General Federation of Woman's Clubs. It was during her administration as president that the State Federation initiated and secured the passage of

the Premarital and prenatal Health Bills. She is also a past president of the Hospital Auxiliary and a member of the Nursing Committee of Oil City Hospital. Dr. and Mrs. Magee have one son, a pre-law student at Washington and Jefferson College.

Tenth District: Mrs. Howard H. Hamman has served Westmoreland County Auxiliary as president, treasurer, secretary, and director. She is legislative chairman of Westmoreland County Federation of Woman's Clubs and for eleven years has been president of the U. B. Church choir. She also has been director and assistant co-ordinator of the Westmoreland Cancer Fund, co-chairman of the Greensburg American Red Cross, vice-president of the Republican Committee of Greensburg and Evening Council of Westmoreland County, finance chairman of the Woman's Club, and a director of the Pennsylvania Association of the Blind. The Hammans have two daughters.

Eleventh District: Mrs. Robert S. Ideson, of Johnstown, a past president of Cambria County Auxiliary, is a registered nurse. She is a member of the Westmont Republican Woman's Club and Wayside Garden Club, and is active in various community projects. Dr. and Mrs. Ideson have four sons, all veterans, one a practicing physician.

Twelfth District: Mrs. Xavier K. Collmann has been president of Luzerne County Auxiliary. She is a registered nurse. Currently she is treasurer of the Mozart Music Club, a member of the Travelers' Aid Board, and a member of the Hospital Auxiliary in Wilkes-Barre. The Collmanns have three sons and one grandchild.

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*Snyder, M. L., Kiehn, C. L. and Christopherson, J. W.: *Mil. Surgeon*, 97: 380, 1945. • Shipley, E. R. and Dodd, M. C.: *Surg., Gynec. & Obst.*, 87: 366, 1947 • Mays, J. L.: *J. Med. Assoc. Georgia*, 36: 263, 1947. • Curtis, L.: *Surg. Clin. N. America*, 1466 (Dec.) 1947.

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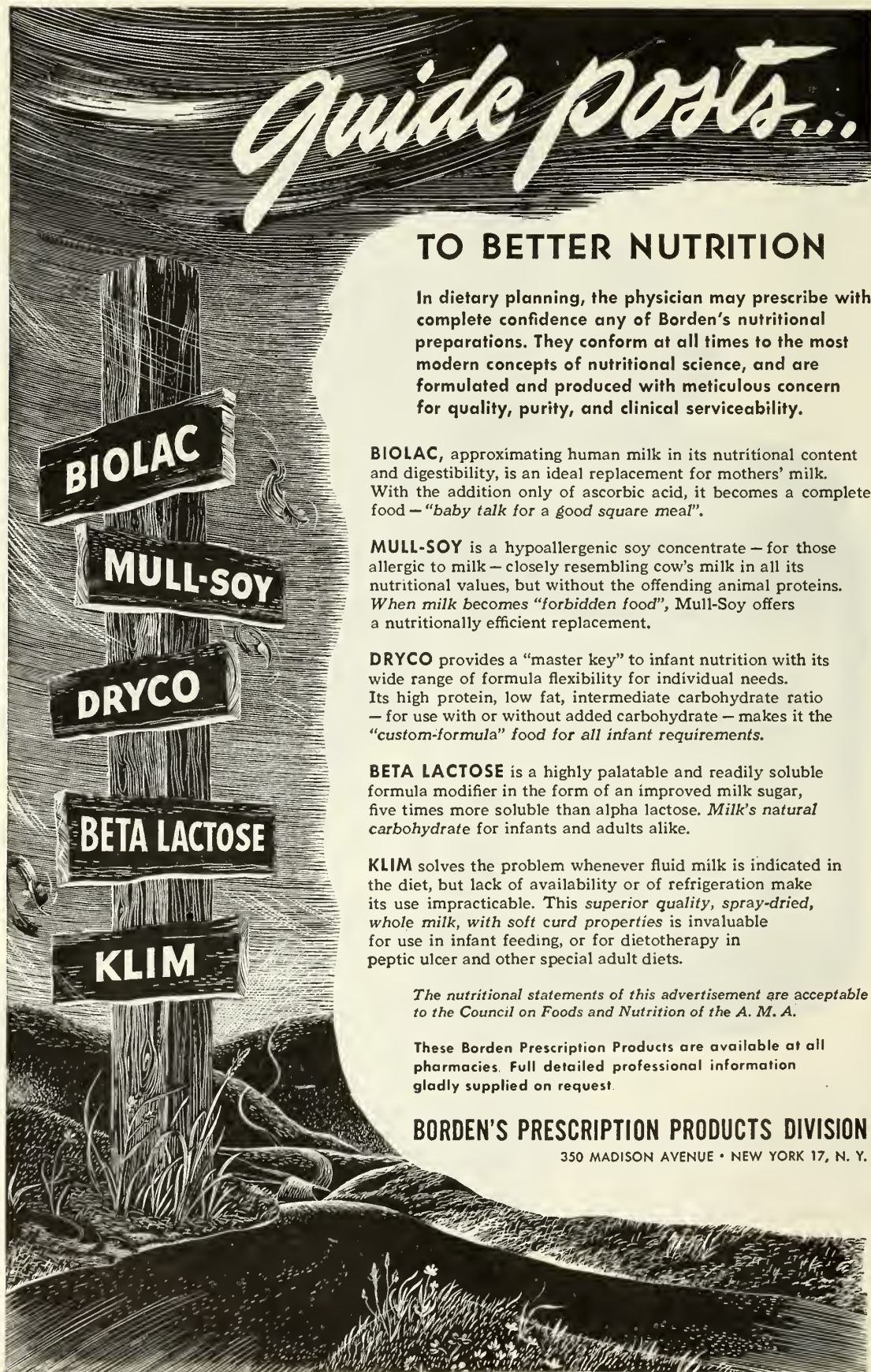
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MEDICAL NEWS

Future Meeting Calendar

SECRETARIES-EDITORS CONFERENCE—Penn-Harris Hotel, Harrisburg, March 3 and 4, 1949.

AMERICAN ACADEMY OF GENERAL PRACTICE—Cincinnati, March 7 to 9, 1949.

AMERICAN COLLEGE OF PHYSICIANS—New York, March 28 to April 1, 1949.

PHILADELPHIA COUNTY MEDICAL SOCIETY POSTGRADUATE INSTITUTE—Philadelphia, April 5-8, 1949.

AMERICAN GOITER ASSOCIATION—Madison, Wis., May 26-28, 1949.

INTERNATIONAL CONGRESS ON RHEUMATIC DISEASES—New York City, May 30-June 3, 1949.

Birth

TO DR. AND MRS. PAUL K. WALTZ, of Mechanicsburg, a son, Michael Paul, January 6.

Engagements

MISS FRANCES M. RITTENBERG, daughter of Dr. and Mrs. Benjamin B. Rittenberg, to Mr. Richard G. Fish, all of Philadelphia.

MISS ISABELLA STEWART CHAMBERLIN, daughter of Dr. and Mrs. Franklin E. Chamberlin, of Glenolden, to Mr. Russell L. Dotts, of Gwynedd Valley.

MISS DOROTHY CRISPIN WEEDE, daughter of Dr. and Mrs. S. Dana Weeder, of Philadelphia, to Dr. Zachary Arnold Simpson, of Charlotte, N. C.

MISS JOSEPHINE TUCKER ULLOM, daughter of Dr. and Mrs. Josephus T. Ullom, of Philadelphia, to Lt. Cmdr. Philip Wharton Evans, of Washington, D. C.

MISS JUNE D. FISCHMAN, of Wyomissing, to Mr. Norman J. Winston, son of Dr. and Mrs. Gilbert I. Winston, of Reading. Mr. Winston is a member of the senior class of Temple University Medical School.

Marriages

MISS BUVEL FOLWELL MATHER to Merle Middour Miller, M.D., both of Philadelphia, February 5.

MISS RITA THERESA QUIGLEY, of Overbrook Farms, to Mr. Thomas Joseph Ryan, son of Dr. and Mrs. Thomas J. Ryan, of Drexel Hill, January 22.

MRS. FRANCES DODGE JOHNSON, of Lexington, Ky., daughter of the late auto magnate, John F. Dodge, to Mr. Frederick L. Van Lennep, son of Gustave A. Van Lennep, M.D., of Ardmore, January 22.

Deaths

⊙ Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

⊙ Basil R. Beltran, Philadelphia; Medico-Chirurgical College of Philadelphia, 1912; aged 59; died Jan. 19, 1949. A nephew of the late Dr. Ernest LaPlace, Dr. Beltran was associate professor of medicine in the Graduate School of the University of Pennsylvania, and was chief surgeon at Misericordia and Fitzgerald-Mercy Hospitals. During World War I, he was director of Base Hospital No. 1 in France, and for his outstanding work there he was awarded the Palmes Academiques by the French government. After the war he became medical director and chief surgeon at Eastern State Penitentiary and was the first medical director of

Nazareth Hospital. He was a Fellow of the American College of Surgeons. Surviving are his widow, a daughter, a son, his mother, and a sister.

⊙ Maurice T. Sloane, Philadelphia; Medico-Chirurgical College of Philadelphia, 1914; aged 58; died Jan. 15, 1949. Dr. Sloane had been on the staff of Presbyterian Hospital for five years, and was associated with the Woman's Hospital for twenty-six years. He also served in an advisory capacity for the Veterans Administration. During World War I, he served in France as a flight surgeon with the Army Air Force. He is survived by his widow, two daughters, and three brothers.

⊙ Gideon L. Howell, Trucksville; University of Pennsylvania School of Medicine, 1912; aged 63; died Jan. 13, 1949. Dr. Howell was the first principal of Kingston Township High School and later served on the school board for twelve years. He practiced medicine for over thirty-six years. He was on the staff of Nesbitt Memorial Hospital in Kingston, serving as roentgenologist and surgeon. His widow, a son, and a daughter survive.

⊙ Amos B. Schnader, Terre Hill; Jefferson Medical College of Philadelphia, 1903; aged 73; died Jan. 20, 1949, after a short illness. Dr. Schnader was vice-president of the board of the Evangelical and Reformed Theological Seminary in Lancaster. He formerly practiced in Mt. Carmel for twenty-seven years.

⊙ George M. Ferguson, Philadelphia; Jefferson Medical College of Philadelphia, 1899; aged 74; died Jan. 18, 1949. Dr. Ferguson was a captain in the U. S. Army Medical Corps during World War I. He retired from medical practice eight years ago. He is survived by two sons, two brothers, and two sisters.

⊙ Maurice Silverman, Philadelphia; Jefferson Medical College of Philadelphia, 1924; aged 48; died Jan. 20, 1949, after a short illness. During World War II, Dr. Silverman served in the Army Medical Corps for three years. He is survived by his widow, two sons, his parents, a sister, and a brother.

J. Howard Driscoll, Philadelphia; Hahnemann Medical College and Hospital of Philadelphia, 1931; aged 42; died Jan. 27, 1949, after a short illness. Dr. Driscoll served in the Army Medical Corps from 1942 until 1946. He is survived by his widow, two daughters, and a brother.

⊙ Cyril A. Whalen, Mahanoy City; University of Pennsylvania School of Medicine, 1934; aged 40; died Jan. 25, 1949. Dr. Whalen was president of the Schuylkill County Medical Society in 1948 and was editor of its *Bulletin*. He is survived by his widow, one son, and two daughters.

⊙ J. Frank Rutherford, Hastings; College of Physicians and Surgeons, Baltimore, Md., 1892; aged 82; died Jan. 14, 1949. He had retired in 1943, but was an affiliate member of the Erie County Medical Society. Two sons and two daughters survive.

Lewis F. Siegler, Philadelphia; Jefferson Medical College of Philadelphia, 1886; aged 82; died Jan. 29, 1949. Dr. Siegler was a former health officer of Lancaster where he practiced for many years. He is survived by his widow and two sons.

⊙ Thomas Turnbull, Jr., Casanova, Va.; University of Pennsylvania School of Medicine, 1887; aged 83; died Dec. 23, 1948. Dr. Turnbull, who was an affiliate member of the Allegheny County Medical Society, was retired.

○ **George R. Hetrich**, Birdsboro; Jefferson Medical College of Philadelphia, 1923; aged 55; died Jan. 25, 1949, following a long illness. He is survived by his widow, two daughters, and a son.

○ **Paul E. Loudenslager**, Haddonfield, N. J.; University of Pennsylvania School of Medicine, 1922; aged 54; died Dec. 7, 1948. He was a member of the Philadelphia County Medical Society.

○ **William C. Toll**, Monessen; University of Toronto Faculty of Medicine, Canada, 1905; aged 69; died Nov. 19, 1948.

○ **George T. Waggoner**, Conneaut Lake; University of Michigan Medical School, Ann Arbor, 1923; aged 51; died Aug. 2, 1948.

○ **Edward C. Straessley**, Beaver Falls; University of Maryland School of Medicine, Baltimore, 1912; aged 59; died Dec. 7, 1948.

○ **Weston W. Lasher**, Saxonburg; University of Pittsburgh School of Medicine, 1893; aged 77; died Dec. 12, 1948.

○ **I. Swartz Plymire**, Petersburg; Jefferson Medical College of Philadelphia, 1903; aged 80; died Dec. 8, 1948.

Miscellaneous

THE PHILADELPHIA CHILD HEALTH SOCIETY, Seventh and Delancey Streets, Philadelphia 6, has just issued a revised set of Food Value Charts. These charts are very complete and sell for \$1.00 a set.

THE EIGHTY-EIGHTH MEETING OF THE READING EYE, EAR, NOSE AND THROAT SOCIETY was held on January 5. The program consisted of a discussion of "Practical Perimetry" by Nubar A. Karakashian, M.D., of Philadelphia.

LESLIE S. KENT, M.D., of Eugene, Oregon, a native of Bannerville (Snyder County), Pennsylvania, is president of the Oregon State Medical Society, the first woman to be elected to this office in the United States.

MARY L. RICHARDSON, M.D., of Philadelphia, has been appointed chief of the Rheumatic Heart Division in the State Health Department. She will direct a program reaching down through thirteen clinics offering treatment to patients suffering from rheumatic fever.

THE WOMAN'S MEDICAL COLLEGE OF PENNSYLVANIA ALUMNAE will hold a dinner meeting, Wednesday evening, June 8, at the Hotel Claridge, Atlantic City, N. J. All alumnae attending the meeting of the American Medical Association are cordially invited to attend this dinner.

THE FIRST ANNUAL SCIENTIFIC ASSEMBLY OF THE AMERICAN ACADEMY OF GENERAL PRACTICE will be held March 7, 8, and 9 at the Netherlands Plaza Hotel, Cincinnati, Ohio. Hotel reservations may be made by writing the Hotel Committee, American Academy of General Practice, Dixie Terminal Building, Cincinnati 2, Ohio.

A GOLD MEDAL, THE HIGHEST HONOR OF THE RADIOLOGICAL SOCIETY OF NORTH AMERICA, was awarded to W. Edward Chamberlain, M.D., of Philadelphia, president of the society, by L. Henry Garland, M.D., at the society's annual banquet held in the Hotel Fairmont, San Francisco, Calif., December 9. The gold medal is awarded for distinguished service to medicine and to radiology in particular.

EARL D. BOND, M.D., director of training and research for the Institute of Pennsylvania Hospital, Philadelphia, was honored by members of the senior staff at a testimonial dinner at the Merion Cricket Club the evening of January 25. Dr. Bond was the recipient of the Philadelphia Award in 1932 for his work in psychiatry. He was administrative head of the hospital's mental and nervous division for thirty years.

IN APPRECIATION OF TWENTY-TWO YEARS OF SINCERE AND HONORABLE SERVICE to his friends, to his profession, and to his fellowmen at the Lankenau Hospital, Philadelphia, the board of trustees and the medical staff of the hospital honored Gilson Colby Engel, M.D., president of The Medical Society of the State of Pennsylvania, at a testimonial dinner at the Lankenau School of Nursing on January 25. More than 200 persons from all walks of life attended the dinner.

TULANE UNIVERSITY OF LOUISIANA SCHOOL OF MEDICINE will annually sponsor a series of lectures in honor of the late Dr. John H. Musser, who served for more than twenty years as professor of medicine. The first lecture was held November 12, when Dr. John McMichael of the Postgraduate Medical School of London, England, spoke on "The Principle of Venous Pressure Reduction in the Treatment of Congestive Heart Failure." The university plans to hold lectures twice a year, bringing to New Orleans international figures in medical science.

RECENT CONTRIBUTIONS FOR RESEARCH PROJECTS to be conducted at the Temple University Medical School and Hospital have been received from the following:

U. S. Public Health Service—a grant of \$10,000 to Valy Menkin, M.D., for a cancer research problem on "The Relation of Cellular Injury to the Development of Neoplasia"; a grant of \$3,600 for studies by Machteld E. Sano, M.D., on "The Lability of the Lymphomata"; a grant of \$37,500 for the teaching of psychiatry.



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DURING ITS 1948 MEETING THE ASSOCIATION OF SURGEONS OF THE PENNSYLVANIA RAILROAD adopted a memorial to the late Dr. Joseph Scattergood, Jr., of West Chester, Pa., a member of the Association who died June 4, 1948, at the age of 43.

The leaflet bearing the In Memoriam included a "speaking" photograph of "young Joe" who will long be remembered for his local professional career as well as his official service to his county, state, and national medical societies.

Dr. Scattergood, Sr., of West Chester, is secretary of the Pennsylvania Railroad Surgeons' Association.

THE FRANK E. BUNTS EDUCATIONAL INSTITUTE AND CLEVELAND CLINIC will present a continuation course for physicians entirely devoted to the diagnosis and management of diabetes and its complications. The course will be held on March 17, 18, and 19. Drs. Henry T. Ricketts of Chicago, John S. L. Browne of Montreal, and H. L. C. Wilkerson of the United States Public Health Service will be the out-of-town guest speakers. E. Perry McCullagh, M.D., is director of the course. In addition to the regular faculty of the Institute, several prominent Cleveland physicians will give lectures.

Inquiries regarding the complete program and registration can be addressed to the Director of Education, Frank E. Bunts Educational Institute, 2020 East Ninety-third St., Cleveland 6, Ohio.

IT WAS ANNOUNCED IN NOVEMBER THAT AN OUTRIGHT GRANT OF \$100,000 had been made by the Rockefeller Foundation for continuance of study in the early detection of cancer developed by research laboratories of the

School of Medicine and Hospital of the University of Pennsylvania and Children's Hospital. The grant will be used to investigate fundamental questions related to disturbances of the skin.

Announcement was also made of a new cancer detection center at Frankford Avenue and Wakeling Street. This center is the first of a number to be opened throughout Philadelphia to provide physical examinations for persons who are apparently well, but wish to make sure they have no malignant tumors.

The Rockefeller grant will make it possible to speed up examination of suspected tissues. Under present methods it is necessary to wait at least four days for an adequate diagnosis, but a new process will shorten this time to four hours.

THE AMERICAN ACADEMY OF ALLERGY, in cooperation with the University of Georgia, will sponsor an orientation course in allergy from March 7 through March 11 at the University Medical School in Augusta, Georgia. This course is under the direction of Leo H. Crip, M.D., of Pittsburgh, assisted by other Fellows of the American Academy of Allergy, and a distinguished faculty.

The course is intended for internists and general practitioners, dermatologists, rhinologists, and laryngologists, and will be exceedingly practical and directly applicable to the practice of most physicians doing general medicine. It will include lectures and clinical demonstrations on allergens, hay fever, and bronchial asthma, with their diagnosis and treatment, also diagnosis, etiology, pathology, and immunology of allergy, allergic rhinitis, atopic dermatitis, and other significant manifestations in the field.

Enrollment is open to anyone interested and the fee is \$50. Applications and inquiries should be addressed to the Executive Office of the Academy, 208 East Wisconsin Ave., Milwaukee 2, Wis.



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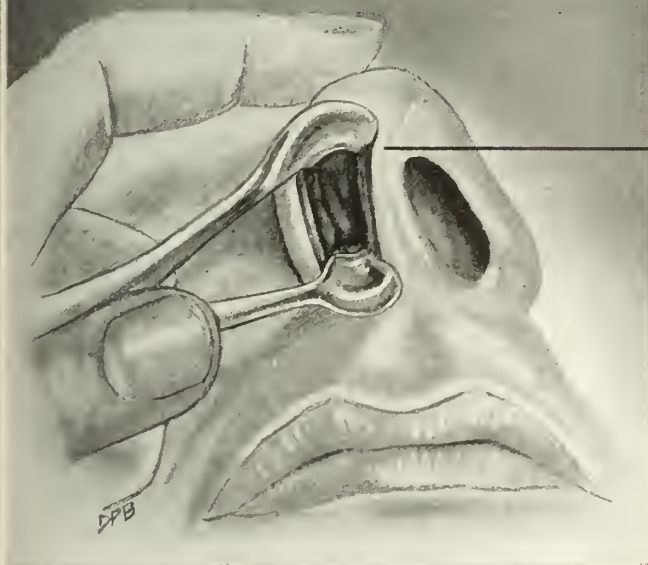
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BOOK REVIEWS

CALCIFIC DISEASE OF THE AORTIC VALVE.

By HOWARD T. KARSNER, M.D., and SIMON KOLET-SKY, M.D., Institute of Pathology, Western Reserve University, and the University Hospitals of Cleveland. Philadelphia: J. B. Lippincott Company, 1947. Price, \$5.00.

This monograph fills a much needed place in bringing our knowledge of calcific diseases of the aorta up to date. The authors are pathologists of experience who appreciate an international reputation. They have used not only their experience in this monograph but have reviewed very completely the current literature. The evidence that calcific disease of the aortic valve is the result of previous inflammation of the rheumatic type is revealed by many investigators. It helps the practitioner to explain many cases of calcific disease of the aorta that progress in mid-life or later in the absence of generalized arteriosclerosis.

Two hundred autopsied cases reveal that this disease usually develops between the fourth and eighth decades, seldom before or afterward. Approximately 57 per cent occur after the age of 50 and 42 per cent before the age of 50.

CORNELL CONFERENCES ON THERAPY.

HARRY GOLD, M.D., Managing Editor. David P. Barr, M.D., McKeen Cottell, M.D., Eugene F. DuBois, M.D., Ralph R. Tempsett, M.D., and Walter Modell, M.D., Editorial Board. Vol. III. 337 pages. New York: The Macmillan Company. Price, \$3.50.

The Cornell Conferences on Therapy are a series of weekly conferences devoted to treatment in which it is the desire of the participants to bring more closely into alignment experimental pharmacology and clinical therapy. Such conferences have been held since 1937 and edited records of these sessions have appeared in various journals. Because of widespread interest, an annual volume has been published for the past three years containing records of those conferences deemed by the editorial board to be particularly worth while. Participants in the discussions included in this volume number fifty physicians or investigators who are attached to Cornell Medical College or neighboring medical institutions. Because of the discussion type of approach and question and answer method, the book is extremely readable and easy of comprehension.

Fifteen subjects are covered. Particularly important are the chapters devoted to the management of congestive heart failure, protein hydrolysates, treatment of barbiturate poisoning and hepatic insufficiency. Other important subjects included are dose of a drug, streptomycin, protein hydrolysate therapy of peptic ulcer, pneumonia, use of BAL, pain due to muscle spasm, thrombophlebitis, alcoholism, infections of the urinary tract, and two sections on the use of cathartics.

Cornell Conferences on Therapy does not replace the textbook on pharmacology or therapeutics, but serves to crystallize one's knowledge of those drugs and procedures discussed. It should be extremely helpful from this standpoint.

MODERN CLINICAL PSYCHIATRY.

By ARTHUR P. NOYES, M.D., Superintendent, Norristown State Hospital, Norristown, Pa. Third edition. 525 pages. Philadelphia and London: W. B. Saunders Company, 1948. Price, \$6.00.

Dr. Noyes has given us another revision of his excellent textbook on psychiatry. He has added new chapters on psychotherapy, shock and other physical ther-

apies, and child psychiatry to encompass within his text a discussion of the fields in which psychiatry has made its greatest current advances.

In a field in which there is much diversity of viewpoint it is fortunate to encounter a teacher so liberal in his acceptance and reporting of varying viewpoints and so judicial in his evaluation of trends and schools of thought. One might wish that the author had used case report illustrations more freely than he has. It is a practical book for the beginning student or for the practitioner who has determined to have only one text on psychiatry on his shelves.

PREOPERATIVE AND POSTOPERATIVE CARE OF SURGICAL PATIENTS. By HUGH C. ILGENFRTZ, A.B., M.D., F.A.C.S., formerly Assistant Professor of Surgery, Louisiana State University School of Medicine, and Visiting Surgeon, Charity Hospital of Louisiana at New Orleans. Second edition. 898 pages with 110 illustrations. St. Louis: The C. V. Mosby Company, 1948. Price, \$10.00.

This book, formerly entitled "Synopsis of Preparation and Aftercare of Surgical Patients," now appears in a new edition. There have been similar books written by other authors recently and in comparison this book is of equal caliber. The author has presented a work which is intended to be useful in practice, and within the purpose for which it has been written this book is recommended. The text is written to comprise 24 systematically arranged chapters dealing briefly with the subject concerned. The exposition is clear and a list of references is found at the end of each chapter. The printing is good and the illustrations are adequate. An appendix and index, both of which are practical, complete the book. The author has incorporated in this text almost all the recent advances in the field. If the student, intern, general practitioner, or specialist does not already have a similar text, this book is recommended.

ESSENTIALS OF PATHOLOGY. By LAWRENCE W. SMITH, M.D., F.C.A.P., formerly Professor of Pathology, Temple University School of Medicine; Associate Professor of Pathology, Cornell University Medical School; and Assistant Professor of Pathology, Harvard Medical College; corresponding member of The Royal Flemish Medical Academy of Belgium; and EDWIN S. GAULT, M.D., F.C.A.P., Associate Professor of Pathology and Bacteriology, Temple University School of Medicine. With a foreword by the late James Ewing, M.D., Memorial Hospital, New York City. Third edition. Philadelphia: The Blakiston Company, 1948. Price, \$12.00.

The third edition of this popular work again calls attention to some of its outstanding deviations from the standard textbook.

The double column arrangement permits the presentation of more material in the book and makes possible the inclusion of many items which might otherwise make the book unwieldy. The technique of using full pages throughout the book for multiple illustrations makes easy comparison of related illustrations possible and conserves space.

The approach is distinctly clinical and over 260 illustrative case histories are included in the text. The reproduction of frequent x-ray studies aids in clinical correlation. The relative space overemphasis given to tumors and parasitic diseases is a recognition of the growing importance of these problems in America.

THE SURGERY OF ABDOMINAL HERNIA. By GEORGE B. MAIR, M.D., F.R.F.P.S.G., F.R.C.S.E., Surgeon, Law Junction Hospital, Lamarkshire, formerly First Assistant, Professorial Unit of Surgery, University of Durham. 408 pages with 136 illustrations. Baltimore: The Williams & Wilkins Company, 1948. Price, \$7.00.

This volume represents an effort to clarify many points concerning abdominal hernia in general. In a monograph of this nature, comparison with larger works is difficult. However, it might be said that this book has been carefully and simply written. The book is organized into 25 chapters, each of which has a bibliography of the material discussed. There is an adequate index at the end of the book. For surgeons, anatomists, physiologists, and sociologists who may be especially interested in hernia, this book is recommended.

THE CASE AGAINST SOCIALIZED MEDICINE.

A constructive analysis of the attempt to collectivize American medicine. By LAWRENCE SULLIVAN. Washington, D. C.: The Statesman Press, 1948. Price, \$1.50.

This 53-page book meets a long-recognized need of the medical man. How often has the doctor felt the need of a quickly digestible discussion of this problem, either for discussonal purposes or when called upon to speak to a lay audience on this topic on short notice.

Lawrence Sullivan is an experienced newspaperman—he writes with the easy lucidity of the reporter. His facts are taken from sworn testimony before Congressional committees by nationally recognized experts. His own decision based on a consideration of the evidence is indicated by his dedication of the book—"To the men and women of American medicine who are too busy in good works to answer the slanderous darts of the bureaucrats." Seven brief chapters are replete with

factual information: (I) What Is Socialized Medicine?, (II) American Medicine Leads the World, (III) Government Propaganda Mill, (IV) The Wagner-Murray-Dingell Bill, (V) Communist Origins, (VI) Prefabricated Statistics, (VII) When Bureaucrats Take Over.

You can with safety give this book to your open-minded lay friend or recommend it to the high school or college student seeking source information. You will certainly want it for your own desk or for your waiting room table. It can be read in its entirety in less than an hour.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

CONTROL OF PAIN IN CHILDBIRTH. Anesthesia—Analgesia—Amnesia. By CLIFFORD B. LULL, M.D., F.A.C.S., F.I.C.S., Director, Division of Obstetrics and Gynecology, Philadelphia Lying-In Unit, Pennsylvania Hospital; and ROBERT A. HINGSON, M.D., F.I.C.S., F.A.C.A., F.I.C.A., Associate Professor of Obstetrics; Anesthesiologist, Department of Obstetrics, Johns Hopkins University and Hospital; Surgeon, United States Public Health Service. With an introduction by Norris W. Vaux, M.D., Consulting Obstetrician and Gynecologist, Philadelphia Lying-In Unit of Pennsylvania Hospital; Professor Emeritus of Obstetrics, Jefferson Medical College. Third edition, revised and enlarged. Philadelphia: J. B. Lippincott Company, 1948. Price, \$12.00.

THE CHILD IN HEALTH AND DISEASE. A textbook for students and practitioners of medicine.

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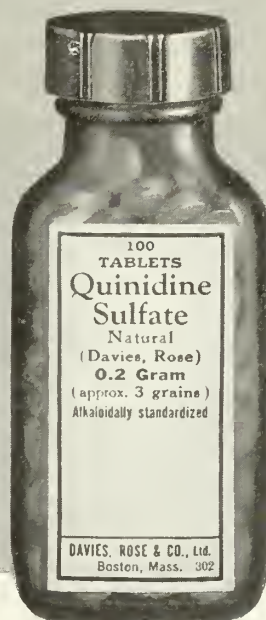
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By CLIFFORD G. GRULEE, M.D., Rush Professor of Pediatrics, University of Illinois; Attending Pediatrician, Presbyterian Hospital, Chicago; Chief Editor, *American Journal of Diseases of Children*; Secretary of the American Academy of Pediatrics; and R. CANNON ELEY, M.D., Associate in Pediatrics and Communicable Diseases, Harvard University Medical School; Chief of Isolation Service and Visiting Physician, Infants and Children's Hospital, Boston; member of the Committee on Awards of the American Academy of Pediatrics. Baltimore: The Williams & Wilkins Company, 1948. Price, \$12.00.

HYGIENE. Manual of Public Health. By J. R. CURRIE, M.A.Oxon., M.D., LL.D. Glas., D.P.H.Birm., F.R.C.P.Edin., Professor Emeritus of Public Health, University of Glasgow; County Medical Officer of Buteshire and Medical Officer of Health of the Royal Burgh of Rothesay, sometime County Medical Officer of Fifeshire and Kinross, Medical Officer Scottish Board of Health, Professor of Preventive Medicine, Kingston, Ontario, and Medical Officer of the City of Chester; and A. G. MEARNES, M.D., B.Sc. (Public Health), D.P.H.Glas., F.R.S.Edin., Senior Lecturer and Examiner in Hygiene in the University of Glasgow; Medical Adviser, Scottish Council for Health Education; Specialist Clinical Officer, Corporation of Glasgow. Third edition. With 212 illustrations and four plates in color. Baltimore: The Williams & Wilkins Company, 1948. Price, \$9.00.

PHYSICIAN'S HANDBOOK. By JOHN WARKENTIN, Ph.D., M.D., and JACK D. LANGE, M.S., M.D. Fifth edition. Palo Alto, Calif.; University Medical Publishers, 1948. Price, \$2.00.

A DOCTOR TALKS TO TEEN-AGERS. A Psychiatrist's Advice to Youth. By WILLIAM S. SADLER, M.D., F.A.P.A., Chicago, Consulting Psychiatrist, Columbus Hospital; Fellow of the American Psychiatric Association, the American Medical Association, and the American Association for the Advancement of Science; Member of the American Psychopathological Association. St. Louis: The C. V. Mosby Company, 1948. Price, \$4.00.

TEXTBOOK OF THE RHEUMATIC DISEASES. Edited by W. S. C. COPEMAN, O.B.E., M.D., F.R.C.P., Physician to the Rheumatism Department and Lecturer in the Medical School, West London Hospital; Physician to Arthur Stanley Institute of Rheumatic Diseases (Middlesex Hospital) and Hunterian Professor, R.C.S.; Senior Physician to the Hospital of St. John and St. Elizabeth; Consultant for Rheumatic Diseases, Royal Hospital for Incurables, and consultant to L.C.C.; Hon. Medical Secretary, Empire Rheumatism Council; member of

Minister of Health's Advisory Subcommittee; chairman of Chartered Society of Physiotherapy and of the British Branch of Ligue Internationale contre le Rhumatisme; Examiner in Physical Medicine for Royal College of Physicians; Heberden Medallist (1940). With 351 illustrations, some in full color. Baltimore: The Williams & Wilkins Company, 1948. Price, \$12.50.

ALLERGY TO COTTONSEED AND OTHER OILSEEDS AND THEIR EDIBLE DERIVATIVES. Excerpts from testimony before the Administrator, Federal Security Agency, in the matter of fixing and establishing definitions and standards of identity for mayonnaise, French dressing, and related salad dressings (Docket FDC-51), public hearings held at Washington, D. C., Nov. 18, 1947, and Jan. 6 to 8, 1948. Memphis, Tenn.: National Cottonseed Products Association, Inc., 1948.

CANCER OF THE ESOPHAGUS AND GASTRIC CARDIA. Edited by GEORGE T. PACK, B.S., M.D., New York, N. Y., Clinical Professor of Surgery, New York Medical College; Attending Surgeon, The Memorial Hospital for Cancer and Allied Diseases. Illustrated. St. Louis: The C. V. Mosby Company, 1949. Price, \$5.00.

DISEASES OF THE EAR, NOSE AND THROAT. By DOUGLAS G. CARRUTHERS, M.B., Ch.M. (Sydney), F.R.A.C.S., Honorary Ear, Nose, and Throat Surgeon, Sydney Hospital, and Eastern Suburbs Hospital, Sydney; Consulting Ear, Nose, and Throat Surgeon, Canterbury District Memorial Hospital, Sydney. Second edition. Baltimore: The Williams & Wilkins Company, 1948. Price, \$7.00.

AN INTRODUCTION TO PHYSICS IN NURSING. By HESSEL HOWARD FLITTER, R.N., M.A., head of Nursing Science Department, School of Nursing, University of Pennsylvania, Philadelphia; Instructor in Education, Hunter College of the City of New York; formerly Instructor of Physics Applied to Nursing, New York University, School of Education, New York City. St. Louis: The C. V. Mosby Company, 1948. Price, \$3.25.

SHOCK AND ALLIED FORMS OF FAILURE OF THE CIRCULATION. By H. A. DAVIS, M.D., C.M., F.A.C.S., Associate Professor of Surgery and Director of Division of Surgery, Graduate School of Medicine, College of Medical Evangelists, Los Angeles Division; Senior Attending Surgeon, Los Angeles County General Hospital and White Memorial Hospital; Visiting Surgeon, Cedars of Lebanon Hospital and California Hospital. New York: Grune & Stratton, 1949. Price, \$12.00.



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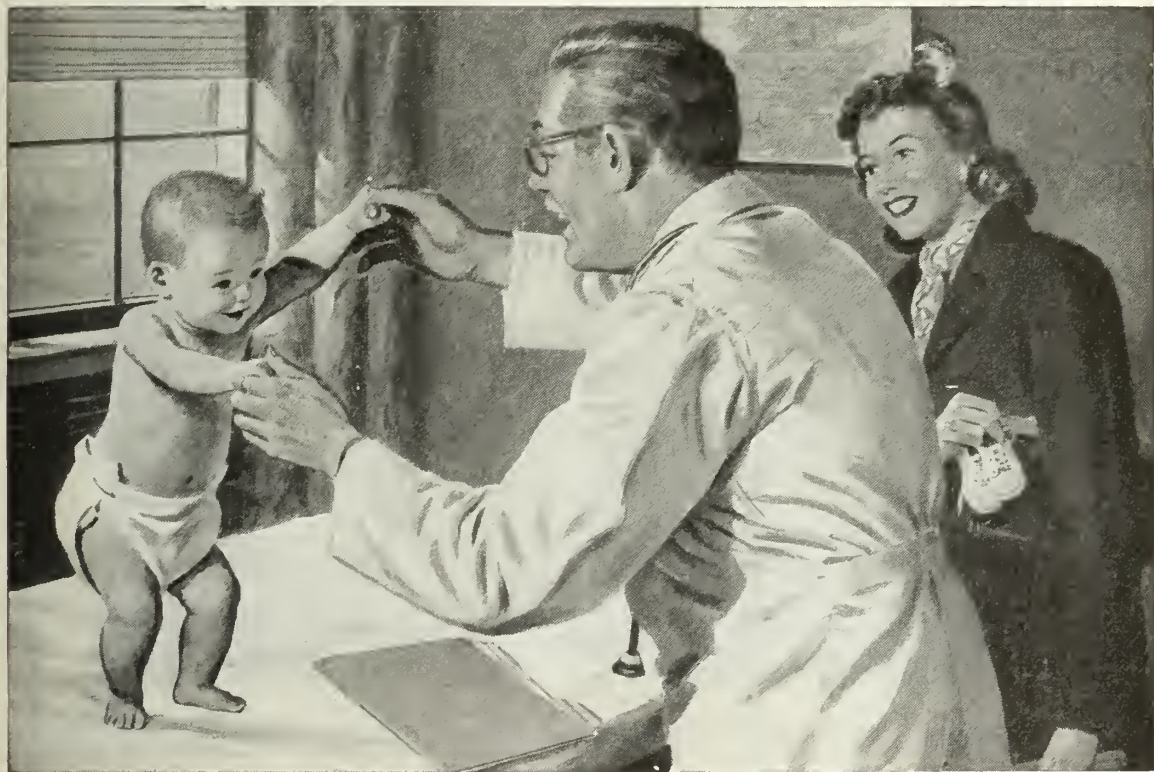
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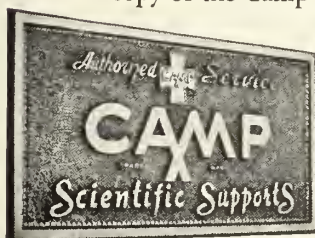
County	All Causes, Excluding Stillbirths	Still- births	Infant Deaths	Maternal Deaths	Cancer	Heart Disease	Intra- cranial Lesions of Vascular Origin	Nephritis	Pneu- monia	Tuber- culosis
Adams	24	4	3	0	0	11	7	1	0	0
Allegheny *	1052	75	74	2	173	346	109	56	24	21
Armstrong	45	2	4	0	12	13	3	0	0	1
Beaver	73	4	4	1	11	18	6	5	3	2
Bedford	23	4	1	0	2	6	5	1	0	0
Berks *	179	8	7	0	30	64	18	5	4	7
Blair *	127	11	18	0	17	47	9	7	3	2
Bradford	38	1	4	0	8	14	0	0	0	0
Bucks	65	3	4	0	8	23	12	1	0	0
Butler *	57	1	4	0	8	18	9	4	0	1
Cambria *	150	13	16	1	26	48	10	12	4	2
Cameron	3	0	0	0	0	2	0	0	0	0
Carbon	40	3	2	0	7	9	3	3	0	1
Centre *	43	1	3	0	7	18	2	4	0	0
Chester *	116	1	3	1	17	36	12	12	1	1
Clarion	19	0	1	0	3	8	0	4	0	0
Clearfield	45	2	4	0	8	12	5	5	1	0
Clinton	33	1	1	0	6	13	6	1	0	0
Columbia	47	2	4	0	8	14	2	4	2	1
Crawford	66	5	8	1	7	23	4	2	2	0
Cumberland	50	1	3	0	6	19	2	4	0	0
Dauphin *	150	7	9	1	31	43	11	10	3	4
Delaware	235	21	17	2	27	88	16	15	4	1
Elk	23	3	5	0	3	4	2	1	0	0
Erie	151	11	8	0	21	61	12	3	0	2
Fayette	128	16	13	0	18	40	10	9	7	1
Forest	3	0	0	0	0	2	1	0	0	0
Franklin *	49	3	3	0	9	16	7	3	2	1
Fulton	5	0	0	0	2	2	0	0	1	0
Greene	39	0	0	0	3	12	6	2	0	1
Huntingdon	37	1	4	0	9	9	2	2	2	1
Indiana	54	3	7	0	3	16	7	2	1	1
Jefferson	43	2	6	0	2	17	5	2	0	1
Juniata	4	0	0	0	0	1	1	1	0	0
Lackawanna	241	6	13	2	41	90	16	9	6	5
Lancaster	166	9	9	0	21	55	15	9	0	1
Lawrence	71	7	7	0	12	19	7	1	3	3
Lebanon *	50	1	2	1	3	25	3	6	1	0
Lehigh *	199	12	12	0	28	66	17	12	5	3
Luzerne	308	11	20	0	56	93	20	16	6	8
Lyeoming	69	5	1	0	11	28	6	6	2	1
McKean	43	3	4	0	8	11	2	2	0	0
Mercer	80	4	9	0	12	24	8	2	2	1
Mifflin	42	3	4	0	5	12	2	3	0	1
Monroe	29	2	0	0	5	5	6	2	1	0
Montgomery *	235	12	12	0	34	89	17	11	4	8
Montour *	32	1	4	0	5	8	0	0	1	0
Northampton	94	4	1	0	13	40	8	3	2	1
Northumberland	63	2	2	0	12	20	7	6	0	0
Perry	13	0	0	0	2	2	2	2	0	0
Philadelphia *	1650	62	99	2	256	597	113	108	37	50
Pike	8	0	0	0	1	3	1	1	0	0
Potter	13	0	0	0	2	1	1	1	1	0
Schuylkill	190	7	10	0	24	60	14	16	8	4
Snyder *	10	0	0	0	1	3	3	2	0	0
Somerset *	50	2	5	0	8	14	6	3	3	0
Sullivan	3	0	0	0	0	1	1	0	0	0
Susquehanna	24	0	2	0	3	9	2	2	0	0
Tioga	33	3	1	0	4	12	3	0	1	0
Union	19	3	1	0	3	7	3	2	0	0
Venango *	43	2	2	0	6	16	5	2	0	0
Warren *	27	1	2	0	5	10	2	0	0	0
Washington	138	1	11	0	33	40	12	4	4	1
Wayne *	26	1	1	0	4	9	3	3	0	1
Westmoreland *	177	15	11	0	24	71	17	8	5	0
Wyoming	10	0	1	0	1	4	1	2	1	0
York	131	8	8	0	22	37	17	6	2	0
State and Federal institutions	227	0	0	0	19	75	11	8	13	42
State totals	7730	396	494	14	1176	2629	655	439	172	182

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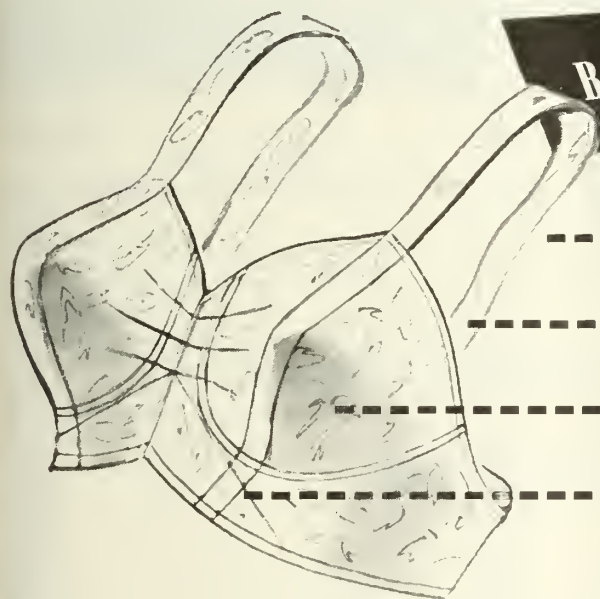
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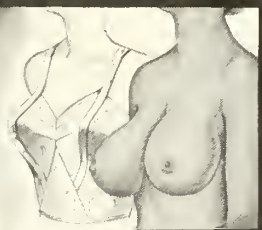
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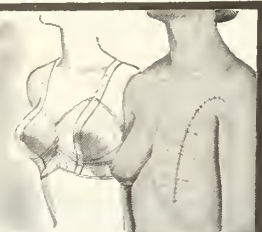
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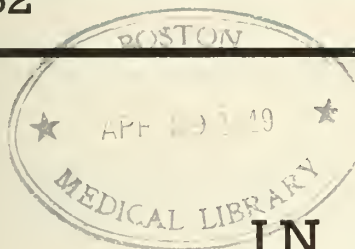
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Charles C. Dennie



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An Editorial



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Leaders Become Targets—Be a Leader

Officers' Department



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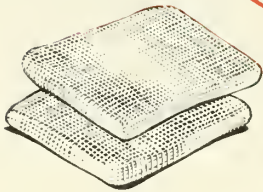
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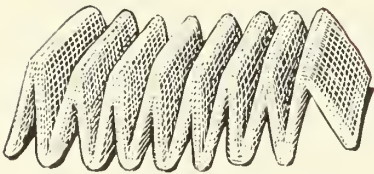
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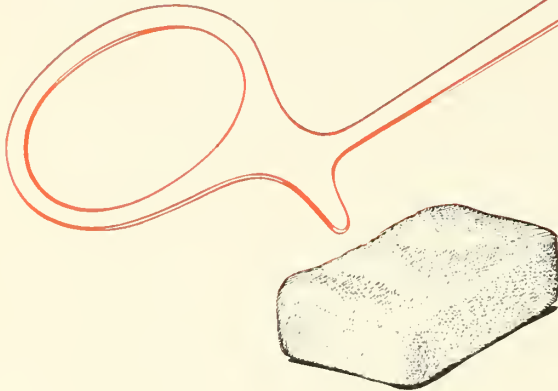
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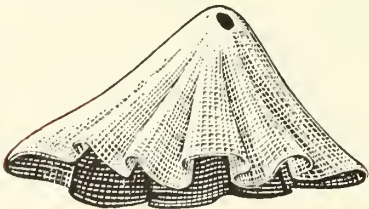


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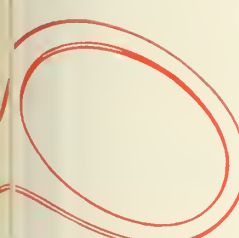
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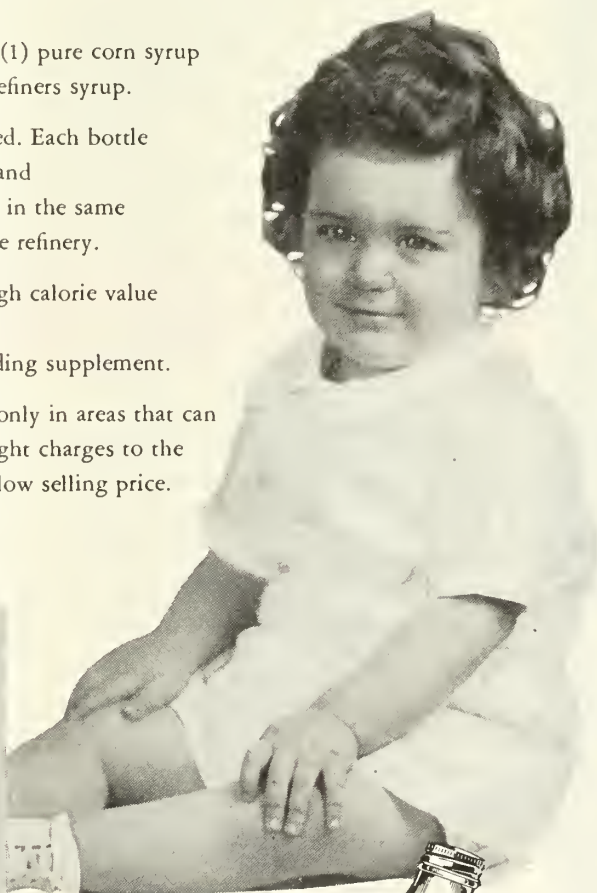
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LETTERS

A.M.A. Assessments

GENTLEMEN:

I am herein enclosing my check to cover the assessment. I do that as a matter of duty as a member of the American Medical Association, despite the fact that I do not agree with the course taken by the American Medical Association in this matter.

_____, M.D.
Pennsylvania.

Feb. 2, 1949

GENTLEMEN:

Please accept the enclosed check as part payment of my A.M.A. membership assessment. I shall pay the remainder as I am able.

At present I am a surgical resident at the _____ Hospital. In addition to subsistence under the G.I. Bill, I receive from the hospital a monthly salary of \$110. The cause is worthy, but my family is on a budget.

_____, M.D.
Pennsylvania.

Feb. 1, 1949

DEAR DOCTOR:

Your communication and partial payment are received with understanding and appreciation.

Inasmuch as the A.M.A. membership assessment is receivable throughout the year 1949, you will doubtless remain in good standing.

Cordially yours,
WALTER F. DONALDSON,
Secretary-Treasurer.

GENTLEMEN:

The enclosed notice of the twenty-five dollar assessment was mislaid with some other papers and not discovered until today. I am enclosing a check for \$100. Do you not think it would be wise to send a second notice if checks are not received within a certain period of time?

_____, M.D.

P.S. If you find it necessary, I will be glad to send an additional contribution.

GENTLEMEN:

Enclosed please find U. S. Postal Money Order in the amount of \$25 in payment of my part of the American Medical Association membership assessment.

At present I am temporarily located in the _____ Hospital, where I am serving as resident physician. However, I am a member of the Berks County Medical Society, a component of The Medical Society of the State of Pennsylvania, and I should like to mail this assessment as a member of that county medical society.

_____, M.D.

Jan. 31, 1949

Appreciation

DR. WALTER F. DONALDSON, *Secretary-Treasurer*,
Medical Society of the State of Pennsylvania.

Thank you very much for your letter of January 26 explaining the operation of the Medical Benevolence Fund of your Society.

It is going to help us immensely in organizing our own, and I feel that we owe you a debt of gratitude.

You have worked your problems out extremely well, and I wish to congratulate you on it.

ALEXANDER HAMILTON PEACOCK, M.D.,
Seattle, Wash.

Jan. 31, 1949

Hospital Costs

GENTLEMEN:

The editorial, "Hospital Costs," in your January issue follows the same single track as the politicians and charitable institutions, viz.: Never reduce expenses, just obtain greater income.

Giving only two examples of hospital waste: (1) A pathologist at \$6,000 a year making a daily visit of one hour or less; the technicians do the routine and are finished at 2 p.m. (2) The clerical office force "feather bedding" relatives and friends of the trustees at no expense to the trustees. These unnecessary expenses are eliminated in many religious hospitals that are balancing their budget with present hospital charges.

May it be suggested, to at least try to reduce waste. Of course, there is a shortage of nurses; they work.

What are other physicians' opinions?

C. A. CAMPBELL, M.D.,
4801 Penn Street,
Philadelphia 24, Pa.

Name Changed

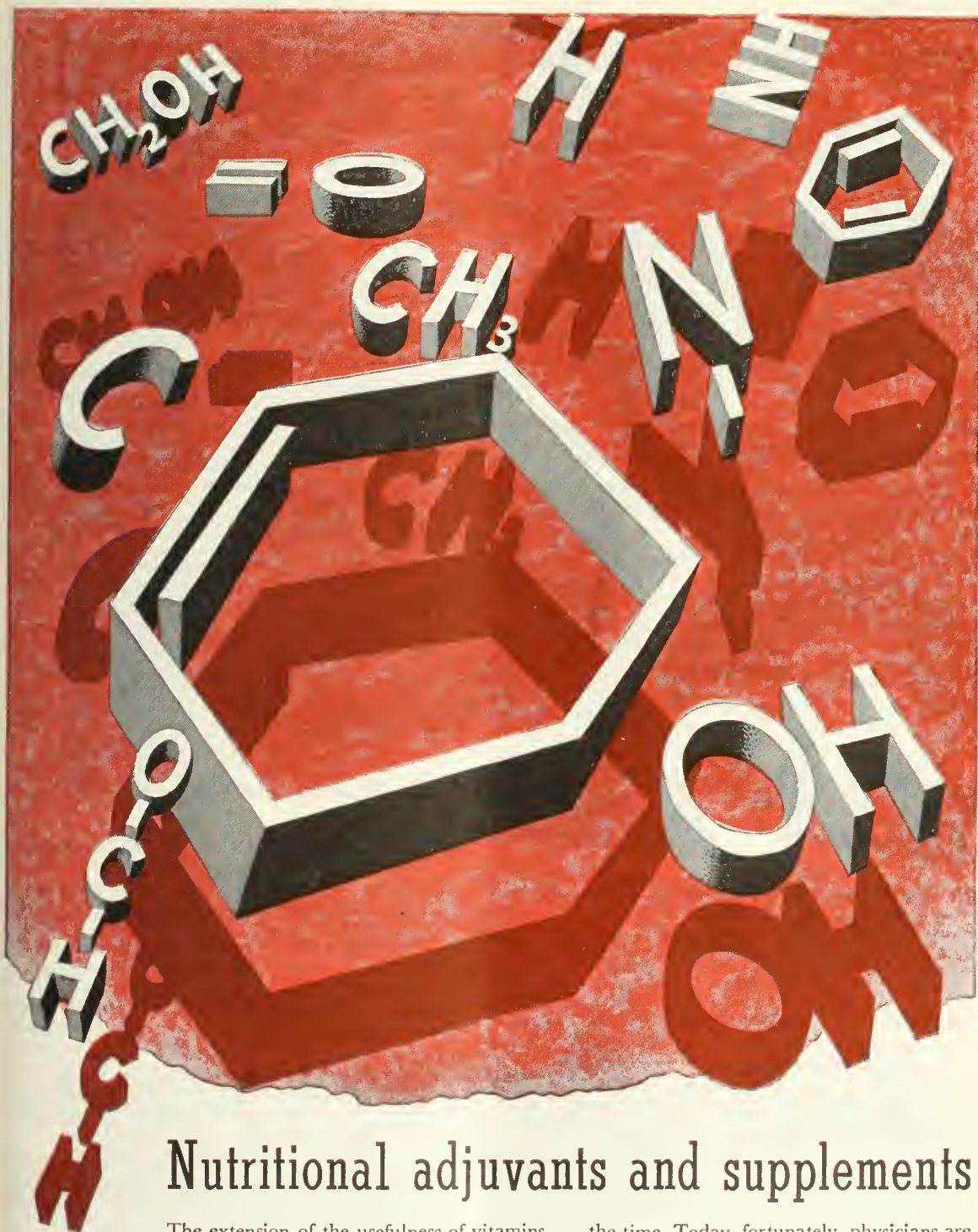
GENTLEMEN:

The Central Pennsylvania Allergy Society will hereafter be known as the Pennsylvania Allergy Association. By an overwhelming vote of approval it was deemed advisable to change the name because many members of the association are from all parts of the State. While many members of the association are also members of either the Philadelphia Allergy Society or the Pittsburgh Allergy Society, it is important that it be known that these three groups are distinct and separate organizations.

The spring meeting of the association will be held in Allentown on the first Wednesday in April with Dr. Alexander M. Peters as chairman. The fall meeting in 1949 will be held in Pottsville with Dr. Joseph Ricciuti, Jr., as chairman.

The following members were chosen as officers for the year 1949: Dr. A. Harvey Simmons, Harrisburg, president; Dr. Alexander M. Peters, Allentown, vice-president; Dr. Ralph M. Mulligan, Reading, secretary-treasurer.

The following men were elected to the board of regents: Drs. Archibald R. Judd, Hamburg, and Stephen D. Lockey (chairman), Lancaster (three years); Drs. Luther J. King, Meadville, and John V. Foster,



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The extension of the usefulness of vitamins, beyond the specific deficiencies which they cure and prevent, is a therapeutic phenomenon of the past decade. Those who specialize in nutritional disease have frequently emphasized to physicians the doctrine that every cell in the body needs every vitamin all of

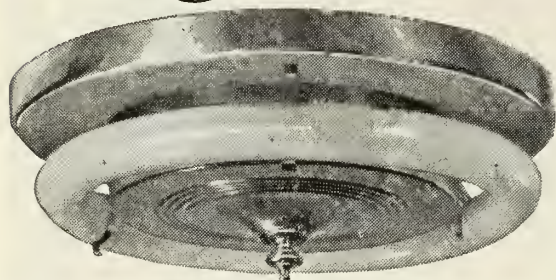
the time. Today, fortunately, physicians are increasingly realizing the importance of the nutritional phase of medicine. Lederle has been pre-eminent in the vitamin field for many years. Its list of vitamin products includes combinations and single vitamins adequate for every clinical need.

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RALPH H. MULLIGAN, M.D.,
Secretary-Treasurer,
Pennsylvania Allergy Association,
Reading, Pa.

DENTAL PUBLICATION DECRIES CONTROLLED CARE

The *Fortnightly Review* of the Chicago Dental Society (January 2) has a few directly aimed words to say about the issue of compulsory health insurance:

"The plan that Mr. Ewing advocates calls for a payroll tax on employees and employers sufficient to provide about three billion dollars a year. . . . He claims that his plan is not contradictory to the American system and rests upon tried insurance principles. Obviously someone is trying to pull a fast one there, for the only insurance principles that Americans know about are those that call for payment of premiums by the insured that are adequate to cover benefit payments based upon experience.

"Only those persons who think that government benevolence should supplant enterprise and thrift can favor exchanging the blessings of American medicine and dentistry under a free system for the compulsory health plan now in the offing."—*Minnesota Medicine*, February, 1949.

STUDY SMEAR TEST FOR DIAGNOSIS OF CANCER

Tumors of the digestive system cannot be diagnosed by the "smear test" alone in its present state of development, say four physicians from the departments of internal medicine and pathology, University Hospital, University of Michigan, Ann Arbor.

Writing in the January 8 issue of *The Journal of the American Medical Association*, H. Marvin Pollard, M.D., Henry C. Bryant, M.D., Malcolm Block, M.D., and Winston C. Hall, M.D., report on a study of the method of cell study developed by Dr. G. N. Papanicolaou of the Cornell University Medical College, New York.

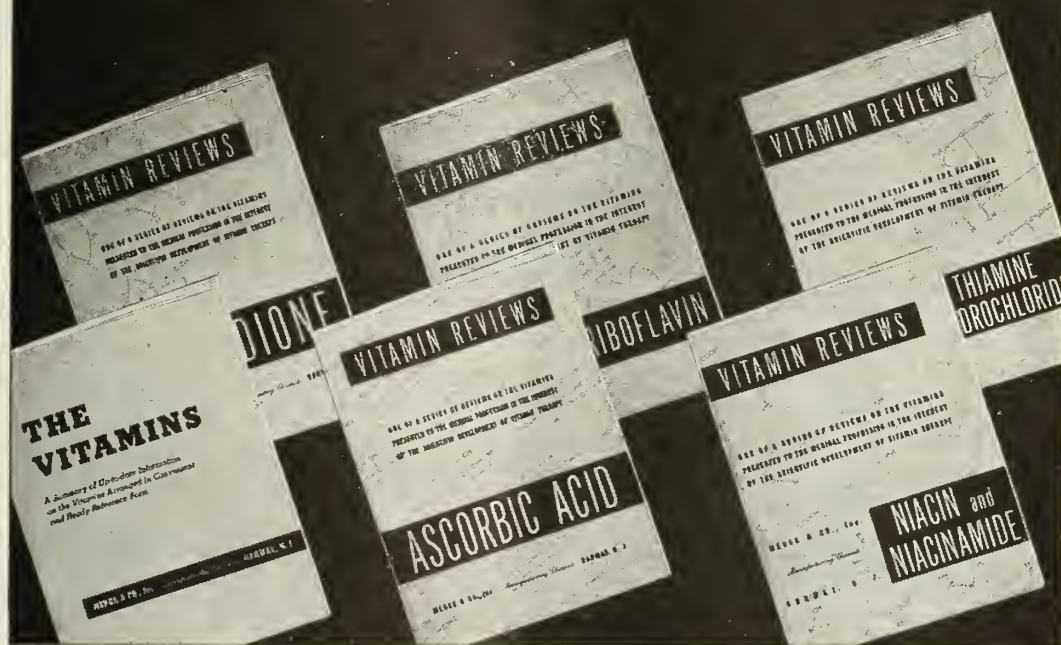
"In the present state of development this diagnostic method should not provide the exclusive basis for either the positive diagnosis or the positive exclusion of gastric tumor," they say, adding:

"The method is valueless except in the hands of an experienced and specially trained pathologist."

The physicians examined the cell structure of stomach contents of 278 patients with symptoms of gastrointestinal disturbance. In 59 per cent of all tests reported as positive the findings were confirmed by clinical and "conventional tissue" study. Findings in 85 per cent of the tests reported as negative were confirmed by other studies.—*Illinois Medical Journal*, February, 1949.

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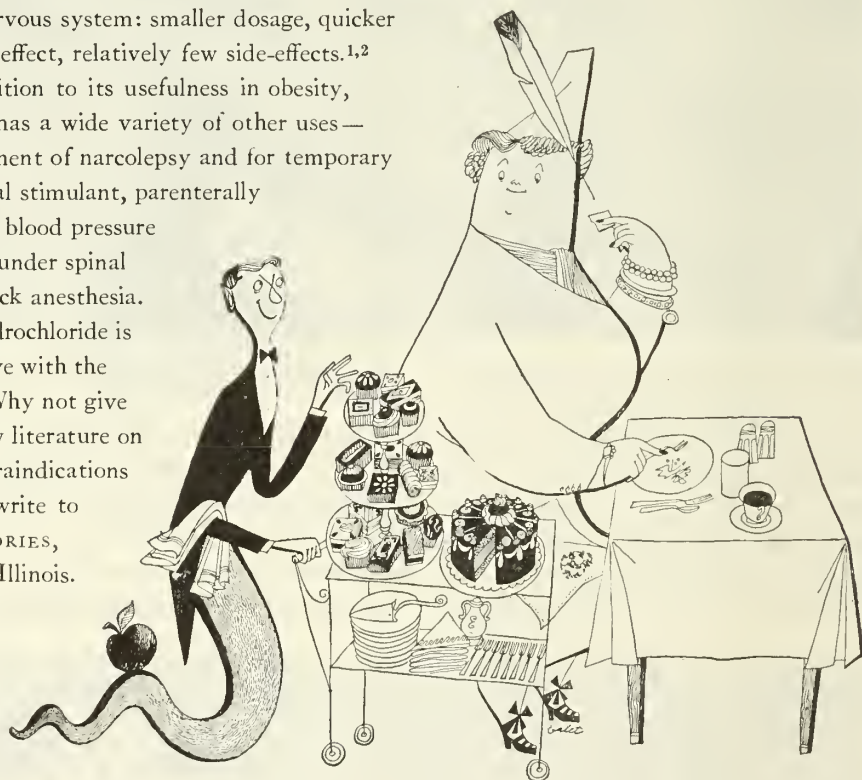
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1. Ivy, A. C., and Goetzl, F. R. (1943), d-Desoxyephedrine: A Review, War. Med., 3:60, January.
2. Davidoff, E. (1943), A Comparison of the Stimulating Effect of Amphetamine, Dextroamphetamine and Dextro-N-Methyl Amphetamine (Dextro-Desoxyephedrine), Med. Rec., 156:422, July.

THE PENNSYLVANIA MEDICAL JOURNAL

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NUMBER 6

MAN DEFENDS HIMSELF

CHARLES C. DENNIE, M.D.
Kansas City, Mo.

SCIENTIFIC medicine has developed with such giant strides in the last century that those who have aided in this development have forgotten that man, unaided, is able to resist diseases successfully. This lapse in the mental process of scientific practitioners has been responsible for the failure to cure syphilis by the aid of penicillin alone.

Bruusgaard and others have definitely shown that more than 25 per cent of all syphilitics cure themselves of their disease without the aid of treatment of any kind. Other workers have shown that heat alone will cause the disappearance of skin lesions, bone involvement, visceral complications, and neurosyphilis by increasing man's resistive power. The use of malaria and heat are two of the outstanding non-specific measures which alone often clinically cure these conditions without the addition of antibiotics or chemical compounds. Syphilologists in their zeal to see what penicillin would accomplish in the treatment of this disease neglected to use these proved methods of treatment in conjunction with it; consequently, the percentage of clinical cures in all types of syphilis is no greater than it was by the old method of seventy-two weeks of continuous treatment. The advantages of penicillin have been the reduction of the time element of treatment and the prevention of many new infections because those infected with early syphilis did not have the time to make the rounds as they

formerly did. Almost any kind of treatment will cure 25 per cent of those infected with syphilis; 25 per cent more are cured by a moderate amount of therapy, and 25 per cent are not cured by any means now known to medicine. It is this last persistent and devilish 25 per cent in which we are interested. Therapeutic measures are divided into four groups:

1. Specific Therapy.
2. The Therapy of Empiricism.
3. The Therapy of Desperation.
4. The Therapy of Frustration.

Specific therapy consists in utilizing certain specific therapeutic measures which are known to produce cures in the great majority of instances. These measures are based upon scientific certainties. There are few specifics used in medicine. By that we mean that there are few diseases in which specific drugs or antibiotics produce a cure—the quinine group in malaria, penicillin and the arsphenamines in the treatment of syphilis and certain other diseases due to spirochetosis, penicillin and sulfa used in the treatment of bacterial diseases. The old so-called specifics such as mercury, iodides, and bismuth are not true specifics.

In this paper penicillin is chosen as the greatest specific used in the widest range of diseases. No one could successfully contradict the fact that penicillin used in the treatment of seronegative syphilis is the true specific, since it cures 98 per cent of cases. It is likewise a true specific in the treatment of infantile syphilis and the syphilis of

Read before the Section on Dermatology at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 5, 1948.

Dr. Dennie is professor of dermatology at the University of Kansas Medical School.

pregnancy, but as the age of the syphilis progresses the efficiency of penicillin decreases. In a review of the literature in which over ten thousand cases of syphilis treated with penicillin are cited, it is clearly shown that as the age of the syphilis increases, the percentage of clinical cures falls.

The experimental use of penicillin alone must be discontinued. There are grave doubts that it should ever have been started. In studying these ten thousand treated cases more intimately, one finds that something can be done for the 25 per cent who are not cured by penicillin alone or with penicillin combined with other methods of treatment. It is a curious observation that Mahoney's four original cases treated with penicillin alone showed one, or 25 per cent, that was not cured. Whether it be four cases or ten thousand cases, that 25 per cent bounds up to confuse us. It is here that the members of the medical profession rest upon their oars while the waves of indecision batter their boats to pieces. They confidently and almost boastfully recite the fact that penicillin alone will cure between 70 and 80 per cent of the early type of syphilis if used properly, but never a word is said about the 25 per cent that remains uncured. That percentage is an astounding number of failures. By the general law of averages there must exist in those ranks just as many men and women of value to society as there were among those who were supposedly cured. What are we to do with these people? There are several doors open to us, but let us see now what penicillin has really done.

It has been well established that the use of penicillin alone in the treatment of early syphilis should not be further utilized. The syphilis of

pregnancy, seronegative primary cases, and early infantile syphilis are possible exceptions. In order to be on the safe side, treatment follow-up should be used on all of these cases. For many years we have veered on the side of undertreatment in early syphilis. Let us not make the same mistake again.

Since the combination of heat and penicillin seems to give the most favorable results, why not follow this procedure with ten weeks of arsenoxide and bismuth, two and one weekly for ten weeks? The percentage of serious reactions would be very small.

In the 17 per cent of failures a follow-up course of similar duration would in all probability materially reduce that figure.

The ideal course in early syphilis of all types would be (exceptions noted): 6 to 8,000,000 units of penicillin, three heat treatments—three hours each—at a temperature of 106 F., followed by ten weeks of treatment consisting of two doses of arsenoxide and one of bismuth, weekly.

In those in whom the serologic response is not favorable, an additional ten weeks of treatment should be given with an additional three heat bouts.

Neurosyphilis

In neurosyphilis of all types the report should make a distinction between paresis sine paresi, paresis, taboparesis, tabes, and neurosyphilis of other types.

When all of these conditions are grouped together, the percentage of favorable results rises because paresis sine paresi and neurosyphilis of all types, excepting the degenerative, respond more favorably than paresis, taboparesis, and tabes.

RAPID TREATMENT OF EARLY SYPHILIS

	<i>Penicillin</i>	<i>Injection Interval</i>	<i>Hours Heat</i>	<i>Retreatment (Per Cent)</i>	<i>Failure (Per Cent)</i>
* Worst treatment	10,000,000 to 20,000,000 intravenously	24 hrs.		52	62.8
† Best treatment:					
Schedule A	1,200,000	7½ days	9 hrs.		17.9
Schedule B	1,200,000	7½ days	none		29.6
	* 2,400,000				
	40,000	3 hrs.	9 hrs.	14	21.6
	* 4,800,000 POB				
	300,000	12 hrs.		13.1	29
	* 4,800,000 POB				
	600,000	24 hrs.		18.2	33.2
Penicillin failures in all early syphilis					25 plus
Neurosyphilis failures					37-38%

* Venereal Disease Division, United States Public Health Service, December, 1947.
† SCHWEMLEIN, BAUER, and BUNDESEN: *J. A. M. A.*, 137: 1209-12, July 31, 1948.

In our own experience certain types of acute paresis are made worse by the initial treatment with penicillin. We believe there should be a preliminary course of sodium iodide intravenously and bismuth intramuscularly with a few heat bouts before the penicillin treatment is instituted. We feel that the 39 per cent of failures which occur when penicillin is used alone could be reduced by sandwiching in heat bouts together with sodium iodide intravenously and bismuth intramuscularly. Not only one course of penicillin should be given but many of them. *It has been noted by some observers that the high initial good results do not hold but slip rapidly backwards to as low as 25 per cent when penicillin is used alone. The same observations are pertinent whether penicillin or the older methods are used in the treatment of neurosyphilis. Early involvement responds more favorably. A look at the pathologic background proves that this observation must be true. Penicillin is a Spirochaeta killer, but has no power of stimulating the defense mechanics of man. It is beneficial in early involvement of any type. When syphilitic disease is old, the invading organisms are few but the wreckage of individual cells and even tissue is great, against which penicillin has no action. Heat in some form is the greatest single aid in stimulating the human organism to clear away this wreckage. The administration of iodides assists in this task.

Our main theme in this whole paper is not to look continuously at the percentage of good results but to regard the failures with apprehension. Our main effort should be the reduction of these failures by utilizing other tested methods together with penicillin, heat, iodides, and bismuth. We have cases of paresis sine paresi which have recovered serologically without the blessings of penicillin. The results were obtained in elderly people by the judicious use of heat, sodium iodide, and bismuth.

Optic atrophy, on the other hand, does not respond well to penicillin, nor does it respond very well to any other treatment. We have found that heat, sodium iodide, and bismuth are the methods of choice. Not all patients can afford or have the opportunity of having cabinet heat used upon them; however, most patients have the opportunity to use a bathtub. Temperatures from 104 to 106 F. can be obtained in the home by the use of bathtub heat. Many patients who have had recurrences following penicillin alone have been successfully treated by this means.

It is clearly evident that the recognition and

revivification of the works and ideas of Wagner-Jauregg, Aschoff, and Walter Bruetsch must be reviewed. Recognition of the defense mechanism in man and the possibilities of its utilization must be accomplished. There has been a great deal of work done along this line, but it is not enough, nor has its possibilities been totally investigated. The work of Curtis shows that the utilization of malaria produces equally good results when compared with penicillin but that the combination of the two does not seem to add to the value of the treatment. He advises against malaria because of the mortality rate. On the other hand, Paul O'Leary and others think that the addition of heat and/or malaria greatly enhances the results of treatment with penicillin. If man's resistance will cure a certain percentage of syphilitic diseases without the aid of outside sources, certainly this resistance should be studied in ways not yet devised.

Research work should again be instituted in the study of the defense mechanism of man. It is entirely within the range of scientific possibilities that a drug can be produced, measured, and administered in quantities that will produce the desired rise of temperature, sustain it for the required amount of time, that is, four to six hours, and then allow the temperature to drop to normal without injury to the patient. Certainly heat has had the most astounding success in many individuals. The author can recall many cases. One paretic, the brother of a professor in a medical school, developed acute paresis. He was given an inoculation of malaria. On the third day his temperature rose to 108 F. He was cooled down to 106, where the temperature remained for twenty-four hours. That was the only treatment he ever had. He was clinically cured and has remained so for twenty years. A congenital taboparetic became suddenly unconscious; his temperature rose to 104 and above for seventy-two continuous hours. An examination of his blood and spinal fluid proved that he had no infection other than syphilis. The temperature suddenly dropped, the patient became conscious, and fifteen years later is still living, one of the very few of the many cases treated who is living today. The author's oldest paretic was also one of the first to be given malaria in this country. He occupied a position which required a great deal of technical skill. He was absent from this job for nine months. He has just been retired on account of old age, twenty-six years after the administration of the malaria. He is in perfect health with no vestige of his syphilis remaining, either clinically or serologically. Dozens of such cases could be recited.

* BARKER, L. P.: Penicillin in the Treatment of Neurosyphilis, *J. Investigative Derm.*, Vol. 10, March, 1948.

Nearly all of them were clinically cured by the administration of non-specific remedies. A few of them had short courses of tryparsamide and bismuth.

The second phase is the development of a new antibiotic or a new drug which has the power not only of stimulating the defense mechanism of the body but also of destroying the offending organism. This is the ideal remedy. It is not outside the power of scientific accomplishment. The arsphenamines have both of these properties in a moderate degree, but no drug or antibiotic has been developed which has both of these properties in a high degree. Penicillin is a strict killer and has not one iota of power to raise the resistance of man against his disease. It is realized that new avenues of approach will not cure all cases of syphilis. The statement is often made that many are in a hopeless state when treatment is instituted, that any method of treatment is useless. Yet some of the most desperate cases of paresis have responded to heat and malaria, while others with milder manifestations have died of their disease. These two extremes show that the strength of man's natural defense was underestimated in the one case and overestimated in the other. Upon the balancing of these two factors depends the cure of some of the lost 25 per cent. If one could cure but half of this number, a great advance would be made.

Examples of an Art

The Therapy of Empiricism may be defined as "the treatment of diseases of unknown etiology or known etiology with drugs which time and use have shown to be of some value." It is the true art of the practice of medicine. The treatment of arthritis by the administration of salicylates, diet in the treatment of gastric and duodenal ulcers, x-ray, radium, and the isotopes in the treatment of cancer and certain blood dyscrasias, diet and chrysarobin with the doubtful addition of vitamins and fat-splitting substances in the treatment of psoriasis, gold and bismuth in lupus erythematosus, calciferol in the control of tuberculous skin conditions, histamine desensitization in allergic conditions, mercury in the treatment of lichen planus, as well as ointments in the treatment of skin conditions, are examples of this art.

One often hears this dictum: if the cause of the disease is once discovered, the cure inevitably follows. The statement is based upon unsound logic. In some diseases the cause was discovered while the science of bacteriology was aborning. A notable example is the detection of the anthrax

bacillus in the production of that disease in man and animal and not much can be done about it even to this day. For the common disease of tuberculosis, no specific has been discovered. Leprosy today resists the age-old remedy of chaulmoogra oil and the new remedies of diasone and promin. On the other hand, we have been able to prevent certain diseases by medical maneuvers when the causes of those diseases have not even been demonstrated today, e.g., smallpox vaccination and streptomycin in the treatment of granuloma inguinale. Donovan's bodies are cited as the cause, but who knows what Donovan's bodies are?

All of these examples illustrate the fact that the Therapy of Empiricism has some value even though we do not know very much about a disease or why we treat it. When a new remedy comes out each month or even each year for an old disease of unknown etiology, we can be sure that it is not worth a tinker's damn, and we are only fooling ourselves when we use it. The answer is more scientific investigation of common skin diseases. We don't know the cause of rare skin diseases and less about their treatment, which is always unsuccessful, therefore it would be better to study the old diseases more thoroughly and provide more efficient methods of treatment. After the medical man has tried every known procedure on diseases of known and unknown etiology without success, he turns to the Therapy of Desperation.

The Therapy of Desperation might be defined as the treatment of a disease of unknown origin by therapeutic measures whose results are also unknown. The best example of this is the sectioning of the vagus nerve for the relief of gastric and duodenal ulcers. While some of the functions of the vagus nerve were known, its complete position in the economy and governing of the human body was not known and was not found out until after the vagus nerve had been sectioned, although the sectioning of that nerve had been performed upon animals. Duodenal and stomach ulcers were healed by this operation, but it made a garbage pail of the stomach.

This operation has been done for several years. It was suggested by one surgeon that all operations along this line be discontinued until ten years had passed in order to see what would happen to the patient and what were the functions of the vagus nerve. An operation that is almost as barbarous is the sectioning of the gray rami of the ganglia outside the spinal column for the relief of scleroderma. We have many theories as to the cause of scleroderma, some of them interesting but none of them true. The ex-

act cause is yet to be discovered. The only relief obtained in sectioning the upper middle and lower cervical ganglia was the apparent stopping of the progress of the disease and the parts became warm. One of the first patients upon whom this operation was performed is still living after fifteen years and every once in awhile we have to amputate the end of a finger. The condition did not improve. The disease ceased to progress, but it often does that whether an operation is performed or not. The ultimate of this operation was performed upon a soldier in whom every one of these rami from behind his ears to his saddle area were sectioned. The poor fellow could not have any peace, day or night. His symptoms increased. The skin manifestations remained the same. The operations along this line have ceased.

But even the theory of desperation is not enough. Most of these extreme procedures in therapeutics are either failures at best or at worst increase the victims' woes. Thus was born the Therapy of Frustration.

The Therapy of Frustration is defined as the treatment of diseases of unknown origin in which all drug or manipulation methods have failed and it is dimly suspected that the cause might lie in the psyche. The Therapy of Frustration is not frustration in the patient but frustration in the doctor. Thus the science of psychosomatic medicine was born. It is the greatest example of our inadequacy in the treatment of disease. The soothing of the disturbed psyche is the oldest form of medicine known to man. Psychosomatic medicine is the new term used to describe it. It has the least scientific background of any of the divisions of medicine, but the art of healing, whose child it is, has been developed to the highest point. It is a definite part of the modern art of healing, but only a part, except in the pure cases of pathologic or functional psychologic processes.

It took the medical men many centuries to finally awaken to the fact that they had missed the bus. Before any considerable percentage of them were aware that psychosomatic medicine had a large place in the entire picture, the patent medicine faker successfully vended his wares under the fluttering gasoline lamp and cured many of his patients, not by his medicine but by the impact of his personality. The laying on of hands, which is conducted by some individuals successfully during each generation, was but an example of psychosomatic medicine unknown as such to the charlatan. Religious groups with therapeutic aspirations flooded the land. The trouble with all of these groups was their suc-

cess. Their failures were due to the spread of their ideas to all diseases, whether due to infectious bacteria or broken bones.

Gradually we are beginning to be aware of the fact that an iron curtain has been drawn in medicine and that each successive step demands investigation behind yet another curtain. Thyroid disease with exophthalmos is now considered to be a complicated disease wherein the pituitary stimulates the thyroid; it in turn is stimulated by the hypothalamus and the hypothalamus got that way through some shock to the psyche. It is thought in certain quarters that diabetes is not primarily produced by withered cells in the pancreas but by impulses from the pituitary gland which burned out the secreting cells and that the pituitary is governed by certain portions of the brain, which in turn is disturbed by injury to the psyche. Since no other cause can be ascribed for the production of gastric and duodenal ulcers, they are beginning to be ascribed to the disturbed psyche. It is a well-known fact that these pathologic conditions often follow shock, tension, or sadness. It is thought that the pathologic impulses which produce peptic ulcers emanate from certain parts of the central nervous system, which is governed by the psyche. One psychiatrist has become famous because of her personal observations that fat people are sad because they are fat and fat because they are sad—dubious double talk which may or may not have some truth behind it. If we follow the concept of the iron curtain, she must be right.

Psoriasis has fallen into the group of psychosomatic problems, in which the psoriasis is attributed to frustration rather than faulty metabolism. Serious articles have been written on this subject and sub rosa conversation in medical societies seems to indicate that many of our top-drawer dermatologists are somewhat in favor of this view. Lichen planus is yet another disease whose flaking polygonal lesions are but evidences of the attempt of the psyche to expel into the skin the pathologic products that produced its panic.

Most of us agree that certain conditions are not handled in the proper manner, that we are treating many diseases in a haphazard and irrational manner, that we have not spent enough time in searching for the cause of *common* dermatoses, not the rare ones, and not enough research work has been done in perfecting exact and efficient therapeutic remedies. Therapeutic efforts are divided into two widely diverging groups—diseases due to known causes of various sorts seasoned with a sprinkling of psychosomatic medicine, and psychosomatic medicine tintured by a small amount of pathologic concep-

tions. The trouble lies in the direction that psychosomatic medicine makes it too easy to diagnose diseases. The psychosomatic physician has marvelous success in curing or at least in reducing the stimuli that disturb the psyche, but the vast majority of visible and detectable diseases of the soma are but little affected by correcting the ills that torment the psyche.

Psoriasis may have the acuteness of its symptoms reduced to some extent by psychosomatic therapeutics. On the other hand, it will be further reduced in many instances by taking out infected teeth or tonsils or by painting the lesions with a good stiff course of chrysarobin. The same thing may happen when suggestion is used in a case of lichen planus, but the best luck the author has had is by the injection of mercurial compounds. Intractable cases of urticaria sometimes disappear when irritating substances are removed which disturb the psyche, but the author has had considerable success in making a complete physical examination, examining the stomach for absence of hydrochloric acid, and ex-

amining the feces for the presence of parasitic ova, together with a well-controlled elimination diet. To this might be added a sprinkling of psychosomatic conceptions.

What I am trying to say is this—if one allows the concepts of psychosomatic medicine to be substituted for complete physical examination, an exact history, and reasonable therapeutic measures, he is going to have more failures than he would if he disregarded psychosomatic principles altogether. Thus psychosomatic conceptions must be one of the parts utilized in the practice of good medicine but not a major part and should never overshadow good common sense. That would be the easy way to escape hard work and clear-cut clinical observations. It would also throw sand in the cogs of scientific investigation. As a last word on this chapter then, one would say that psychosomatic medicine has an important part in modern therapy and will have yet a more important part, but it must never overshadow the foundations of physical medicine.

UPLIFTING GENERAL PRACTITIONERS

Robert Myers, M.D., president of the Missouri Chapter of the American Academy of General Practice, appeared on the program of the American College of Surgeons on Feb. 11, 1949, at the Hotel President, Kansas City. His subject was "Integration of the General Practitioner into the Medical Hospital Staff Organization." He ably presented four points which, to your reporter, seem worth repetition.

1. The general practitioner has been crowded into the medical and administrative background by the rise of specialism in the last twenty-five years—and a corresponding loss of influence with the people he serves. The general opinion has been, in recent years, that the practitioner group catches all the misfits and incompetents of medicine. This idea must be changed.

2. The family doctor must be brought up to date in all points of general medicine and surgery by postgraduate and refresher courses, which are now being offered by leading teaching centers in this country. In order to retain membership in the American Academy of General Practice, he must complete fifty hours per year in recognized study.

3. Two years additional training is being recommended by the National Academy of General Practice before entering practice. The directors of the national group have under consideration extending the general practitioner training to a third year. It is their belief that this group of medicine must have a much wider knowledge because of the fields to be covered. This program is a most ambitious one and deserves serious consideration. Medicine must advance from the "grass

roots" as well as at the top. The family doctor must raise his own standards.

The third part considered by Dr. Myers was the trend to socialized medicine; in his opinion the family physician is a great bulwark against continued encroachment of the government in the field of medical care. He cited statistics which never have been successfully refuted. More than 60 per cent of the doctors in the U. S. A. are general practitioners—they do 80 per cent of the general care of the sick—50 per cent of the obstetrics—40 per cent of the major surgery. In direct proportion to the disappearance of the general practitioner, and his loss of prestige, so will the government agencies advance their claims for inadequate medical care.

4. The fourth part of the discussion centered around closing doors of opportunity for the practitioner in hospitals. These institutions have become the workshops for all doctors, and the family doctor must not be discriminated against. On the other hand, he must measure up to the standards of better medicine and surgery and assume his share of responsibility in improving the quality of medical care. There should always be a working partnership between the practitioner and the specialist.

The address was closed with this thought: "The American system of medical practice, recognized as the finest in the world, is based on the concept that competent and conscientious general practitioners, occupying the role of the time-honored family physician, shall be the keystone of that system. Unless this indispensable practitioner is preserved, our system, as we know it, will collapse."—*Jackson County (Mo.) Medical Society Bulletin*.

Vertigo: Diagnostic and Therapeutic Considerations

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VERTIGO may be defined as a subjective experience (consciousness) of a disturbance in the relationship of the individual to his surroundings (disorientation in space), accompanied by a feeling on the part of the subject that either he is moving in space or that objects in the outer world are moving about him. While vertigo as here defined is common, many patients complain of various sensations such as dizziness, giddiness, reeling, light-headedness, swimming, faintness, cloudiness before the eyes, losing control of the body, nausea, and other designations which may or may not reflect components of true vertigo and are not infrequently unaccompanied by any feeling of movement.

From a clinical standpoint, vertigo is a common occurrence and frequently presents diagnostic and therapeutic difficulties. It is believed that a better understanding of the known anatomicophysiologic basis of this symptom will simplify the diagnosis and management in these cases and this will therefore be discussed first.

Anatomicophysiologic Basis of Vertigo

Spacial orientation, that is, the appropriate position of the various parts of the body in space, at rest and in motion, depends on a complex organization of which the following components are of clinical interest.

Afferent Pathways.—These pathways convey impulses to the central mechanisms and include:

1. The labyrinth. This is a highly specialized organ in which the semicircular canals are sensitive to movement and angular momentum, while the otoliths are probably concerned in the adaptation of the organism to gravity.

2. Proprioceptors of the neck region. The proprioceptors of the joints and muscles of the neck are important in relating labyrinthine impulses which convey information concerning the position of the head in relation to the rest of the body.

3. Proprioceptors of the trunk and lower

limbs. These are concerned with the position of the body in relation to the acts of walking, standing, and sitting.

4. Proprioceptors of the ocular muscles. These are concerned with the problems of focusing, accommodation to distance, and observation in the various parts of the fields of vision.

5. Retinal impulses. Visual impulses derived from the retina are obviously concerned with spacial orientation.

Central Mechanism.—The afferent impulses derived from the various end-organs are integrated in a central mechanism including the vestibular nuclei, posterior longitudinal bundle, the cerebellum, the red nucleus, and neural pathways reaching the cerebral cortex, probably in the temporal, frontal, and possibly parietal lobes (see diagram).

It is suggested that disturbed function anywhere along the end-organs, or the afferent pathways, or in the various components of the central mechanism may result in some form of vertigo.

Normally, the end-organs, the afferent pathways, and the various components of the central mechanism operate in a manner of which we are totally unaware, comparable to the other viscera which are physiologically silent. A disturbance in any of the above-mentioned pathways or any portion of the central mechanism gives rise to a false perception which the patient interprets as vertigo. Vertigo is in reality a form of illusion due to a physiologic disturbance causing a false sense perception.

The most clearly defined vertigo is the type in which the person feels as if he is rotating (subjective vertigo) or in which he feels that surrounding objects are turning around him (objective vertigo). This occurs most commonly in disturbances of the peripheral organ, namely, the labyrinth, though it rarely may occur in ocular disturbances. It is generally true that the most clearly defined types of vertigo are due to the disturbances of the labyrinth and that the further the lesion is from the labyrinth, the less clearly defined vertigo is.

Read before the Section on Nervous and Mental Diseases at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 7, 1948.
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In considering vertigo, one should take into account its type, severity and duration, and associated symptoms.

The severest type of vertigo occurs in association with diseases of the labyrinth and with certain lesions of the brain stem, notably in occlusions of the postero-inferior cerebellar artery.

Vertigo is often episodic and paroxysmal. This is best seen in lesions of the labyrinth where paroxysmal attacks of vertigo, rotational in type, lasting from minutes to hours and even days, are accompanied by fear of movement of the head, tinnitus, impairment of hearing, nausea, vomiting, and prostration. In addition, there is often nystagmus, either horizontal or horizontal-rotary in type. In the great majority of cases, the tinnitus and impairment of hearing are unilateral, but bilateral labyrinthine symptoms are not uncommon. Severe lasting attacks of vertigo are rarely observed in lesions of the central mechanism, but do occur occasionally in posterior fossa tumors, and especially in occlusions of the postero-inferior cerebellar artery, and in Bruns' syndrome. Bruns' syndrome is characterized by episodes of severe vertigo, headache, and visual disturbances on movements of the head, and is due to cysts and tumors in the fourth ventricle.

The closer the lesion is to the labyrinth and eighth nerve, the more likely is there to be found tinnitus and impairment of hearing. However, rarely, auditory symptoms may be lacking, even in lesions of the labyrinth. Vertigo due solely to lesions of the brain stem, cerebellum, or cerebrum are unaccompanied by tinnitus or impairment of hearing.

Sudden changes in position of the head may precipitate or increase vertigo in lesions anywhere in the neural pathways, but are best noted in labyrinthine lesions and in lesions of the brain stem, in Bruns' syndrome, and in the post-concussion states.

Nystagmus is a common but by no means constant accompaniment of vertigo. It is commonly noted in labyrinthine involvement when it is horizontal or horizontal-rotary in type. It is frequent in lesions involving the vestibular nerves, the vestibular nuclei, and the posterior longitudinal bundle. In these situations it may be horizontal or vertical, and when vertical it can be stated with certainty that it involves not the labyrinth but the above-mentioned neural pathways. Nystagmus does not occur in lesions involving only the cerebrum.

Nausea, vomiting, pallor, bradycardia, tachycardia, prostration, and other vegetative symptoms may occur in association with vertigo in

any part of the neural pathways, but are most marked in lesions of the labyrinth and the brain stem.

Other associated symptoms of vertigo include incoordination of the trunk and limbs, falling reactions, and abnormalities in the various Bárány tests which are at times extremely useful in localizing the lesion.

Clinical Types of Vertigo

The clinical types of vertigo are best discussed from an anatomicophysiology standpoint rather than from the standpoint of frequency. From the standpoint of frequency, vertigo occurs most commonly in the psychoneuroses, especially the anxiety states, in states of disturbed cerebral circulation, and in post-traumatic states. From the standpoint of severity, they are most frequently observed in labyrinthine disease and in lesions of the brain stem. There are some notable exceptions to this generalization.

Aural Vertigo.—Aural vertigo is observed in association with the following etiologic factors:

1. Obstruction of the external auditory canal or of the eustachian tubes.
2. Sudden changes in atmospheric pressure, sea- and air sickness.
3. Acute, subacute, and chronic infections of the middle ear and adjacent regions in the temporal bone.
4. Cholesteatoma, hemorrhage, and embolism in the temporal bone.
5. Otosclerosis.
6. Vascular disturbances accompanied by severe anemia, hyperemia, polycythemia, vasomotor instability, carotid sinus hypersensitivity, and increased intracranial pressure.
7. The various forms of labyrinthitis.
8. Herpes zoster of the geniculate ganglion.
9. Ménière's syndrome.
10. Drug intoxications.

Aural vertigo varies in severity, duration, and in the number and severity of associated symptoms. The severest forms are seen in acute labyrinthitis or perilymphitis and in Ménière's syndrome. In these conditions there is not only subjective or objective vertigo but, in addition, tinnitus, impairment of hearing, nausea, vomiting, nystagmus, and ataxia of the trunk and limbs. The presence of tinnitus and impairment of hearing localizes the lesion in and or near the end-organs, that is, the temporal bone, and is of significant diagnostic importance.

Acute labyrinthitis or perilabyrinthitis may occur in association with acute or subacute otitis media, but may also appear suddenly in the course of chronic temporal bone infections and not infrequently in the course of silent or forgotten temporal bone infections. It may be suppurative or non-suppurative. In acute labyrinthitis there are associated evidences of local and systemic infection. There is often pain in the ear, also aural discharge. The patient lies on one side, usually the sound side, and on attempting to get up falls to the side of the lesion. The nystagmus is horizontal-rotary in type and the quick component is to the sound side to which the patient feels he is falling. Acute labyrinthitis must at all times be differentiated from meningitis and especially from brain abscess.

Ménière's syndrome (recurrent aural vertigo) is a common condition, the cause of which is not clear. Characteristic clinical features include the occurrence of attacks of severe rotational vertigo accompanied by tinnitus and increased deafness, nystagmus, vomiting, and prostration. Between attacks there is usually tinnitus and impairment of hearing, and these symptoms increase during the attack. In rare instances there may be loss of consciousness during the attack. The attacks vary in frequency and severity and tend to decrease as deafness increases.

The etiology of Ménière's syndrome is not clear. In Ménière's case there was a hemorrhagic exudate in the labyrinth. Others consider Ménière's syndrome to be due to a disturbance in the lymph circulation such as an acute hypersecretion producing an acute hydrops of the labyrinth; edema of the labyrinth due to disturbances of water or salt metabolism; increased permeability of the capillaries of the labyrinth and of the choroid plexus; vasoconstriction of the labyrinth capillaries; allergic reactions; hypersensitivity of the carotid sinus; spasm of the auditory artery, and compression of the eighth nerve in the posterior fossa.

The author has observed a number of cases with a Ménière-like syndrome due to unusual forms of intoxications including formaldehyde, insecticides, and other causes which will be reported in another presentation.

The treatment of the Ménière syndrome is not uniform. The following suggestions are offered:

1. Search for some etiologic factor, especially some toxic factor.
2. The use of vasodilators, especially nicotine and thiamine chloride. From 100 to 200 mg. in divided doses daily has been found useful.

In severe cases these agents may be given intravenously or subcutaneously.

3. Histamine. In severe vertigo, this is sometimes useful; 2.75 mg. of histamine acid phosphate dissolved in 250 cc. of normal salt solution is given at the rate of 30 to 40 drops per minute over a period of two and a half hours. In milder cases, histamine may be administered as follows by the subcutaneous route: an initial dose of 1/10 cc. and increase 1/10 cc. daily until the patient takes a full cc., and thereafter 1/2 to 1 cc. every three to five days, gradually decreasing the frequency of the administration as the symptoms improve.

4. The Furstenberg régime. This is a régime which has for its purpose the overcoming of a disturbance of water and salt metabolism and reduction of the edema of the labyrinth. Furstenberg advises a diet low in salt, elimination of sodium, an abundance of animal protein and cereal products, and a limitation of vegetables, fruit, and milk. In addition, Furstenberg advises the use of six capsules three times daily, each capsule containing 7 1/2 grains of ammonium chloride. He stresses the importance of not using chocolate-coated or enteric-coated pills. He advises that this dosage be continued for three days and then omitted for two days. With this régime there is no restriction of fluid.

5. Surgical procedures—section of the eighth nerve in the posterior fossa and labyrinthectomy by electrocoagulation.

Some forms of vertigo probably originating in the labyrinth are unaccompanied by tinnitus, deafness, or nystagmus but are accompanied by severe disturbances of the vegetative nervous system such as nausea, vomiting, and prostration. This is particularly true in sea- and air sickness which are evoked by repeated movements of the organism in unaccustomed planes, and may also occur in the early stages of the so-called Ménière syndrome.

Vertigo Due to Lesions in the Eighth Nerve.

—This may be due to inflammatory lesions such as in arachnoiditis, neoplastic processes, or compression by an aneurysm. The conspicuous symptoms in lesions of this sort are tinnitus and impairment of hearing, while vertigo is neither common nor severe. Tumors around the acoustic nerve (neuromas and meningiomas) are rarely accompanied by the Ménière-like syndrome.

Vertigo Due to Lesions in the Brain Stem.

This is relatively common. It is seen in its most typical and severe form in occlusions of the posterior-inferior cerebellar artery and is readily

diagnosed by associated symptoms. It also occurs in other vascular lesions of the brain stem such as occlusion of the superior cerebellar artery. Brain stem lesions may be responsible for the vertigo of some post-traumatic states. Vertigo may be the earliest manifestation of multiple sclerosis and may occur at any stage in multiple sclerosis. It is also observed in syringobulbia and rarely in neoplastic processes of the brain stem with or more commonly without Bruns' syndrome, various forms of encephalitis, and syphilis. The diagnosis in these cases depends on the evaluation of the associated symptoms pointing to the involvement of the brain stem.

Vertigo in Cerebellar Disease.—Cerebellar involvement per se will give rise to neither vertigo nor nystagmus. In neoplasm and abscess of the cerebellum, there may be pressure upon the vestibular nuclei or nerves which may give rise to a varying degree of vertigo.

Vertigo Due to Ocular Lesions.—Spatial disorientation due to false projection of the visual fields or to the involvement of the extra-ocular muscles is not uncommon and is often alarming to the patient.

Vertigo Due to Cerebral Disturbances.—This occurs most commonly as a forerunner to the various forms of a stroke and is commonly associated with thrombosis, hemorrhage, and embolism of the cerebral blood vessels. It is often the only symptom of cerebral arteriosclerosis without any focal signs. The anemia and hyperemia of the brain found in association with cardiovascular renal disease, with the severe anemias, with polycythemia, and with febrile reactions are commonly accompanied by vertigo. It is not uncommon with all forms of encephalitis, but especially syphilitic meningo-encephalitis. Carotid sinus hypersensitivity with diminished cerebral blood flow may produce vertigo and syncope. It may occur in association with brain tumors unaccompanied by increased intracranial pressure. It is occasionally observed in association with

migraine. Vertigo may reflect the aura of a grand mal attack or may be associated with petit mal attacks. In vertigo due to cortical disturbances, tinnitus and impairment of hearing are rare, but nausea, vomiting, and other vegetative nervous system disturbances are relatively common.

Vertigo Due to Cranial Trauma.—Cranial trauma is often followed by vertigo. The mechanism of this is not altogether clear, but it is a common experience. It occurs most typically in post-concussion states when it is usually postural in type, that is, the patient develops vertigo in sudden changes of the position of the head and it is often accompanied by bouts of headache. Frequently when the patient suddenly changes the position of the head, the complaint of vertigo is accompanied by a horizontal nystagmus which lasts for the duration of the vertigo. However, it is to be remembered that slight cranial trauma is often followed by a complaint of vertigo which probably reflects a psychogenic situation rather than a true vertigo.

Vertigo in Increased Intracranial Pressure.—This is not uncommon. There are many theories regarding its etiology. There are many who hold that it is due to a choked labyrinth.

Vertigo Due to Systemic Causes.—Any systemic disorder may produce vertigo, though the exact modus operandi is not known. Thus, it is commonly observed in arteriosclerotic cardiovascular renal disease, hypertension and hypotension, in anemia and in plethora (increased red corpuscles), and the various blood dyscrasias, in allergic reactions, in gout, diabetes, hyper- and hypothyroidism, avitaminosis, drug intoxication such as with salicylates, quinine, nicotine, alcohol, formaldehyde, and some of the insecticides, and probably rarely in focal infections.

Vertigo Due to Psychogenic Factors.—This is probably one of the commonest forms of vertigo. It is often ill-defined and is rarely rotational in type. It should be carefully differentiated from sensations that do not reflect true vertigo. Dizziness, giddiness, etc., are merely words used by the sufferer to convey an unpleasant feeling and probably have no actual relationship to physiologic disturbances. However, true vertigo does occur in the psychoneuroses and actual neuroses, and undoubtedly reflects a physiologic disturbance somewhere along the anatomicophysiologic pathways produced by circulatory alterations. In the author's experience the so-called giddiness of the psychoneurotic is a symbol of marked insecurity, and in the post-traumatic litigation

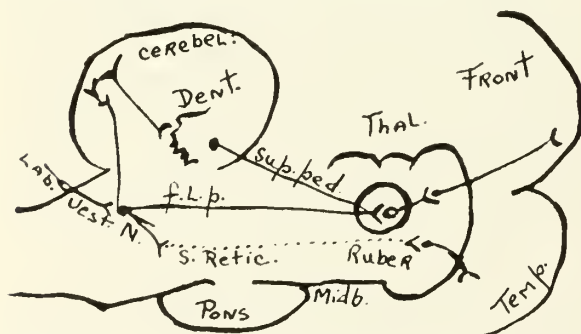


Diagram of spatial orientation—vestibular components (after Spiegel).

cases it is in addition an expression of resentment and hostility of long standing which the individual is trying to work out through his so-called giddiness.

Relative Frequency of the Various Clinical Types of Vertigo.—From a practical standpoint, it may be well to point out the relative frequency of the various types of vertigo. Bearing in mind the anatomicophysiologic basis of the symptoms, the *mild* types of vertigo are to be found most commonly in the psychoneuroses and neuroses associated with states of anxiety and their equivalents in which vertigo reflects a disturbance in the capillary circulation in the various pathways concerned with spacial orientation. Numerically, the next common type would be the one associated with cerebral vascular disease where again labyrinthine components are not conspicuous. Next in frequency probably are the labyrinthine and brain stem lesions which are most clearly delineated and are severest in type.

Diagnosis

The etiologic diagnosis of vertigo requires a careful evaluation of the various historical data and a careful clinical examination including routine and special laboratory procedures.

In evaluating any vertigo, one should procure a careful description of the sensations experienced by the patient. The presence of tinnitus, impairment of hearing, and other auditory disturbances should be carefully considered. In every case an attempt should be made to localize the lesion and to search for causes. In the majority of cases the Bárány tests are invaluable if properly performed. Rhino-otologic examinations should be the rule in any case of lasting vertigo. Neuro-ophthalmologic studies are helpful in the majority of cases. Obviously, a careful neurologic examination and a careful somatic study are necessary in most cases.

The differential diagnosis is at times difficult since it takes in so many phases of the various specialties. It is my belief that if one thinks of vertigo in terms of anatomic localization, an etiologic diagnosis will be successful in the majority of cases though it may require some observation and therapeutic tests.

Treatment

The treatment depends a great deal on the underlying etiologic and pathologic factors. The treatment of Ménière's syndrome has already been discussed. Several types of other forms of aural vertigo are problems for the otorhinologist.

Ocular vertigo often yields to refraction and other ophthalmologic measures.

The organic diseases of the brain stem, cerebellum, and cerebrum are benefited by various palliative measures, and some neoplastic processes require surgical intervention.

The removal or correction of the various systemic factors is often helpful. Many circulatory and metabolic disturbances are amenable to treatment if properly diagnosed.

Psychogenic vertigo is a problem for psychotherapy which implies psychologic investigation by one of the several methods currently in use. In addition, the author has found the use of histamine quite helpful as an adjunct to psychotherapy in cases of psychogenic vertigo.

ABSTRACT OF DISCUSSION

JOHN A. MALCOLM (Pittsburgh): Dr. Yaskin has left little to be said. In a limited time he has covered this problem extremely well. However, I will re-emphasize certain clinical aspects.

A few years ago in Pittsburgh we had a symposium on vertigo. It was my job to present the problem from the neurologist's point of view. That discussion was later published in the *Laryngoscope*, and I find that our opinions about this problem are, on the whole, very much in agreement.

A diagnosis, of course, is the first consideration. We must know with what we are dealing before we attempt to treat it, and I always like to emphasize history. In the majority of cases the patient is not dizzy when he comes to the office. We depend upon him for a description of his symptoms and a history of the sequential events. The thing I want to know first is whether it is vertigo, and many times it is not, because a sensation which is described as a visceral symptom, which the patient calls dizziness, is, in my conception, not true vertigo.

As a neurologist primarily, a neurologic examination takes first place; a general physical examination, of course; then later, in the cases in which diagnosis is not apparent or in which the etiology is obscure, examination by specialists in other fields.

We should keep in mind, I believe, that the primary aim is localization of the lesion, just as it is in neurologic diagnosis. That should be done before we consider etiology or the type of lesion. That, I believe, is the neurologist's responsibility, either to localize the lesion in the nervous system or exclude it from the nervous system and leave the problem to a physician in another field.

The etiology is frequently obscure, although in the majority of cases some clarification can be made.

I am going to take issue to some extent with Dr. Yaskin's opinion about the occurrence of vertigo in psychic disorders. Perhaps my criteria are too limited, but I believe that true vertigo is relatively rare in the psychoneuroses. The complaint of dizziness is a very common one, but when analyzed, it is found to be not a sense of actual motion, which I believe is an essential part of vertigo. There is frequently a feeling of instability, but there is not a loss of balance. These patients can maintain balance, and they perform the various equilibratory tests very well. When vertigo does occur in a psychoneurosis, I am more inclined to believe that it is due to some concurrent physical trouble.

In these days of psychosomatic medicine it is almost

unsafe to say that an ingrown toenail is not due to an introverted personality. I cannot believe that the vasomotor instability in psychoneurosis may produce a true vertigo. Therefore, let me make myself clear. I do not say that psychoneurosis cannot cause vertigo, but I believe that we will make fewer errors if we think in terms of organic disease first.

This problem of diagnosis brings into the picture the efforts of workers in other fields, general medicine and otology particularly. We have a good many arguments in Pittsburgh with the otologists as to the value of the caloric or vestibular tests. A number of these men minimize their contribution. I think it is because they do not really want to do them. The test is tedious and requires careful interpretation. Comparatively few physicians can take the time to do it. If you have an otologist who will do it, he is a great help, because he can do more perhaps than anybody else in distinguishing between the affections of the labyrinth, the eighth nerve, and the central mechanism.

Of course, the ophthalmologist, roentgenologist, and the neurosurgeon are helpful, the neurosurgeon more for treatment. I am speaking of those cases which are not neoplastic or abscessed.

I hesitate very much to consider section of the eighth nerve to cure vertigo. In a few isolated cases something must be done, because the individual is so miserable and incapacitated that he must have help. I have in mind three cases in which the lesion was localized to the eighth nerve, with recurrent violent paroxysms of vertigo. At operation, the purpose of which might have turned out to be section of the eighth nerve, not an aneurysm but a vascular arterial anomaly was found to be irritating the eighth nerve and, of course, a cure resulted.

Perhaps I should say that in this group of other fields we should include the psychiatrist.

In connection with the operation on the labyrinth, we had one otologist in Pittsburgh who was very much interested in this—he is not the only one—but who makes a diagnosis of hydrops of the labyrinth, which was mentioned in this paper. He exposes the membranous labyrinth and coagulates the fluid with an electric needle. First he thought there would be no impairment of hearing, but it does impair the hearing later. However, it does help very much in the cure of the vertigo.

I am going to close my discussion with a question for Dr. Yaskin. We know that vascular disturbances do have an important part in causing paroxysmal vertigo. I wonder if he has had any experience with injection or operation on the cervical sympathetic nerve for relief of these conditions.

RUDOLPH JAEGER (Philadelphia): I want to compliment Dr. Yaskin on his very clear coverage of this subject. I think it was a classical discussion.

I would like to speak about one disorder which he mentioned, of which I think I know something, and I know the neurosurgeon has a cure for it. In my experience this cure has been 100 per cent.

I do not speak of coagulation of the labyrinth, because Dr. Malcolm says that sort of treatment "helps very much," in his words. That is not enough. We have plenty of treatments which "help very much." We want a specific, certain cure for Ménière's vertigo, and the positive, safe cure is by section of the vestibular portion of the eighth cranial nerve.

I should like to emphasize the utter uselessness of the multitude of medical treatments for this disease, and

this includes histamine, which now is a "cure" for almost every neurologic and a good many medical disorders, dehydration, the sodium-free diet, and so forth. The medical treatment of this disease, in my opinion, is entirely psychotherapy, and it has never cured or actually helped a true case of Ménière's disease.

The operative cure of this disorder (which was discovered by Walter Dandy) is by cutting the vestibular portion of the auditory nerve. It leaves no disability; it is safer than a tonsillectomy in the hands of a skilled nose and throat surgeon, if done by a skilled brain surgeon. I certainly have no patience with those physicians who treat these poor, suffering individuals on and on and on by this and that medical treatment.

This criticism does not include all cases of Ménière's disease, because some are very mild, but most doctors who treat this disorder medically are deluded by the fact that the spontaneous remissions are the effect of the specific treatment in their hands.

HANS H. REESE (Madison, Wis.): I shall not discuss this paper in detail. We have to differentiate primarily whether we want to use histamine as a vasodilator therapeutically or whether we want to use it for desensitization in patients "allergic" to it.

Horton's treatment is (1) a histamine infusion therapy against vasospastic or vasoparalytic factors, and (2) a valuable desensitization against histamine allergy. Dr. Yaskin, you outlined only a histamine regimen in which you are desensitizing your patients, but you are not treating vasoconstrictive problems by your recommendation.

Dr. Jaeger is too emphatic in his statement that only the neurosurgeon has the cure for Ménière's syndrome. The neurosurgeon should come into the picture after our patients have been treated unsuccessfully with some of the often very beneficial procedures (salt-free diet, acidifying with ammonium chloride, and replacement of the sodium chloride by potassium chloride). In my experience of over twenty-five years, there are many mechanisms which give rise to a clinical syndrome of Ménière's disease, which under medical treatment subside; but if the severe vertigo persists, surgical resection of the vestibular nerve is recommended and its results are attested by Dr. Jaeger's discussion.

JAMES W. MCCONNELL (Philadelphia): I am not here to argue with Dr. Yaskin about anything.

It is said that the prophet is not without honor, save in his own country, among his own countrymen. I have always regarded Dr. Yaskin as a most meticulous research man in anything he does, but I failed to hear him mention one thing from my personal experience, which caused a great deal of discomfort and was called vertigo and incoordination.

One morning I attempted to get out of bed and fell to the floor. I had not known that I had any disease of any kind, but something had occurred during the night. My son helped me to get back into bed. I thought I would try it again, and I fell to the floor the second time. I had no nausea, but I had a queer uncertain feeling in my head which resembled vertigo, and I certainly had complete incoordination.

I called up my highly regarded friend, Dr. Walter Roberts, who is a leading aurist in this town. I said, "Walter, I have an acute vestibulitis." He said, "Bill, you are wrong; you have an abscessed tooth."

I had never had a bit of trouble with my teeth up to that time. I had my chauffeur drive me to the dentist's office, and he extracted the tooth. It was definitely ab-

scessed, but had given me no pain or anything else. I therefore think we ought to include a bad tooth.

Dr. YASKIN (in closing): I would first like to thank the discussants and to state that it serves me right for not reading my paper, because my patients do have focal infections, including sinuses and teeth, and I left out something much more important. Tobacco is a common cause of vertigo, and I know it is, because I had it, especially in Vienna, from their poor cigars. I had both vertigo and a loss of hearing in the high tones. So I am very grateful to the doctor for bringing up the problems of nicotine, which are included in the paper.

Regarding Dr. Malcolm's remarks, which were very helpful, I will try to answer his question about sympathectomy, or injection of the ganglion. We tried this on a number of cases several years ago, and both migraine and Ménière's syndrome are apparently not amenable to these neurosurgical procedures, at least not in my experience.

Dr. Malcolm made a strong point of the fact that, in his experience, vertigo is not common in the psychoneurosis. It was the thesis of my paper to bring out the fact that vertigo may vary in severity and in quality from the extreme vertigo observed in labyrinthine disease to a feeling of unsteadiness such as you and I have when we have a temperature of 101. You may go to the bathroom and feel as though your head is swimming. That is vertigo, nevertheless. Based on a careful study of my cases, I find that it is quite a common symptom, and if Dr. Malcolm accepts my definition of vertigo as being what it is, with a slight deviation, slight disorientation in space, then I believe that, in my experience, it is common. Here, again, I believe that it

is a physiologic situation, purely psychosomatic, and apparently it is helped by certain medicinal agents.

Dr. Malcolm emphasized the value of certain tests. I do not believe that I would like to run my clinic without them, not for vertigo so much as for differentiating posterior fossa tumors from those above the tentorium. Very often these tests are the determining factor for our studies and operative procedures.

As to Dr. Jaeger's remark, he tells us that the various medical methods which are used are really forms of psychotherapy. Suppose it is psychotherapy. After all, psychotherapy still has some value in this world, and a great many people do get well with psychotherapy. However, I question whether it is all psychotherapy. I am quite sure that Dr. Jaeger did not mean to imply that every patient who comes to his office with Ménière's syndrome is rushed to the surgical department for operation. What he probably meant to say was that severe cases of Ménière's syndrome, which do not yield to symptomatic treatment, lose a great deal of time from work, and are inefficient, should be given the benefit of some form of surgical procedures. Being trained by Dandy, he naturally prefers the section of the nerve. There is a great deal to be said in favor of nerve section in severe cases which do not yield to medicinal treatment. For one thing, now and then one finds not only a vascular anomaly, as Dr. Malcolm found, but tumors which are not suspected, and a lot of other things which are amenable to surgery.

Dr. Reese's remarks, I believe, are valuable. His point that histamine is a desensitizing procedure rather than a substitution form of treatment is something which I think I know less about than he does.

THE DOCTORS' PLAN

The American Medical Association yesterday offered organized medicine's alternative to compulsory health insurance.

The plan proposed by the doctors would establish a Federal Department of Health, under a physician-director who would hold cabinet rank.

The responsibility of the department would be to coordinate all federal health activities, except in the armed forces, and expand voluntary hospital and medical care endeavors.

Among the objectives listed by the A.M.A. are new medical and hospital facilities, including those for care of the aged and chronically ill, stepped up medical and nursing education, medical research, public health education, and other programs.

The plan, essentially, is a counter-proposal to President Truman's call for "free" medical care for everyone, supported by a tax on payrolls and directed by an enormous extension of federal bureaucracy.

As such, the doctors' recommendation deserves close consideration by the public because in this issue is the loaded question of freedom versus the paralytic regimentation of socialized state control.

The doctors' plan appears to meet, with a sense of freedom, all of the goals which the President claimed are necessary in the medical field if we are to be a nation of healthy people, blessed with all the benefits of the progress in medical science.

A man from Mars might wonder what the argument is about. America has more medical facilities now than any other country on the globe. It leads in numbers of doctors, nurses, drug manufacturers, hospitals, and cases treated.

Despite the rejections as physically unfit in the first stages of the draft in World War II, a matter which provided ammunition to the medical socializers, Americans are healthier and more vigorous than their contemporaries anywhere.

We Americans are living longer. Fewer of us are dying from ailments. Many more of us are having our troubles corrected by surgery. We are obtaining more medicine, as such, and we are fighting, and in many cases winning, brilliant battles against all types of disease.

Why should the free system, which provided such achievements, now be subject to abrupt change? The answer is in the socializing currents of this age, flowing mainly from Europe, and ready, unless diked, to engulf us.

The doctors' plan, as submitted yesterday, is an effort to build this dike. It represents some sacrifices of principle, but it retains the basic philosophy of freedom. With the importance of this generally realized, it may be the means of saving America from sinking, as England has done, into the bureaucratic flood.—Editorial, McKeesport *Daily News*, Feb. 7, 1949.

Pennsylvania's School Health Program

SAMUEL J. DICKEY, M.D.
Harrisburg, Pa.

BEFORE I discuss the topic assigned to me, I should like to bring to this representative group of medical men the thanks of the Secretary of Health and those of his staff who are charged with the administration of this program. Particularly, I wish to thank Dr. Donaldson and Dr. Palmer for their fine cooperation and assistance in working out many knotty problems which have naturally arisen in carrying out the provisions of the acts. I also wish to extend the thanks of the department to the many medical examiners who, in most instances, have done yeoman service in making the program a success. This is demonstrated by the fact that in the past school year over 15,000 physicians gave part time or 222,000 hours in carrying out the program.

The procedure and responsibilities for providing for complete medical and dental examinations of school pupils and school employees at regularly stated intervals are outlined in three legislative acts—425 and 426 of the General Assembly of 1945 and 522 of the General Assembly of 1947.

Under the provisions of these acts certain responsibilities are placed upon three departments of the Commonwealth, namely, the Department of Health, the Department of Public Instruction, and the Department of Public Assistance.

The requirements as outlined in various acts possess great potentialities for the discovery and correction of defects which will be found among the school children of the Commonwealth. The best results will be obtained, however, only insofar as the representatives of the county medical societies and representatives of the local community become interested, active, and cooperative in taking advantage of and assisting in the administration of the various programs.

Local Interest and Cooperation Essential

It is the wish of the Department of Health that the program be carried out in the democratic way and that the problems presented in obtaining corrections of defects, etc., be made the re-

sponsibility of the local community rather than of the state. This procedure will keep public health responsibilities within the framework of local organizations. This plan is recommended by leading public health authorities. I quote a statement made by Dr. Haven Emerson of New York: "Local rather than federal government is the proper source of basic health services for the people. It is the health service delivered from door to door, day by day, by local governments that produces direct and visible results."

No program such as the one in which we are engaged will be successful unless the members of the local medical societies take the lead in its activities. I am sure that all medical men, when properly informed as to the intent of this legislation, will participate wholeheartedly in the program. I am supported in this by a statement made by our state president, Dr. Elmer Hess, in these words: "It must be remembered first that the average physician is against the third party coming between him and his patient. Until he understands that this is not the object of the school health program, he will probably not be too cooperative. As soon, however, as the physician realizes that this program is not another lay club to regiment him, he is more than cooperative. I think he will see that this program is practical and humanitarian. The physicians of America are cooperative so long as humanity and not politics is to be served."

The program has been in operation since September, 1945, and while our statistics are not completed, I should like to give you a few of the outstanding facts that have so far been developed.

Remedial Defects Decrease

In the year 1945-1946 Philadelphia reported complete examinations of 102,099 pupils. Of this number, 82,500 or 80 per cent were found to have remediable defects. The percentage of defects seems rather large, but it includes the dental defects, of which there were 44,442. When these dental defects are eliminated, the number of remediable defects is reduced quite materially—38,058. The corrections reported were 28,632

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or 35 per cent. In comparison, in the year 1947-1948 there were 100,540 children examined. Of this number, 80,000 or 80.1 per cent were reported to have remediable defects; of this number, 55,191 or 40 per cent were reported as having had corrections.

The total number of pupils examined in seven second-class districts in the year 1945-1946 was 33,018. The number with remediable defects was 13,008 or approximately 40 per cent. Of the total number of defects found in these second-class districts, 8544 or 69 per cent were reported as having been corrected. In the year 1947-1948 seven second-class districts reported examination of 45,204. The number with remediable defects was reported as 12,073 or approximately 27 per cent. This shows that much corrective work must have been done in order to have reduced the percentage of remediable defects so markedly.

Reports from nine third-class districts show that in 1945-1946 there were 9473 pupils examined; 4980 were reported with remediable defects or 53 per cent. From these same districts 3897 corrections were reported. Approximately 46 per cent of the defects reported during the examination were corrected. In the year 1947-1948 nine third-class districts reported examination of 10,511 pupils. The number with remediable defects was reported as 3838, or approximately 37 per cent. Here again it is demonstrated that much corrective work must have been done in these districts as shown by the drop in the percentage of defects found. May I add parenthetically that these findings correspond satisfactorily with the revised figures reported by the draft boards during the last war.

The above statistics cover the reports from first, second, and third-class districts. I now direct your attention to the reports of the results in fourth-class districts. During the year 1945-1946 there were 39,690 children in 250 districts examined; 23,684 were reported as having remediable defects or 59 per cent. During the year 1946-1947 a total of 239,620 pupils in approximately 1800 districts were examined; 138,510 or 57 per cent had remediable defects. In the year 1947-1948, in approximately 1800 districts, 263,756 pupils or approximately 92 per cent of the rural school population were examined; 15,127 or 42 per cent of this group were reported as having remediable defects as compared with the 57 per cent reported in the year 1946-1947.

A report from 550 school districts on corrective work for the first four months of the school year 1948-1949* shows the following results of

follow-up of correctable defects: The total number of defects corrected or under treatment totaled 39,126. In the follow-up of these cases 4583 were referred to school physicians; 26,220 were referred to family physicians and 21,972 were referred to various other agencies and hospitals, such as Department of Health clinics, Bureau of Rehabilitation, etc.

Since the enactment of Act 522 by the Legislature of 1947, approximately 80 per cent of the school districts of the State have been provided with school nursing service. I think these reports show that although we have not as yet developed a complete and smoothly working follow-up program, the statistics reported on the 550 school districts above show that as a result of the increase of the number of school nurses the corrective program has vitally expanded.

Caution in Reporting Defects as Correctable

In closing, may we ask all school medical examiners to use great care in making their reports of correctable defects. We are making a real effort to get a true picture of the health of the school children without giving the proponents of socialized medicine any ammunition that may be used by them for further favorable reactions toward the passage of the Murray-Wagner-Dingell Bill or any other form of socialized medicine. Of course, we do not want any physician to distort the statistics or to misrepresent the actual physical conditions of our children. I agree that the child is more important than the statistics.

It is quite proper, regardless of the type of defect found in the examination, to record on the Pupils Health Record Card these findings which will be useful in later examinations. However, many so-called defects are transient and will disappear without much additional medical care. As an example, nits and lice should not be counted as correctable defects within the meaning of the statistics. Neither should contagious skin lesions, such as scabies, but they should be noted on the Pupils Health Record Card.

Nasal discharge when due to an acute upper respiratory infection should not be included in your statistical report. Impacted wax in the ears should not be considered as a defect to be reported for statistical purposes.

Perforated ear drums are not correctable and therefore should not be reported except when they result in imperfect hearing. Such cases certainly should be included in the statistical report when, in the opinion of the examining physician, the condition could be corrected or improved by

* At the editor's suggestion, statistics up to and including December, 1948, are included in these paragraphs.

further medical care or by the use of proper mechanical aids.

This is a brief summary of the results of the school health program for the first three and one-half years of its life. We feel that it has succeeded and that as it improves through the years it will increase in usefulness.

EDITOR'S NOTE: Praise from unexpected sources is usually doubly welcome. The following complimentary comments, which appeared in *The Evening News* of Harrisburg on March 2, 1949, reflect credit on the school health examination program:

School Health Program Praised by Committee

Medical and dental societies and the family doctor were praised today by a special legislative committee for improving the health of school children under a 1947 law.

Under the program established by the General Assembly, half of Pennsylvania's 1,800,000 school children are eligible for examination each year in addition to 20,000 teachers and approximately 8000 school employees.

The full or part-time services of 1500 physicians and 1000 dentists are necessary to carry out the program, according to a report filed with the Legislature by the Public Health and Sanitation Committee covering September through December of last year.

"This is a fine indication that on a State level both the medical and dental societies are supporting this program and the private practitioner is meeting the demands made upon him and performing well his responsibility in this phase of public health," the report asserted.

The Department of Public Assistance was scored for using only \$17,631 of \$296,830 available allocated by the Health Department for the payment of necessary medical, dental and surgical care of children on relief rolls.

INTERNATIONAL CONGRESS ON RHEUMATIC DISEASES

More than 150 physicians from foreign countries are expected at the International Congress on Rheumatic Diseases to be held at the Waldorf-Astoria in New York City from May 30 to June 3, 1949. Many of these physicians will present papers before the plenary sessions which will be held in the mornings. In the afternoons, clinics will be held at several of the New York hospitals.

Already many papers have been accepted for the Congress which include, in addition to presentations by

prominent U. S. authorities, numerous distinguished foreign guests. Among these are:

"Rheumatism, a National Problem," Lord Horder of London.

"The Treatment of Progressive Rheumatism with Copper Salts," Jacques Forestier, Aix-les-Bains, France.

"Relations Between Rheumatic Fever and Rheumatoid Arthritis," Eric Jonsson of Stockholm.

"Transfusions of Blood from Pregnant Women in Patients with Rheumatoid Arthritis," Imre Barsi-Basch of Budapest.

"Procaine Infiltration in Painful Musculoskeletal Disorders," Professor S. de Seze of Paris.

"Statistical Analysis of 1000 Cases of Rheumatoid Arthritis in Relation to Insidious and Acute Onset, Menopause, Pregnancy, Psoriasis, Ankylosing Spondylitis, and Still's Disease," Svend Clemmesen, Copenhagen.

"Some Aspects of Psychogenic Rheumatism," Dr. William Tegner of London.

"Muscle Soreness and Myositis as a Symptom of Chronic Overstraining, Especially in Neurotics," Henrik Seyfarth of Oslo.

"Chronic Polyarthritis and Psoriasis," P. Barcelo of Barcelona, Spain.

"Involvement of the Nervous System in Rheumatoid Arthritis," Veikko Laine of Heinolan, Finland.

"Periarthritis of the Shoulder," Fernando H. Ramos of Montevideo.

The official languages of the Congress will be English, French, and Spanish, but instantaneous translations of the scientific papers given at the plenary sessions will be made by means of the I.B.M. wireless system. The meeting is open, and the registration fee is \$10.00.

MISCONCEPTIONS ABOUT SKIN DISEASES NUMEROUS

Popular misconceptions about skin diseases cause many persons to overtreat skin inflammation with antiseptics, say G. B. Underwood, M.D., and L. Edward Gaul, M.D., of Evansville, Ind.

Writing in a recent issue of *The Journal of the American Medical Association*, the two dermatologists say:

"We believe that the science of skin hygiene has rested too long in the hands of those with something to sell. Persons in all walks of life seem to regard the skin as an inert covering, something as tough as leather and deserving the same care—soaping, greasing, oiling, painting, dyeing, polishing, and, of late, conditioning.

"Deeply entrenched in the minds of people is the fear of infection. This specter haunts most channels of public information. The dictum is preached that a break in the skin permits the invasion of disease organisms unless an antiseptic is applied forthwith. The promoters of enterprises that trade on the human skin talk knowingly and cite eminent authorities, but their propaganda commonly causes skin trouble."

The dermatologists report cases in which people have made their skin inflammations worse by applying unsuitable preparations and suggest that a new council of the American Medical Association could end "bewilderment in diagnosis and treatment for the skin."

Management of Industrial Ocular Injuries

HAROLD M. GRIFFITH, M.D.
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IN PRESENTING this subject, I hope to review the experience gained in a quarter-century of the practice of ophthalmology in an industrial city in this industrial state. It is not intended to introduce anything new, and I imagine that my experience will parallel that of a great many of you.

It is a well-known fact that injuries form a quite small percentage of any ophthalmologic practice, but a large proportion of injuries in an industrial community occur in industry and are covered by the compensation insurance laws of the state.

The efficient care of such injuries becomes, therefore, of importance not only to the injured individual but to the employer and insurance carrier. A great many men, particularly in smaller plants, are relatively indispensable to the uninterrupted operation of the plant. That is, there may not be a skilled man to do the particular job of the injured man. It is doubly important, then, to return the injured man to work at the earliest date consistent with safety. More and more, in recent years, both management and insurance carriers are coming to realize this and to insist that all persons with eye injuries be sent to an ophthalmologist rather than to the plant physician or to a general practitioner. However, a statistical study of one of our large plants disclosed that during the past three years there has been an average of 7000 eye cases yearly of all types. It is manifestly impossible for an ophthalmologist to see all of these and carry on his regular practice, since they occur around the clock. As a matter of fact, I do not consider it necessary to refer all of them to an ophthalmologist.

Of the total mentioned above, slightly more than 92 per cent were foreign bodies, corneal or conjunctival. The vast majority of these came to the dispensary shortly after injury, or at the completion of the turn, and could be readily removed.

In several of our larger plants, including the one in which the previous figures were recorded,

nurses are on duty in one or more dispensaries for all or part of the day. In these plants, all injuries are brought first to the dispensary. It is possible to instruct good nurses to do a great deal in the handling of eye injuries.

For example, I am sure that we have all had many cases referred with the statement "I tried to remove the foreign body with a cotton applicator, and if I can't get the foreign body after several trials, I give up." In my opinion, the cotton applicator in such circumstances is good for only one thing, that is, to remove epithelium, usually in large amounts. I much prefer to teach nurses the proper handling of a spud, and I insist on the use of the angled, or golf-club type spud, with the smallest possible tip. They then remove only foreign bodies which are not embedded, and make no attempt to remove the underlying stain which is so often found.

Where there are welding operations, there will naturally be a great many cases of accidental exposure among the adjacent workers, with consequent electric ophthalmia. Many of these men come back in six or eight hours, with the onset of symptoms, and will be relieved by cold compresses. Likewise, there are many cases of mild conjunctivitis, the result of dust, gases, or fumes, or of rubbing a foreign body. These, too, may respond to cold compresses. All such cases, treated by the plant nurse, are to be referred promptly if they do not respond to the first treatment. Injuries involving any laceration or abrasion, any impairment of vision, or any suspicious symptoms are referred at once. It is well worth while to spend adequate time trying to train powers of observation. I recall one very small foreign body, embedded in the iris, which was picked up promptly because a first-aid man saw an air bubble in the anterior chamber, although the wound of entrance was not seen by him.

In smaller industries, it is necessary to be continuously available for treatment of injuries. I feel strongly that if one undertakes the care of injuries in a given plant, he or an associate should be within reach at the moment an injury happens. Time is of essence in any penetrating

Read before the Section on Eye, Ear, Nose and Throat Diseases at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 5, 1948.

wound, and the loss of many eyes can be traced directly to delay in treatment.

The character of injuries has changed greatly within the span of my experience. Improved safety in operations and improved understanding of safety on the part of both management and labor have resulted in marked reduction in serious injuries. Magnet extractions, for example, numbered twice as many in my first five years as in the past five years, and this in spite of the speed-up and employment of inexperienced men during the war years.

Whenever possible, a man treated in the office is returned to work. This necessitates the most intimate knowledge possible of the plants and jobs, in order to say whether he may do his own job, or some other, or should be sent home. Some of the implications are obvious, as, for example, the necessity for binocular vision in many skilled or hazardous operations, which is precluded by the application of a patch. However, there are many instances where a man may safely work with a patch, and again I emphasize the necessity of familiarity with work and working conditions. Management always will welcome the opportunity to take you through the plant, and usually will welcome any suggestions you may make from the standpoint of eye safety.

In ophthalmology our motto, aim, and watchword must be conservation of vision. In industrial injuries the vision of the patient becomes doubly significant, because any loss of vision due to injury may have a monetary value in addition to its economic importance. It is necessary, whenever feasible, to determine the vision of each eye immediately, with and without correction. At the time of injury, most patients are anxious about the possible damage to vision and will admit the utmost they are capable of seeing. Later, it may be difficult to elicit as good vision, even when no further damage has occurred.

Careful ophthalmoscopic examination, and at least gross fields, should be done where the injury is more than trivial. Previously existing pathologic conditions in either eye may be discovered, and we need only suggest the possibility of a pre-existing glaucoma to emphasize the need for such care. Blind eyes, or those already having loss of industrial vision, are just as susceptible to injury as those with 6/6 vision. History, examination, and check of company records may be necessary to establish the previous visual status of the injured eye. After a few days, a previous pathologic condition may be obscured.

This naturally leads to a consideration of those cases which are seen late—often too late. As I have already pointed out, this is seldom the fault

of management, because under the compensation insurance system injured men usually are offered prompt and efficient treatment. But many employees do not report injuries promptly, and particularly is this true of eye injuries. In my experience, miners, as a class, are the worst offenders in this respect, probably because they get so much dust that the embedded foreign body does not hurt much worse than the loose ones. It is my impression, too, although I have not attempted to prove it statistically, that the most serious corneal ulcers I encounter are found in miners, the result of neglected abrasions. An advanced hypopyon ulcer is often present within forty-eight hours of injury.

But more important, it seems to me, are the patients hospitalized with multiple injuries, especially head injuries, which include some damage to ocular structures, who are not seen for several days or longer. Of course, many of these are in critical condition with life in danger, and immediate treatment of ocular injuries may be inadvisable and relatively unimportant. Nevertheless, the earlier these cases are seen by the ophthalmologist, the better will he be able to diagnose and treat them. It scarcely needs to be mentioned that an ophthalmologic consultation should be had in every head injury of serious character, but this, too, is honored at least as much in the breach as in the observance.

I believe it would be good missionary work for each of us to avail himself of every opportunity to urge such consultations in discussions at county society meetings and elsewhere.

The phase of treatment of ocular injuries does not come within the scope of this presentation, but if time permits, I should like to discuss a few procedures which I have found valuable in shortening disability or saving vision.

Corneal foreign bodies should be removed completely, including any stain, at the first visit, if possible. Unless infection is present already, the eye should be patched, with instillation of sulfathiazole or penicillin ointment, and with or without mydriatic as indicated. The use of silver nitrate as described by Gillette¹ has been of help in most cases. Application of 1 per cent silver nitrate facilitates freeing of the foreign body by producing corneal edema.

Corneal wounds should be sutured whenever possible after freeing or excising any iris prolapse. With 6-0 silk on an atraumatic needle, the procedure is not difficult and is superior to splinting with a conjunctival flap.

Magnetic intra-ocular foreign bodies which have reached the vitreous should be removed by the posterior route, almost without exception.

Even if lens damage has already occurred, there is invariably more traumatic iridocyclitis attendant upon pulling the foreign body back into the anterior chamber. Of course, a sclerotomy wound should be posterior to the ciliary body and should be treated by diathermy as prophylaxis against a subsequent retinal detachment.

Concerning non-magnetic intra-ocular foreign bodies, I have nothing to offer, save to say that all is not lost in every case. I recall one case in which a tiny fragment of marble embedded in the retina has been present for several years, with very little visual loss. I much prefer to treat such cases conservatively rather than add to the trauma by too radical surgery.

And finally, for those of us who practice in the smaller communities, where there is no eye hospital, I believe that an exclusive eye operating room should be available. Preferably, it should be in a separate location from the general operating rooms, and should have its own staff of nurses. No single factor can do more to promote good management of ocular injuries, as well as other ophthalmic surgery, than a well-organized eye department in the general hospital.

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ABSTRACT OF DISCUSSION

C. WILLIAM WEISSER (Pittsburgh): It is a privilege to open the discussion of Dr. Griffith's fine paper. He has stressed the important phases of industrial ophthalmology, which has changed considerably since the days about fifty years ago when my father began to practice ophthalmology in Pittsburgh. At that time the prevention of accidents was ignored in the attempt to achieve production as cheaply as possible. Consequently, the most common major ophthalmologic industrial operations were enucleation and evisceration.

The fifty years of which I speak have seen the advent of the important industrial positions of safety engineer and workmen's compensation department and the development in medicine of industrial ophthalmology. Liaison among these three has resulted in a tremendous lessening of serious industrial accidents, enormous savings in compensation payments, and most important to us, the saving of so many eyes and so much visual acuity. Enucleations are now rare and are more often the result of carelessness on the part of the man who has failed to

wear his safety goggles or of the employer who has not been alert to the dangers in his plant.

As Dr. Griffith has pointed out, valuable information to both industry and the ophthalmologist can be obtained by a visit to the plant to learn the specific visual problems and the dangerous areas and procedures. Occasionally, the industrial survey for job analysis can be of great aid in the prevention of accidents and in the more efficient use of eyes.

I agree with him that, when possible, it is well to have a trained nursing staff at the plant, as it is impossible for the eye physician to care for every minor corneal foreign body.

The only meager contribution I might make to this fine paper would be the mention of two personal preferences. First, I prefer to replace the prolapsed iris rather than to excise. If there is no grave damage to the lens, replacement of the iris is the far better procedure. I have done this twelve times in the past few years—in seven cases without lens damage and in five with lens damage. The resulting visual acuity was 20/20 in five and 20/40 in two of the without lens damage cases, one of these being repaired twenty years after injury. In the five cases with gross lens damage, only one has industrial vision. One eye was enucleated, one eye is blind, one has light perception, one 20/200, and the last 20/20. As you know, in these latter cases with lens damage the injury is more severe and the inflammatory reaction more serious and prolonged. Although these eyes are prone to have poor visual results with any procedure, it is wiser to excise the prolapsed iris if the lens is damaged. We give all cases tetanus antitoxin, penicillin, sulfonamides, and foreign protein.

The second procedure is the removal of all corneal foreign bodies under direct slit lamp observation and the application of tincture of iodine to the area of removal. A foreign body and its underlying stain can be completely removed with less damage by doing it under slit lamp observation. Although there is nothing original about these procedures, I feel that they are not stressed often enough.

JOSEPH AARONOFF (Oil City): I do quite a bit of this work because we have in our town a branch of the United States Steel Company and the Pennsylvania Railroad.

In reference to putting a patch on a patient's eye, I never cover an eye at all and I get very good results. I send the patients back to work. We are required to send them all back to work unless they are very badly injured—on the railroad particularly. It is important.

L. PELLMAN GLOVER (Altoona): It may be interesting to you gentlemen to know that the courts of Pennsylvania have ruled just in the past month that traumatic cataract as a case for compensation is now paid for in the total cost of the eye. You do not need to worry about going to the courts anymore.

The word "vertigo" must bring to the mind of every doctor of medicine, regardless of any special interest, difficult situations in diagnosis or treatment with which he or she has been confronted.

All such should be interested in the paper and its discussion on medical vs. surgical treatment appearing on pages 591 to 597, this issue.

Uterine Prolapse in Second Trimester of Pregnancy

Successful Treatment of a Case

THEODORE F. HAWKINS, M.D.

Philadelphia, Pa.

MANY cases have been reported of prolapse of the uterus in early pregnancy terminating in spontaneous abortion if the prolapse was not corrected. It is unusual for prolapse to occur during or to continue past the fourth or fifth month of pregnancy, because the uterus rises out of the pelvis at this time, pulling the cervix high in the vagina, thus decreasing the possibility of spontaneous abortion.

Findley,¹ in reviewing the literature, found that Tracon had two cases in which prolapse occurred during pregnancy, one in the fourth month. Dufour and Wimmer had one each which went to the sixth month, while Plasse's case progressed to the seventh month. He called these cases exceptions to the rule of early abortions. None of these cases went to term; none produced a live baby. Patterson² reported a case of prolapse occurring at the sixth and a half or seventh month of pregnancy, which went into premature labor at the eighth month.

Pregnancy at or near term with prolapsed uterus occurs with less frequency than prolapse in early pregnancy. Kibel³ reports one case in 15,696 deliveries from Jan. 1, 1938, to Nov. 1, 1943, at the Bronx Hospital; while Keettel⁴ reports one case in 13,000 over a fourteen-year period at one hospital, and one in 2000 cases at another. A total of 167 cases were collected by Keettel, while later Kibel increased the number to 203 cases.

Mitra and Nandi⁵ reported an interesting case of prolapse in a para V during her sixth pregnancy. No mention was made, however, of the stage in this pregnancy when the prolapse occurred.

Findley believed that prolapse of the uterus had never been observed at full term; Patterson stated that complete prolapse at term was practically impossible, and felt that most cases reported were partial only. Of the three cases reported by Keettel, only one was a prolapsed

uterus; the others showed an elongated, hypertrophied, edematous cervix. This appeared to be the condition existing in many of the cases reported as uterine prolapse with term pregnancy.

As to treatment, all are agreed that some method should be used to maintain the uterus out of the vagina until after the fifth month when its growth should pull the cervix up in the vagina and maintain the uterus in its anatomical position. As Kibel reported, Frank and Seitz recommended the use of the pessary until the fifth month. Findley advocated plastic repair without interruption of the pregnancy if the prolapse occurred early, while others suggested radical surgery in the form of cesarean section especially if it occurred at or near term.

The case presented is of interest for several reasons. First, it was handled for the most part in a rural district, some distance from a hospital. Second, only one other case has been reported where the prolapse occurred after the fifth month and before the eighth month of pregnancy; and third, this case proceeded to term with a live baby delivered.

Case Report

J. S., a 20-year-old gravida IV para III living in a rural community, presented herself Jan. 20, 1943, with the complaint, "My womb is down." She gave a history of having had a fallen womb for the preceding two months, which she replaced by lying down and forcing it up with her hands. The uterus would descend again on exertion or on continued standing or walking. The patient finally sought medical aid when replacing the uterus became difficult and painful.

She complained of frequency and pain on urination, obstinate constipation, profuse vaginal discharge, and lesions on the genitalia and thighs, the last of three months' duration. Antisiphilic treatments had been taken irregularly for the preceding year, the last treatment three weeks prior to first visit.

Menstruation began at age 11, recurring every twenty-eight days, except for the first six months when it was irregular, and was of three days' duration. Previous pregnancies occurred in 1938, 1940, and 1941, with no history of complications and all ending in normal spontaneous deliveries. The last menstrual period was June 26, 1942.

From the Department of Obstetrics and Gynecology of Mercy Hospital, Philadelphia, Pa.

Physical examination revealed a pyknic-type female, who appeared to be in acute pain. General physical findings were within normal limits except for much dental caries. The blood pressure was 140/80, and the weight 141 pounds. The breasts were soft and full, the nipples erect, and secretions were present. The abdomen was prominent with mild striae present. Pelvic measurements were adequate.

The external genitalia showed numerous condylomata accuminatum of varying sizes over the vulva, extending to the anus and over the inner aspect of the thighs. The entire cervix and a portion of the lower uterine segment appeared to extend from the vagina. The cervix was hyperemic, edematous, lacerated, and eroded. The uterus was the size of a seven months' pregnancy; fetal heart tones were heard over the lower left abdominal quadrant, 150 per minute.

The cervix, vulva, and thighs were flushed with 1:5000 bichloride solution and painted with tincture of merthiolate. The patient was placed in the knee-chest position and the uterus was replaced with moderate ease, though some pain was experienced by the patient. The condylomata were treated with 25 per cent trichloroacetic acid. The patient was sent home with instructions to remain in bed, to use daily potassium permanganate douches, to get up only to take hot sitz baths twice daily, and to return to the office in five days.

Urinalysis was negative, except for a trace of albumin. The Wassermann reaction was strongly positive.

A diagnosis was made of prolapsus uteri complicating pregnancy of seven months; early latent syphilis; and condylomata accuminatum of the vulva and thighs.

The patient was fitted with a stem pessary and belt. Antisyphilitic therapy was instituted. The condylomata showed improvement after the first visit. In two weeks these had completely disappeared and the patient was able to be out of bed all day without pain or descent of the uterus. The pessary was removed for trial March 8, 1943, having been retained for six weeks. No further prolapse occurred, therefore the pessary was not replaced. The remaining course of the pregnancy was uneventful.

On April 29, 1943, the patient was delivered spontaneously of a normal 8 pound 8 ounce male infant after eighteen hours of labor.

The patient was advised against early ambulation and strenuous activity immediately postpartum. Examination six weeks postpartum revealed marked relaxation of the perineum, with first-degree prolapse of the uterus, the cervix being at the level of the ischial spines, and profuse vaginal discharge was present. The cervix was lacerated, eroded, and everted. There was a large tender mass in the left adnexal region which was thought to be a cystic ovary.

The patient was kept under observation until September 25, at which time she was brought to this hospital for surgery.

The choice of operation was open to question. Consideration had to be given to the age of the patient, though she had borne four children; the presence of

an adnexal mass which might rule out vaginal hysterectomy; and the need for maintaining the menstrual function for psychologic reasons, even though the patient should have been sterilized. We are in agreement with TeLinde,⁶ who defers surgery in such instances for two reasons: "First, radical plastic vaginal repair will suffer injury at subsequent deliveries; and second, the best types of operations for prolapse are not compatible with future pregnancies." Ventral fixation of the uterus was decided upon because of the infrequency of recurrence of prolapse, although bladder complications frequently result. Consideration had to be given also to complications which might result should uterine myomata develop or malignant changes occur.

Operation was performed Sept. 30, 1943, at which time there were found, besides the vulval and vaginal pathology previously noted, a normal uterus, both tubes normal, and the right ovary small with a few retention cysts. The left ovary was enlarged, measuring 8 cm. x 4½ cm., and of the chocolate cyst variety. The appendix was macroscopically normal. The operation consisted of linear cauterization of the cervix, perineorrhaphy, left oophorectomy, sterilization by resecting the cornual ends of the tubes from the fundus and fixing the distal cut ends to the posterior aspect of the uterus, ventral fixation of the uterus, and appendectomy.

Hospital course and recovery were without incident, and the patient was discharged Oct. 14, 1943, after nineteen hospital days and on the fourteenth postoperative day.

The patient was seen periodically following discharge from the hospital. The last examination was in April, 1946, at which time examination showed no return of the prolapse and no other pelvic pathology. General physical findings were negative except for excessive weight gain.

Summary

A case of prolapsus uteri occurring during the period from the fifth to the seventh month of pregnancy has been presented. Since only one other case has been reported in which a live baby was delivered, the prolapse having occurred at this time, this may be considered a rare one. The patient proceeded to term, using a pessary with belt for support for six weeks, and was delivered spontaneously. Later, combined plastic and abdominal operative procedures were carried out with good results.

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The Pennsylvania Department of Health desires the services of 25 young physicians from July 15 to 31, inclusive, at the newly created Camp for Underprivileged Boys at Indiantown Gap, Pa. Remuneration will be \$10 per day plus expenses and transportation. More complete details will be published in a subsequent issue of the *Journal*. For further information, communicate with Norris W. Vaux, M.D., Secretary of Health, Commonwealth of Pennsylvania, Harrisburg, Pa.

Deaths from Selected Causes in Pennsylvania, October, 1948

County	All Causes, Excluding Stillbirths	Still- births	Infant Deaths	Materna- Deaths	Cancer	Heart Disease	Intra- cranial Lesions of Vascular Origin	Nephritis	Pneu- monia	Tuber- culosis
Adams	27	0	0	0	6	6	5	3	0	0
Allegheny *	1263	79	71	1	163	479	98	72	46	29
Armstrong	68	5	5	0	15	16	6	7	3	0
Beaver	95	3	5	0	12	35	7	6	2	0
Bedford	38	3	2	0	4	7	7	5	0	2
Berks *	205	9	10	0	26	72	15	15	7	4
Blair *	124	13	3	2	17	48	9	11	3	2
Bradford	61	0	5	0	14	23	2	1	3	0
Bueks	95	3	4	0	10	42	7	4	2	4
Butler *	54	5	3	2	8	18	4	3	1	1
Cambria *	167	6	12	0	24	65	7	10	4	2
Cameron	2	0	0	0	0	0	0	0	0	0
Carbon	47	2	2	0	7	14	2	4	3	0
Centre *	51	4	4	0	7	20	7	2	0	1
Chester *	126	2	5	0	15	49	17	8	3	3
Clarion	26	0	2	0	3	8	2	5	1	0
Clearfield	66	2	12	0	12	17	3	1	4	2
Clinton	44	1	9	0	2	14	6	2	1	0
Columbia	43	2	3	0	4	17	5	0	1	2
Crawford	77	3	6	0	11	29	7	3	2	0
Cumberland	67	3	4	0	11	28	4	5	1	0
Dauphin *	185	11	8	0	22	63	12	19	3	2
Delaware	210	10	20	0	29	81	20	9	2	5
Elk	26	3	0	0	4	9	1	4	1	0
Erie	168	4	12	1	20	52	18	11	6	2
Fayette	142	9	19	1	17	43	10	17	9	1
Forest	3	1	1	0	0	1	0	0	0	0
Franklin *	45	0	2	0	2	19	2	6	0	1
Fulton	6	0	0	0	1	1	1	1	0	0
Greene	39	2	1	0	3	16	5	2	2	0
Huntingdon	38	2	2	0	3	10	5	5	0	0
Indiana	52	2	9	0	8	25	0	2	2	0
Jefferson	38	2	4	0	3	14	5	6	0	0
Juniata	6	1	0	0	1	1	0	1	0	0
Lackawanna	268	11	13	1	41	85	19	18	12	4
Lancaster	205	12	9	0	24	73	24	16	3	4
Lawrence	83	3	3	0	10	25	14	1	3	0
Lebanon *	56	2	4	0	10	14	2	7	3	0
Lehigh *	190	14	14	0	36	46	15	8	5	2
Luzerne	351	16	18	0	51	124	25	19	12	6
Lyeoming	90	2	7	0	14	26	11	4	1	1
McKean	52	4	6	0	8	19	6	3	0	0
Mercer	74	2	5	0	12	19	5	6	1	1
Mifflin	34	1	1	0	3	15	2	2	3	0
Monroe	40	1	1	0	3	18	8	3	0	0
Montgomery *	256	13	6	0	31	114	21	12	2	7
Montour *	21	3	2	0	2	4	3	0	1	1
Northampton	100	3	5	0	13	31	13	6	4	2
Northumberland ...	122	1	5	1	13	44	9	5	5	2
Perry	13	1	0	0	2	7	0	1	0	0
Philadelphia *	1938	44	85	1	323	703	146	102	61	59
Pike	10	0	0	0	3	4	0	1	0	0
Potter	13	0	1	0	3	4	0	0	1	0
Sehuykill	183	6	12	1	22	69	13	13	2	5
Snyder *	12	0	1	0	3	6	0	1	0	0
Somerset *	53	3	4	0	1	17	7	5	3	1
Sullivan	2	0	0	0	4	1	0	0	0	0
Susquehanna	26	1	0	0	7	8	6	0	1	0
Tioga	38	3	3	0	3	15	4	2	1	0
Union	18	0	2	0	4	3	0	0	1	0
Venango *	47	3	5	0	3	20	6	1	0	1
Warren *	32	0	1	0	5	13	4	2	1	1
Washington	160	4	6	0	29	59	11	9	6	3
Wayne *	23	2	2	0	0	7	3	1	1	0
Westmoreland *	209	11	16	1	34	87	19	10	8	1
Wyoming	18	1	0	0	4	5	1	0	0	0
York	160	11	8	0	23	62	18	4	3	1
State and Federal institutions	276	0	0	0	17	86	24	9	14	45
State totals	8877	370	490	12	1245	3175	738	521	270	210

* Exclusive of deaths in State and Federal institutions except general hospitals.

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EDITORIALS

MODERN DIAGNOSIS OF EARLY SYPHILIS

(EDITOR'S NOTE: This is the first of a series of guest editorials prepared by members of the Pittsburgh Syphilis and Venereal Disease Control Program and the Department of Dermatology and Syphilology, University of Pittsburgh School of Medicine. They should refresh the minds of practicing physicians on the procedures necessary to establish a diagnosis of syphilis, the modern therapy, the follow-up of treated cases, and certain public health aspects.)

The prompt diagnosis of early syphilis in the patient who presents himself to the physician is of extreme importance. It is a matter of record that the earlier therapy is instituted after diagnosis, the earlier are cases arrested. In addition, the number of late complications of syphilis such as late secondary cases, central nervous system syphilis, cardiovascular syphilis, etc., can be largely avoided.

From the public health standpoint early diagnosis and institution of antisyphilitic therapy are important because the infectious stage is quickly controlled and further spread of the disease is halted.

For all practical purposes any lesion of the genitals should be considered as syphilitic until proven otherwise. Similarly, indolent, painless, slow-healing lesions of the lip also should be regarded with suspicion. It is suggested, too, that every female should have a speculum vaginal examination, since so many chancres of the cervix are overlooked in the routine checkup.

The typical chancre is a single, more or less circumscribed, superficial ulcer which is usually

painless (unless secondarily infected) and is always accompanied by regional lymphadenopathy. The lesion presents a moist ulcerated base, occasionally crusted, with an indurated border which when palpated with the gloved finger feels like a rubber button. Rather characteristically the adenopathy is painless, discrete, and the individual nodes have a "rubbery" feel.

Inasmuch as only about 10 per cent of all early cases of syphilis will give a positive serologic test for syphilis in the first two weeks, it is important to establish the diagnosis by darkfield examination rather than to await a positive serology report from the laboratory. The time element for a diagnosis can be shortened from four or five days to a few minutes since the darkfield examination is a simple short procedure.

Technique of Darkfield Examination. — The lesion is cleaned with saline solution and serum is expressed by pressure and collected in a glass pipette or wire loop. It is then transferred to a clean glass slide, covered with a cover slip, and examined under a darkfield microscope using oil immersion technique. In the hands of the experienced physician or laboratory worker, the diagnosis is easily established by the presence of the *Treponema pallidum*, which appears as finely coiled grey-white spiral organisms with characteristic motion and morphology.

There are a few spirochetes which resemble the pallida type, but to the experienced eye, dif-

ferentiation is not too difficult. Among these are *T. refringens*, *T. buccalis*, *T. macrodentium*, *T. microdentium*, and *T. vincenti*.

The most important cause of negative dark-field examinations in active syphilis is the previous application of antiseptics, mercurials, sulfa drugs, and caustics in either powder or ointment form. Hence, it should be remembered that only moist saline compresses should be applied to a suspicious lesion until the diagnosis is established. A series of three daily darkfield examinations should be performed before a negative report is accepted. Following this, weekly or bi-weekly serologies should be checked for at least three months before ruling out an early syphilitic infection.

Gland Puncture.—When the darkfield examination of the local lesion is negative, aspiration of a regional lymph node can be performed using a 10 cc. glass syringe, a 19 to 20 gauge needle, and 1 cc. of normal saline. After local anesthesia has been obtained, the gland is punctured as though spearing an apple, the saline is injected, aspirated back and forth, and then a drop is examined on a glass slide by darkfield illumination in the usual manner.

The early lesion of syphilis must be differentiated from other conditions which it may resemble closely. Among genital lesions to be considered are lymphogranuloma venereum, granuloma inguinale, herpes progenitalis, folliculitis or infected sebaceous cyst of penis, and chemical burns resulting from caustics applied as home therapy, etc. Extragenital lesions, especially of the lip, must be differentiated from herpes simplex, perlèche, granuloma pyogenicum, carcinoma, tuberculosis, and traumatic ulcer.

There are many standard serologic tests used throughout the country. Probably the best known are the Wassermann and the Kahn. Modifications such as the Kline, Kolmer, Mazzini, and Hinton are used in many laboratories. Serologic laboratories do at least one standard flocculation and one standard complement-fixation test and then perform quantitative (titered) tests along these lines. The latest popular test employs cardiolipin and promises to be a very specific and sensitive test.

The quantitative serologic test is important in diagnosis as well as in follow-up therapy. In early syphilis, when the result of the serologic test is negative or weakly positive, a test repeated in a week or two will show a definite increase in the degree of positivity (titer) which will enable one to arrive at an earlier diagnosis.

Quantitative testing as shown by dilution fac-

tors or Kahn units should not be confused with the old one plus readings done on quantitative testing. Similarly, the treated patient's progress can be followed much more intelligently with titered serologies. The steady reduction of titer indicates satisfactory progress. On the other hand, an increase of titer, for example, may represent a serologic relapse, or an indication of beginning clinical mucocutaneous relapse.

(In a later editorial, a more complete discussion of titered serologies will be considered at greater length.)

Many physicians ponder the feasibility of performing diagnostic lumbar punctures in early syphilis. Even though a fair percentage of early cases show some degree of spinal fluid involvement, the diagnostic puncture is not indicated since the method of therapy will remain the same in positive cases. It is recommended that spinal fluids be examined six to eight months after intensive therapy and earlier in the few cases in which clinical signs and symptoms of central nervous system involvement are manifest.

When spinal fluid is withdrawn, it is extremely important to have a cell count performed within a few hours since disintegration of cellular elements may obscure the picture. In addition, a total protein content should be determined together with a standard colloidal gold and a quantitative spinal fluid serologic test. By such tests, the progress of the treated patient with central nervous system involvement can be more closely followed and better evaluated.

SAUL R. BERGAD, M.D.

THE HYDRA

As cancer consciousness increases among patients and doctors, and the search for early cancers is more often rewarded, new problems in treatment appear. While the surgical management of carcinoma of the colon used to be a straightforward proposition, recent awareness of the fringes of cancer that occur in the colon have complicated the picture. One may start with the concept of Atwater and Barga¹ that multiple polyps (not congenital polyposis) occur in 69 per cent of patients over the age of 60 years. Many patients had innumerable polyps in their material which could only be seen with a magnifying glass. Add to this the fact that many, if not most of the cancers of the colon, are thought

1. ATWATER, J. S., and BARGA, J. A.: "The Pathogenesis of Intestinal Polyps," *Gastro-enterol.*, 4: 395-408, May, 1945.

to arise from a pre-existing benign polyp and the problem is stated.

Such information indicates that roentgen examination of the colon should no longer be directed to discovering large cancers. The radiologists must look for these polyps throughout the colon, particularly when rectal bleeding has occurred or when rectal polyps have been seen. All of us must adopt the point of view that where there is bleeding, there may be a polyp; where there is one polyp, there are usually others; where there are polyps, there may be cancer; where there is one cancer of the colon, there may be several.

Under these circumstances, surgical management of polyps scattered throughout the colon becomes a difficult business. Since one cannot tell which polyp is malignant without histologic examination and one cannot eradicate cancer of the colon without resecting the bowel, how much bowel is to be resected with multiple polyps, if any? These questions indicate that the cancer problem, and particularly cancer of the colon, has become like the hydra monster of Greek mythology which grew two heads to replace each head that was cut off.

ROBERT P. BARDEN, M.D.

A TAX, NOT INSURANCE

U. S. Senator Robert A. Taft of Ohio addressed an audience of more than a thousand persons in the Schenley High School, Pittsburgh, Saturday night, February 19, on "Medicine and the American Way."

He described President Truman's program for "government medicine," since all workers will be compelled to pay for it, "as a tax and not insurance, and but another step to further bureaucracy which will socialize medicine, result in poor medical service, and impair medical research."

In March Senator Taft will introduce a bill alternative to S. 5 which "will save taxpayers money by requiring a state and local authority, with Federal funds to furnish adequate sickness service to those unable to pay for it themselves, functioning through Blue Cross and Blue Shield plans."

He stated that the President's plan has been advanced with a deliberate effort to conceal its necessary results and to present it as only a slight modification of our present system. Thus, the International Labor Office, which is the prin-

cipal international proponent of sickness insurance, admits that this so-called insurance is not really insurance, or will not remain so for long.

Their recent volume entitled "Approaches to Social Security" says:

"The fact is that once the whole employed population, wives and children included, is brought within the scope of compulsory sickness insurance, the great majority of doctors, dentists, nurses, and hospitals find themselves engaged in the insurance medical service, which squeezes out most of the private practice on the one hand, and most of the medical care hitherto given by the public assistance authorities on the other. The next step to a single national medical service is a short one. . . ."

Of course the adoption of such a plan deprives men and women and their families of their freedom of choice in spending the money they earn, the Senator concluded.

VISUAL HYGIENE

Is Video a Menace?

With the advent of television it behooves the medical profession to give this subject some thought in advance to prevent possible irreparable damage to the population. The writer recently had occasion to see television for the first time in its latest development in a private home. The machine was placed in a very small room and several young people were crowded in watching the performance for an hour and a half. There is no doubt in the writer's mind that this is rather harmful to the eyes, and sooner or later many people are bound to pay a dear price for it.

The industry, it seems, has given no thought to this angle. On the contrary, there are only glowing reports in the daily press about the future growth of "Video," also remarks by a number of leading radio performers who state that they see an even greater future for "Video" than for radio. Should this prophecy turn out to be true, it might constitute a true health hazard. The eye is a much more delicate organ than the ear and apt to suffer from excessive use. On the other hand, "Video" is bound to have such a tremendous attraction, especially for the younger people, that all prophylactic precautions should be taken in order to avoid injury to its devotees.

The writer would suggest that the medical profession, preferably the ophthalmologists, select a committee to study this problem and develop minimum requirements of distances from which it is safe to watch "Video," also reasonably safe periods for continuous watching of video per-

formances for even normal people, and to study the effects on various types of eye conditions which may be aggravated greatly by this new form of entertainment.

Now, before increased production and high-power salesmanship of this product gain momentum, is the time to take these precautionary hygienic steps.

It would seem that the industry itself should be interested in studying this problem before it expands too much.

MAX H. WEINBERG, M.D.

WE COULD SLIP INTO SOCIALISM WHILE HATING IT

After the election returns were in, the *Post* raised the question, Did We Buy Socialism With Truman? Some readers are still bending our ear with complaints that we were unfair, not only to President Truman but to the American people. Of course, these optimists assert, neither Mr. Truman nor the American people want socialism, and we were practically indecent to say such a thing. What we said was that, although neither the President nor those who voted for him want socialism, the essence of socialism is what we are very likely to get. Now we have the President's State-of-the-Union message, the so-called Economic Report and the inaugural address. The defense rests.

According to Mr. Truman, Americans have "abandoned the 'trickle-down' concept of national prosperity . . . (and) believe that wealth should be created for the benefit of all." What this seems to mean is that, instead of the benefits of a dynamic, imaginative free-enterprise system "trickling down" to all classes, including the laziest man on the street, the ordinary man is now to get his trickle from the Government, which, according to the President, "must see that every American has a chance to obtain his fair share of our increasing abundance." Since the only way the Government can see that one man gets his "fair share" is to take something away from another man, it is obvious that \$6,000,000,000 in new taxes will be cheap in comparison with what will have to be taken from Peter if Paul is to get what he thinks is his fair share.

Apparently foreseeing that, when the Truman New Deal gets to rolling, there won't be much to trickle down from American industry, the President is ready with a recommendation that whenever the steel industry doesn't produce enough to satisfy the bureaucrats' idea of ample production, the Government shall finance or actually build competing plants. Having all but crippled the industry's sources of new capital needed for improvements and expansion, the Government, under the whip of the CIO "economists," threatens to mow down free enterprise with subsidized competition.

The costs of medical care and social security are to be raised to new heights, on the theory that American medical care, the best in the world, can be improved if it is made as much as possible like medical care in France and England, where it is terrible. "Building costs must be lowered," but apparently by charging

them up to Uncle Sam rather than by insisting on modifications of the make-work, slow-down and stand-in practices of the building trade-unions, which have raised wages enormously and reduced production per man to new lows. The proportion of rental housing must be increased, and to tempt "private enterprise" into this field, rent control must be "extended and strengthened." To keep everybody in line, the Government must exercise control over the allocation of materials.

Despite all the lip service to "private enterprise," the President's program leads straight to socialism, as must any program which rests on the assumption that the Government is responsible for the economic welfare of every citizen, that the Government must give him Federalized medical care and subsidized housing, underwrite farm prices and dictate the minimum which people may accept as wages and how much they shall be permitted to retain as "profit," in the unlikely event that the concept of profit can survive such a hodgepodge of mothering. The people didn't vote for socialism; they voted for Mr. Truman. Mr. Truman probably doesn't want socialism, but he has allowed a lot of CIO planners to talk him into a scheme of things which, if permitted to run its course, adds up to socialism, however the poor misbegotten thing is christened.—Editorial, *Saturday Evening Post*, Feb. 5, 1949.

WAINWRIGHT TUMOR CLINIC MEETING

The Wainwright Tumor Clinic Association will hold its annual meeting April 20 at the Institute for Cancer Research, Fox Chase, Philadelphia.

The Institute for Cancer Research, which is adjacent to the Jeanes Hospital, is in the northeastern section of Philadelphia, approximately ten miles from City Hall. The Institute may be reached by automobile by traveling on Rising Sun Avenue into Fox Chase; by public transportation, get off the Broad Street Subway at Logan and take an "O" bus; by train, take a suburban train at the Reading Terminal, 12th and Market Streets.

Dr. Stanley P. Reimann, director of the Lankenau Hospital Research Institute and scientific director of the Institute for Cancer Research, has arranged the all-day program which begins at 10 a.m.

The following papers will be presented: "Carcinoma of the Rectum and Rectosigmoid," Martin S. Kleckner, M.D., Allentown; "The Value of Periodic Examination and Early Detection," Catharine Macfarlane, M.D., Philadelphia; "The Treatment of Cervical Tumors and Metastases," John V. Blady, M.D., Philadelphia; "Carcinoma of the Bladder and Its Relationship to Transitional Cell Buds," Albert E. Bothe, M.D., Philadelphia; "Biopsy and Curettage for Diagnosis of Uterine Cancer," George A. Hahn, M.D., Philadelphia; "Carcinoma of the Esophagus and a New Surgical Approach," Charles P. Bailey, M.D., Philadelphia; "Carcinoma of the Thyroid," Robert C. Horn, Jr., M.D., Philadelphia; "Cancer Problem in Pennsylvania," LeRoy E. Chapman, M.D., Warren.

Demonstrations of laboratory and clinical procedures will be held in the new laboratory building of the Institute for Cancer Research and also in the Jeanes Hospital from 3 p.m. to 5:30 p.m.

Luncheon will be served at Jeanes Hospital, at which time the business meeting of the association will be held.

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*

8104 Jenkins Arcade

Pittsburgh 22, Pa.

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State From What It Is to What It Ought to Be.

PRESIDENT ENGEL'S TEN-POINT PROGRAM

Under date of Jan. 13, 1949, President Gilson Colby Engel dispatched a night letter to the twelve members of the Board of Trustees and the secretary-treasurer of The Medical Society of the State of Pennsylvania containing the ten points herewith appended. There are some additional comments by Dr. Engel, which of course did not appear in his night letter:

1. The creation of a federal Secretary of Health with cabinet rank, this officer to be a qualified Doctor of Medicine.

All health agencies in the Federal Government should be represented under sub-heads of this cabinet rank in the positions of deputies in charge of bureaus, and further broken down to divisions.

2. To remove partisan politics from all health appointments.
3. To consolidate the Medical Corps of all service units (Army, Navy, etc.) under one head, who would be a deputy under the Secretary of Health.
4. To promote health education programs in conjunction with state and local county medical societies.

This would be one of the greatest moves in the preaching of preventive medicine. Prevention of disease is basically the most important factor in a healthy nation, and this involves proper food and proper housing as well as the medical phases of prevention.

5. To support medical research.

Medical research should be supported by the Federal Government by grants to the state and local level given to accredited institutions that have the facilities and personnel to carry on extensive research.

6. To give financial aid in the education of doctors who would promise in return to serve five years in a rural community where needed.

These grants should be made to accredited medical schools who in turn through their deans of admissions would give out scholarships to students who were willing to sign the agreement. This alone would tremendously improve the shortage of doctors in rural areas.

7. To finance the education of student nurses throughout the country who are in training in accredited training schools.

This point alone would take most hospitals out of the red. Hospitals formerly depended upon

private capital to make up the deficit caused by the medically indigent. However, because of increased taxation, private capital to support these institutions has practically disappeared. It is unfair to charge the sick patient for the training of these nurses. This phase of the program alone would be a tremendous step forward in the economic stabilization of hospitals of America. Nurses, further, should be put on Social Security.

8. To aid the medically indigent through the media of Blue Cross (hospital service) and Blue Shield (Medical service).

This could be done in the simple manner of having Blue Cross and Blue Shield pay the way of the medically indigent and the government reimburse Blue Cross and Blue Shield.

9. The construction of small diagnostic units and small hospitals in the rural areas.

Small diagnostic units in rural areas which contain some laboratory, electrocardiograph, and x-ray facilities would be able to do considerable studies on the people of the locale and decide whether they should be sent to a nearby general hospital for treatment or whether treatment could be carried out at home. These diagnostic units could also be used as health centers for the community.

10. A markedly improved mental health program with the establishment of mental hygiene clinics throughout the country.

These clinics would go a long way toward preventing mental diseases.

In response, President Engel received replies ranging from unqualified support from the majority of the members of the Board of Trustees, to approval from other trustees of all but one point, approval of all but seven points, and with advice that the plan be cleared through Secretary and General Manager George F. Lull of the American Medical Association.

On January 17 Dr. Engel telephoned Dr. Lull and on his advice also telephoned Chairman Elmer Henderson of the A.M.A. Board of Trustees. Telephone approval was given of the ten-point program "to be supplied to one or more Senators as a basis for a counter-bill of their own with the blessing of the doctors of America—no mention to be made of any medical society or organization."

On January 19 Dr. Lull, having received a copy of Dr. Engel's ten-point program, began his more formal reply with the following:

"It is very true that many men in Congress state that if we should come up with something positive in place of the Wagner-Murray-Dingell Bill, they would back it. It is very difficult to come up with something positive which would not involve the government in federal subsidies and therefore increase the possibility of the government entering more and more into medical activities."

He then pointed out that the House of Delegates of the American Medical Association is already on record as approving points *one, two, and four* and that bills had either been presented in Congress or were under study covering points *three, five, six, nine, and ten*. He objected to point *seven*, but gave full approval of point *eight*.

Early in February, Dr. Engel received a communication signed by Dr. R. L. Sensenich, president of the American Medical Association, and Chairman Elmer L. Henderson of its Board of Trustees, which stated that Dr. Engel's ten-point program is compatible with established policies of the A.M.A. House of Delegates except that points *six* and *seven* have never been specifically acted upon by the delegates.

They suggested a modification of point *eight* and noted the omission in the ten-point proposal by Dr. Engel of any provisions for local public health units; maternal and child health preventive care; care of the aged, underprivileged Negroes, Indians, and Eskimos; and advised also the establishment of a medical care authority in each state with suitable medical and consumer representation to administer all medical care funds.

They concluded their comments with this sentence, "Your recommendations with the modifications here indicated and additions suggested are in accord with official actions of the House of Delegates."

President Engel has had (as of February 11) notable approval of his program from the current presidents of thirty-seven of the constituent state medical associations of the American Medical Association, all of whom, together with editors of all state medical journals and certain officers and representatives of the component county societies of The Medical Society of the State of Pennsylvania, have received, together with a copy of the ten-point program, the appended letter dated Jan. 31, 1949, from Dr. Engel:

"DEAR DOCTOR:

"I want to give you the background of the ten-point program which Senator Lister Hill of Alabama is planning to develop into a bill to be introduced into the United States Senate.

"On Dec. 21, 1948, I wrote an open letter to Federal Security Administrator Oscar Ewing, in which I challenged many of his arguments in support of compulsory health insurance.

"Shortly thereafter the International News Service requested that I prepare a constructive program with regard to the problem of medical care in the United States. I complied with this request and the ten-point program which I submitted was released to the newspapers on Jan. 9, 1949.

"Within two weeks I was invited by Senator Hill to confer with him regarding my proposals. Before arranging this conference, I secured approval of the ten points by the Board of Trustees of The Medical Society of the State of Pennsylvania and also the personal approval of Dr. Elmer L. Henderson, chairman of the A.M.A. Board of Trustees, and Dr. George F. Lull, secretary of the American Medical Association.

"On January 25 I had a conference with Senator Hill. For almost three hours we discussed in detail every point in the program. Toward the end of this session Senator Hill said:

"I am definitely interested and will begin working immediately to whip these ten points into proper form for legislative consideration."

"I have already received enthusiastic letters from the presidents of twenty-three state medical societies regarding this program. When the bill is presented by Senator Hill, either on his own behalf or in conjunction with some of his colleagues, it will be important for medical societies throughout the country to rally to its support."

Respectfully submitted,

GILSON COLBY ENGEL, M.D., *President*,
The Medical Society of the State of
Pennsylvania,
255 S. 17th St., Philadelphia 3, Pa.

EDITOR'S NOTE: The appended additional information was received from Dr. Engel in Florida in time for addition to galley proof for the March PENNSYLVANIA MEDICAL JOURNAL:

"At the present time I have the full report of the presidents of 39 state medical associations.

"American Hospital Association has endorsed through Mr. Bugbee.

"President Schriver of national Blue Shield, and President Colman of national Blue Cross approve."

Brief mention of progress in the preparation of a bill to be introduced by U. S. Senator Lester Hill of Alabama based on Dr. Engel's pointed program was made in the February PENNSYLVANIA MEDICAL JOURNAL, page 525.

Federal encroachment on the practice of private medicine "would do more to advance statism against democracy than anything that the Russians or the Communists are doing."—GENERAL DWIGHT D. EISENHOWER.

PHYSICIANS AND HOSPITALS ASKED TO COOPERATE

The administration of the medical and hospital work of the United Mine Workers of America Welfare and Retirement Fund is under the general direction of Warren F. Draper, M.D., former Deputy Surgeon General of the United States Public Health Service and Major General in charge of the Public Health Branch at Supreme Headquarters, Allied Expeditionary Forces, during World War II. He served also as State Health Commissioner of Virginia and as a member of the House of Delegates of the American Medical Association from 1925 to 1946.

Medical societies and leading members of the medical profession have given assurance of their desire to demonstrate the practicability of the program and make it a success. With an enterprise of such far-reaching significance, it is the hope of the Fund that the physicians and hospitals of this country, with the aid of their organizations, will join in an undertaking to render high standards of medical and hospital care at as reasonable cost as such quality of care could be furnished under any system that could be devised.

The U. M. W. A. Welfare and Retirement Fund is concerned in the main with pensions, disability benefits, death benefits, and medical, health, and hospital services for members of the organization. In the last mentioned, it is the purpose of the Fund to provide a prepaid form of hospital service and medical attention in all of the districts and in all local unions. Arrangements are being made to utilize present medical and hospital services under conditions which guarantee high standards of medical and hospital care and are satisfactory to the physicians, the hospitals, and the Fund alike.

When these arrangements are completed in a given district, it will mean that the expense of medical and hospital services will be borne by the United Mine Workers' Welfare and Retirement Fund and that the members will be freed from paying a monthly amount deducted from their wages—so much a month to the hospital fund and so much a month to the doctor—as now exists in many places.

It is possible that experience may demonstrate the necessity of providing additional and more specialized facilities for meeting the needs, but this will come from knowledge gained through present procedure and through the availability of funds.

Medical administrative offices, each in charge

of a full-time physician employed by the Fund and working under the direction of the Executive Medical Officer, are being established at ten locations in or near the soft coal mining areas as follows:

Johnstown, Pa., serving District 2—Dr. S. B. Brinkley
Pittsburgh, Pa., serving Districts 3, 5, 6—Dr. Leslie A. Falk
Morgantown, W. Va., serving Districts 31, 16, 4—Dr. Lorin E. Kerr
Charleston, W. Va., serving District 17—Dr. John T. Morrison
Beckley, W. Va., serving District 29—Dr. Deane F. Brooke
Denver, Col., serving Districts 10, 15, 22, 27—Dr. William Dorsey
Knoxville, Tenn., serving Districts 19, 23—Dr. John D. Winebrenner
Birmingham, Ala., serving District 20—Dr. Allen N. Koplin
St. Louis, Mo., serving Districts 12, 13, 14, 21—Dr. Cecil A. Z. Sharp
Louisville, Ky., serving Districts 8, 11, 23, 30—Dr. Asa Barnes

The area medical administrators, in collaboration with the physicians and hospitals in the districts, will work out simple and satisfactory agreements for providing medical and hospital care to eligible members and their dependents. The detailed arrangements may vary to some extent according to conditions within the districts.

In the beginning the activities will be directed to the hospitalization of those who are receiving disability benefits and pensions and therefore cannot obtain services through a checkoff on their wages. Included also will be U. M. W. A. members with serious conditions for which adequate treatment facilities are not available in the localities where they live. Through this approach the area medical administrators will be able to establish procedures and train their personnel before assuming a larger work load. The program will be extended gradually as the necessary arrangements can be made.

IS IT DEDUCTIBLE?

WALTER F. DONALDSON, M.D.,
Secretary-Treasurer.

Check covering my A.M.A. membership assessment is enclosed. Is this \$25 a deductible item for income tax
(Turn to page 616.)

Program of the American Medical Association for the Advancement of Medicine and Public Health

A Federal Department of Health

1. Creation of a Federal Department of Health of Cabinet status with a secretary who is a Doctor of Medicine, and the coordination and integration of all Federal health activities under this department, except for the military activities of the medical services of the armed forces.

Medical Research

2. Promotion of medical research through a National Science Foundation with grants to private institutions which have facilities and personnel sufficient to carry on qualified research.

Voluntary Insurance for the Care of the Medically Indigent

3. Further development and wider coverage by voluntary hospital and medical care plans to meet the costs of illness, with extension as rapidly as possible into rural areas. Aid through the states to the medically indigent by the utilization of voluntary insured hospital and medical care plans with local administration and local determination of needs.

Medical Care Authority with Consumer Representation

4. Establishment in each state of a medical care authority to receive and administer funds with proper representation of medical and consumer interest.

New Facilities

5. Encouragement of prompt development of diagnostic facilities, health centers, and hospital services, locally originated, for rural and other areas in which the need can be shown and with local administration and control as provided by the National Hospital Survey and Construction Act or by suitable private agencies.

Public Health

6. Establishment of local public health units and services and incorporation in health centers and local public health units of such services as communicable disease control, vital statistics, environmental sanitation, control of venereal diseases, maternal and child hygiene and public health laboratory services. Remuneration of health officials commensurate with their responsibility.

Mental Hygiene

7. The development of a program of mental hygiene with aid to mental hygiene clinics in suitable areas.

Health Education

8. Health education programs administered through suitable state and local health and medical agencies to inform the people of the available facilities and of their own responsibilities in health care.

Chronic Diseases and the Aged

9. Provision of facilities for care and rehabilitation of the aged and those with chronic disease and various other groups not covered by existing proposals.

Veterans' Medical Care

10. Integration of veterans' medical care and hospital facilities with other medical care and hospital programs and with the maintenance of high standards of medical care, including care of the veteran in his own community by a physician of his own choice.

Industrial Medicine

11. Greater emphasis on the program of industrial medicine, with increased safeguards against industrial hazards and prevention of accidents occurring on the highway, in the home, and on the farm.

Medical Education and Personnel

12. Adequate support with funds free from political control, domination and regulation of the medical, dental, and nursing schools and other institutions necessary for the training of specialized personnel required in the provision and distribution of medical care.

Leaders Become Targets—Be a Leader

The appended comprise the introductory remarks of Mr. Clem Whitaker of the publicity team, Whitaker and Baxter, as delivered preceding the presentation of the A.M.A.'s public instruction program to the Conference of State Medical Societies at Chicago, Ill., Feb. 12, 1949. This meeting was attended by more than 200 representative A.M.A. and state medical society officers and lay employees. Pennsylvania was represented at this conference by Dr. Donaldson, secretary-treasurer; Executive Secretary Perry; Mr. Brown, executive assistant to our Committee on Public Relations; and Dr. John A. Daugherty, president of the Medical Service Association of Pennsylvania. Dr. Francis F. Borzell, of Philadelphia, was also in attendance.

Mr. Chairman and Ladies and Gentlemen:

None of us here in Chicago needs to be told that *there's a war on!*

The bullets are flying thick and fast and a few stray shots from our own troops already have perforated the walls of 535 North Dearborn Street and our campaign headquarters at One North La Salle Street.

Winston Churchill promised the British people nothing but "*blood, sweat and tears.*" I think we can add to that, with great assurance, that some of us in this room are almost certain candidates for *ulcers*. But no one, unfortunately, ever gets the purple heart for ulcers.

Seriously, American medicine is engaged in a bitter war for survival as a free institution.

The welfare of our country, as well as the welfare of the medical profession, is directly at issue.

This may well be the most momentous struggle of free men against government domination which will be fought out before the American people in our generation.

Today's session is a meeting of the War Department, and the men and women in this room are here because they will be field commanders or members of the general staff in American medicine's all-out war against socialization.

The responsibility is tremendous; the work involved for many of us will be nerve-wracking, and in many cases it may even seem thankless. But let's lift our sights to the horizon. This, without doubt, is the greatest opportunity any of us ever will have to play a vital role in determining the destiny of American medicine, and even more important, the destiny of the American people.

This is it! This is D-Day for all the things we believe in!

We all know the history of what's happened elsewhere. When medicine goes down, it's the beginning of the end.

To freedom of speech, freedom of religion, freedom of assembly, and a free press, the world needs to add a new fifth freedom—*freedom of medicine!*

There's been considerable sharpshooting at the A.M.A. by doubting Thomases who wonder out loud whether the A.M.A. really means business in this campaign, and whether a vigorous crusade will be conducted.

Miss Baxter and myself have been given warm, wholehearted support by the Coordinating Committee of the A.M.A. in every phase of the campaign program which we have proposed and undertaken. There hasn't been a dissenting vote. There hasn't been any holding back. There hasn't been any question, at any time, that the American Medical Association wanted a militant program, an affirmative program—and a program which we believe deserves the support of every member of the medical profession, and every lay employee who represents it.

Naturally, the A.M.A., having accepted leadership in this fight, is going to be a target, from this point on, for all the bureaucrats, the socializers, and the malcontents. But let's put a stop to carping criticism in our own ranks. We can defeat our enemies, but it's difficult to fight our friends.

This is a gigantic campaign—and it can't be put together overnight. You men and women, because most of you have had practical experience in organization work, know that. But there are others who don't—and all of you, as you go back to your home states, after today's session, can be tremendously helpful in stilling doubts and putting out fires until battle orders are received and materials start to flow.

Let's divert the energies of the expert needlers and the masters of invective into the proper channels, and have them direct their barbs at Oscar Ewing. It will save a great deal of time here in the A.M.A. offices and in our headquarters, and will enable us to get the campaign in high gear much more quickly.

I am reminded of those first awful weeks after the disaster at Pearl Harbor when the Japs taunted us with "Where is the United States Navy?" and when thousands of Americans, alarmed at the lack of action, echoed the cry and exclaimed: "Where's our Navy? Why isn't it fighting?"

When those cries were making headlines, the United States Navy, even though crippled and battered, was putting its ships in order and carefully mapping the battle strategy which finally enabled it to sink the Jap fleet in action. The Jap Navy, which made almost every naval error in the books, might have been better off if it, too, had spent some time in intelligent planning and organizing.

The A.M.A.'s Navy and Army, let me assure you, are not inactive. And when the showdown battle comes in Congress, I have an idea that all of us will be glad, and proud, that we built on a sound foundation.

We're still about 500 letters behind at the end of each day in the avalanche of correspondence that has descended on our offices, but we are gradually catching up. Before many weeks have rolled by, you may think you hear too much from us. But we do look forward to working with you, and we will be very grateful for your cooperation in the months ahead, when the chips are down.

purposes? I know the A.M.A. Fellowship dues are deductible, but is this assessment deductible?

Jan. 31, 1949

SECRETARY'S NOTE: The Bureau of Legal Medicine and Legislation of the American Medical Association has expressed the opinion that the current A.M.A. membership assessment of \$25 is deductible for income tax purposes.

Article XI of the A.M.A. Constitution provides that "funds may be raised by an equal assessment or dues of not more than \$25.00 annually on each of the active members on recommendation by the Board of Trustees and after approval by the House of Delegates."

Such action was unanimously taken during the Interim Session of the A.M.A. in St. Louis in December, 1948.

Chapter II of the By-Laws of the American Medical Association under "Tenure and Obligations" includes the following:

"Active members shall pay dues or assessment which are required by the By-Laws. Any active member who is delinquent in the payment of his dues for one year shall forfeit his active membership if he fails to pay the delinquent dues within thirty days after notice of his delinquency has been mailed by the Secretary to his last known address."

The constituent state medical associations and the component county medical societies have undertaken to collect the current A.M.A. assessment from their respective active members, all of whom are concurrently active members of the American Medical Association.

PLAN FOR COLLECTION OF \$25 ASSESSMENT

To the Secretaries of the Component County Medical Societies:

We are herewith advising our component society secretaries of the plans for billing their members for the American Medical Association \$25 assessment. It involves a request for a separate check for that amount in favor of "American Medical Association—Assessment," to be forwarded to the office of the secretary-treasurer. This will save considerable banking and bookkeeping technique, and afford this office opportunity to record each payment accurately before sending checks to the A.M.A.

As you know, the A.M.A. has formally requested state societies to make the collection, and our Board of Trustees has authorized a technique to be developed with adequate help in this office (at A.M.A. expense) to facilitate said collection with expenditure of the irreducible minimum of time and effort by county society secretaries.

We do not wish to interfere with your plans in this problem and our responsibility may be met if checks in favor of the A.M.A. when received by you are forwarded by you *via* this office, thereby permitting us to maintain accurate records.

We are preparing to send, early in January, to each active member of The Medical Society of the State of

Pennsylvania and of the A.M.A. in Pennsylvania (10,465) an envelope containing:

- (1) a statement of the A.M.A. assessment which requests check made as above indicated, with opportunity to report if the check has been sent to the county society;
- (2) a stamped envelope addressed back to this office to contain check and the statement;
- (3) a brief explanatory letter.

This plan should relieve your society of details and expense but not of responsibility for urging prompt and complete support of this assessment and plan by means of which the A.M.A. may realistically demonstrate unity among its 140,000 members and for the first time, with new virility, speak and act for its members.

Each active member of our State Society will receive a letter on this subject within a few days from Dr. George F. Lull, secretary of the American Medical Association.

Very truly yours,
WALTER F. DONALDSON,
Secretary-Treasurer.

Dec. 27, 1948

EXCERPTS FROM MINUTES OF BOARD OF TRUSTEES MEETINGS

Oct. 3, 1948

A regular meeting of the Board of Trustees of The Medical Society of the State of Pennsylvania was held at 10:30 a.m., Sunday, Oct. 3, 1948, in the Bellevue-Stratford Hotel, Philadelphia.

Officers in attendance were: Drs. Hugh M. Miller (1st), John J. Sweeney (2d), Francis J. Conahan (3d), Charles V. Hogan (4th), Park A. Deckard, chairman (5th), Joseph S. Brown (6th), George S. Klump (7th), Herman H. Walker (8th), Frank A. Lorenzo (9th), James L. Whitehill (10th), Leard R. Altemus (11th), and Thomas R. Gagion (12th), Elmer Hess, president, Gilson Colby Engel, president-elect, and Walter F. Donaldson, secretary-treasurer.

Others present were: Drs. C. L. Palmer, chairman of Committee on Public Health Legislation; Howard K. Petry, chairman of Committee on Public Relations; and Louis W. Jones, chairman of Committee on Medical Economics; and Mr. Lester H. Perry, executive secretary.

Chairman Deckard called the meeting to order at 10:30 a.m.

The minutes of the July 15 and 16 meetings were approved as corrected (slight typographical errors).

Formal Approval of Mail Vote of Sept. 3, 1948

SECRETARY DONALDSON: As set forth here, the vote was favorable to both items on that ballot—the Monday luncheon meeting to be addressed by Dr. Hawley on the proposed Blue Cross-Blue Shield merger, and the other to approve of the Society issuing a letter to Pennsylvania physicians, soliciting participating physicians for MSAP. (See page 230, December, 1948 PENNSYLVANIA MEDICAL JOURNAL for Dr. Hawley's similar address to the House of Delegates.)

It was moved, seconded, and unanimously carried that the mail vote of Sept. 3, 1948, be formally approved.

Reports of Medical Defense Cases

Tenth District—Dr. Whitehill reported on medical defense case No. 374.

Reports of Board Committees

CHAIRMAN WHITEHILL: The *Finance Committee* reports that the 1948 audit is available for your review.

Cash balances on hand Sept. 30, 1948, in five separate accounts were reported.

DR. WHITEHILL: I think some of our investments will need to be revamped in the next year or so, and possibly be more diversified.

DR. ENGEL: I believe in diversification of investments, and for years have engaged an investment counselor.

A motion was unanimously carried that the Finance Committee accept President Engel's source of counsel and advice, or at their discretion before acceptance employ equally qualified advice.

It was moved, seconded, and unanimously carried that the report of the Finance Committee be accepted.

The report of the *Publication Committee*, presented by Chairman Gagon, provided a statistical report on Volume 51 of THE PENNSYLVANIA MEDICAL JOURNAL, October, 1947, through September, 1948, 1488 pages, with an increase of 72 pages over Volume 50. The report touched on the increase in cost of printing, and referred to the financial section of the report of the secretary-treasurer to the 1948 House of Delegates, in the September JOURNAL, as telling the financial story of Volume 51.

The circulation of the September JOURNAL was reported as 11,482 copies.

The report was concluded with the advice that some equitable means should be formulated to allocate available space to the several active committees of the Society that seek publication of their purposes and activities.

It was moved, seconded, and unanimously carried that the chairman of the Publication Committee return the article submitted by the chairman of the Commission on Control of Syphilis and Venereal Diseases and ask him to condense it to 2000 words.

It was moved, seconded, and unanimously carried that the report of the Publication Committee be accepted.

Report of Building Maintenance Committee

CHAIRMAN CONAHAN: The last second and third floor tenants moved from 226 State Street on September 16, and Mr. Perry has contacted the architect.

Of the meetings held at 230 State Street from January to September, ten were night meetings held by non-state medical society groups. I request the opinion of the Board members on the question of risk.

After free discussion, it was moved, seconded, and unanimously carried that the Society's building be not used for meetings except those pertaining to the affairs of The Medical Society of the State of Pennsylvania.

There was general agreement that meetings of the Woman's Auxiliary or the committees of which Dr. Palmer is a member may be held at 230 State Street inasmuch as their work is related to that of the State Medical Society.

It was moved, seconded, and unanimously carried that the report of the Building Maintenance Committee be accepted.

PRESIDENT HESS: I have nothing to report except that I have been very happy to have served with you

and wish to thank you all for your cooperation and for your accomplishments in the name of the Society.

PRESIDENT-ELECT ENGEL: With the heavy duties thrown on those in the administrative work of this organization, it is important to choose a first vice-president who may be expected to attend the meetings of the Board of Trustees, committee meetings, and be an ex officio member wherever he can help to carry on the administrative burden of this society. I further think that it should be spread between two or more vice-presidents.

(There was general agreement that Dr. Engel's statement was a matter for consideration by the House of Delegates.)

DR. GAGON: I would like Dr. Miller to define the word "institution" as it appears in his motion of July 16. (Secretary's note. See page 1440, September PENNSYLVANIA MEDICAL JOURNAL.)

It was moved, seconded, and unanimously carried that the words "medical staff" be substituted for the word "institution" in the motion by Dr. Miller as passed at the July 16 meeting.

SECRETARY DONALDSON: I have prepared several items for your action and instruction to Chairman Deckard for the supplemental report of this Board of Trustees to the House of Delegates. (Secretary's note: See page 227, December, 1948 PENNSYLVANIA MEDICAL JOURNAL.)

It was moved, seconded, and unanimously carried that the Board of Trustees adopt the resolution included in the supplemental report to the House of Delegates, as read by Dr. Donaldson.

SECRETARY DONALDSON: We have an invitation addressed to the president from Frank W. Nash, chairman of the Council on Dental Health of the State of Pennsylvania. Dr. Hess thinks, and I agree, that we should be represented at their meeting. I think that you might choose one representative from our Committee on Child Health, and possibly Dr. Palmer could represent us.

It was moved, seconded, and unanimously carried that Drs. Deckard and Stein, of Harrisburg, represent The Medical Society of the State of Pennsylvania at the conference.

SECRETARY DONALDSON: I sent all of you a copy of a communication that I received on September 20 from Mr. J. W. Holloway of the Bureau of Legal Medicine and Legislation of the A.M.A. (read parts of this correspondence). He wants the reactions of the various state medical societies to such a proposal. I have submitted this to our legal counselor, but have not yet received a reply. Would you like to postpone action until we hear from him? (It was so agreed.) (Secretary's note: A reply received the next day advised that "medicolegal problems are increasing. In order to keep the members of the medical profession closely advised on development in the field and also throw its weight behind progressive legislation, such a national organization would be of real benefit to the profession.")

DR. HESS: It seems to me that very few medical men understand anything about the legal aspects of the jobs they are doing, and if we can get clarification from some source, it would be very valuable.

Dr. Gagon then voiced his approval of a letter which Dr. Donaldson wrote to Dr. Sica, chairman of the Board of Trustees of the Medical Society of the State of New Jersey (see permanent record).

The Board heard an informal report from Dr. Louis W. Jones on what he had done with the VA problem since the Board's July 15-16 meetings.

It was moved, seconded, and unanimously carried that the meeting be adjourned until 8 p.m., October 3, to reconvene in Room 108.

The meeting was adjourned at 1 p.m.

PARK A. DECKARD, *Chairman*,
WALTER F. DONALDSON, *Secretary-Treasurer*.

The Board of Trustees reconvened at eight o'clock, Sunday evening, Oct. 3, 1948, in the Bellevue-Stratford Hotel, Philadelphia.

Officers in attendance were: Drs. Hugh M. Miller (1st), John J. Sweeney (2d), Francis J. Conahan (3d), Charles V. Hogan (4th), Park A. Deckard, chairman (5th), Joseph S. Brown (6th), George S. Klump (7th), Herman H. Walker (8th), Frank A. Lorenzo (9th), James L. Whitehill (10th), Leard R. Altemus (11th), Thomas R. Gagon (12th), Drs. Elmer Hess, president, Gilson Colby Engel, president-elect, and Walter F. Donaldson, secretary-treasurer.

Others present were: Drs. C. L. Palmer, chairman of Committee on Public Health Legislation; Louis W. Jones, chairman of Committee on Medical Economics; Howard K. Petry, chairman of Committee on Public Relations; Francis F. Borzell, chairman, and William Bates, Advisory Council on Medical Service; Laurie D. Sargent, past chairman of the Board of Trustees; and Mr. Lester H. Perry, executive secretary.

Chairman Deckard called the meeting to order at 8 p.m.

The first item of business was consideration of the *Report of the Executive Secretary* (see p. r.).

Of the two matters requiring action, one was previously disposed of, namely, the use of 230 State Street for outside organizations. Remaining for action was the question of whether or not the Society would pay expenses to the A.M.A. meetings in St. Louis for these employees—Messrs. Brown, Jansen, Perry, Richards, and Stewart.

It was moved, seconded, and unanimously carried that the Board approve the recommendation of the executive secretary that expenses for the forthcoming meeting be paid for the executive assistant and publicity assistant of the Public Relations Committee, staff secretary to committees, convention manager, and executive secretary.

DR. WHITEHILL: It should be thoroughly understood that this action is for that particular session only (St. Louis, November 30 to December 3).

MR. PERRY: I mention St. Louis because of the special features of this year's convention and the fact that we have the additional staff to undertake it.

PRESIDENT HESS: At the last meeting of the Blue Cross-Blue Shield Commission, which I attended as a member of the A.M.A. Council on Medical Service, this joint commission promised that it would do nothing about the formation of a national insurance company until it received the approval of the A.M.A. Council on Medical Service. In the meantime the joint commission has drawn plans for two corporations—one of them a veritable national insurance company.

The A.M.A. Council on Medical Service believes that an enrollment corporation at the national level is proper to handle national accounts, but does not believe that a national insurance company at this time is proper. The

latter proposal has created so much consternation among some of the state service plans that many of their representatives were in Chicago at the A.M.A. Council meeting during the last three days. Dr. Hawley has been granted the privilege of presenting his case before this Board and our House of Delegates tomorrow, so I thought that to help us in making our decision, Secretary Tom Hendricks should come here to tell us exactly what happened in Chicago the last three days.

It was moved, seconded, and unanimously carried that Mr. Thomas Hendricks be invited to attend the October 4 luncheon meeting of the Board of Trustees.

Report of the Convention Manager

A copy of Mr. Stewart's report, dated Sept. 28, 1948, was distributed to the Board members (see p. r.).

Report of Committee on Public Health Legislation

DR. PALMER: You have a copy of the report (see p. r.), also a letter from the Pennsylvania Osteopathic Association which was received the day before yesterday (see p. r.).

We of your committee—Drs. Grier Miller, Deckard, and myself—think that if the final decision of the Pennsylvania Osteopathic Association is that they must have as many osteopaths (1100 in Pennsylvania) on a proposed composite licensing board as there are doctors of medicine (13,000 in Pennsylvania), our committee, with the approval of this Board and the House of Delegates, should reply that we can discuss their first four points, but if the fifth point is their final decision, we cannot waste any more time discussing the situation.

It was moved, seconded, and unanimously carried that Dr. Palmer proceed in the name of the State Medical Society along the lines of thought expressed.

It was moved, seconded, and unanimously carried that the resolution regarding animal experimentation be approved.

It was moved, seconded, and unanimously carried that the views of the Committee on Public Health Legislation regarding practical nurses be approved.

DR. PALMER: The next item is Red Cross blood banks. We believe that if we follow the suggestions of the June, 1948 A.M.A. House of Delegates meeting, we can cooperate with the Red Cross. They will be so notified if you approve.

It was moved, seconded, and unanimously carried that the Board of Trustees approve the ideas of the Committee on Public Health Legislation concerning Red Cross blood banks.

DR. PALMER: The Woman's Auxiliary, which has been very cooperative, has a very ambitious program. Our committee adopted a recommendation that representatives of their organization attend our meetings. The Auxiliary now desires to have approval by the Board of Trustees and the House of Delegates that county auxiliary committees on public health legislation be permitted to approach the same committees of the county medical societies with the idea of cooperating in health legislation work. If the Board agrees to that, it will be carried to the House of Delegates.

It was moved, seconded, and unanimously carried that this suggestion of the Committee on Public Health Legislation be approved.

It was moved, seconded, and unanimously carried that Dr. Palmer be allowed to accept the position of professional relations officer of the Medical Service Association of Pennsylvania.

SECRETARY DONALDSON: The Committee on Revision of the Constitution and By-laws held a final meeting this afternoon, which was attended by Dr. Borzell. Every item was cleared except one having to do with the fate of our own society's Council on Medical Service, of which Dr. Borzell has been the chairman for a number of years. He is resigning from that and the council is not mentioned in the proposed revision. Drs. Bates and Borzell are here to speak to this Board about the advisability of continuing in some form one or two of the functions of that council.

DR. BORZELL: The Middle Atlantic States Regional Conference, which was organized at the request of the A.M.A. Council on Medical Service, has been successful and the structure of that conference has become a pattern which is being followed in other regional conferences throughout the nation.

Unless some provision is made by the Board, or by the House of Delegates, to keep intact in the personnel of the Advisory Council certain members of the State Society who were taking an interest in its affairs, namely, the chairmen of certain active committees and certain officers of the Society, there will be no official representation of the State Medical Society at the next regional conference which will be held soon in Philadelphia.

DR. BATES: I would like to see the Middle Atlantic States Conference continued. It has accomplished something in the last three and a half years. This Board, with its right to appoint committees, might, as it reorganizes, appoint an Advisory Committee on Medical Service consisting of such men as it sees fit, without any authority from the Constitution. Among the functions of that committee should be designated representation in the Middle Atlantic States Conference.

DR. ENGEL: It was on the basis of that Middle Atlantic States Conference that we were able, in a three weeks' period, to set up and call a conference on disaster emergency medical service in atomic warfare.

DR. BATES: In the proposed Constitution and By-laws, for the first time, we have named every committee and commission, defined their functions, their breadth of authority, where they originated, etc. Do we need to go back and include this in our projected report this week to the House of Delegates?

(It was the consensus of those present that it was not necessary to mention an Advisory Committee on Medical Service in the projected report of the Committee on Revision of the Constitution and By-laws.)

Report of the Committee on Public Relations

CHAIRMAN PETRY: You have received a rather extensive report from the Committee on Public Relations (see p. r.), and there is a rather extensive one going to the House of Delegates. Since the Public Relations Committee is dispensing some \$30,000 this year, I feel that we are in duty bound to give you full reports of our activity so that you may know what use is being made of this money.

The Committee on Public Relations believes that the Woman's Auxiliary should be asked to take over the annual health poster contest. It has been our experience that a great many county medical societies are not willing to make the required effort. We think that the Woman's Auxiliary might very properly take over the arrangements for future poster contests.

We are getting more requests for speakers from

county societies to talk at local meetings on the question of political medicine. We have two good men in the Harrisburg office who can present this subject quite satisfactorily; but if we are going to adopt the policy of furnishing lay speakers on any large scale, it will be necessary to increase the lay personnel of our Society. It was the recommendation of the committee that such an increase be made.

DR. GAGION: Have you any idea how to get into a county society of 175 members who have not developed one man qualified to go out and speak on the subject of socialized medicine?

DR. PETRY: The idea in adding another competent speaker to the staff was that he go out to discuss training with the county societies.

It was moved, seconded, and unanimously carried that the Board of Trustees recommend to the 1949 Scientific Work Committee that papers for the scientific program be in the hands of the secretary sixty days prior to the annual session, and if not in sixty days prior to the session, that such speakers be replaced by other speakers.

Report of the Committee on Medical Economics

CHAIRMAN JONES: I reported informally on the Veterans Administration situation this morning. (Dr. Jones read a supplemental report of two paragraphs to the House of Delegates—see page 228, December, 1948 PENNSYLVANIA MEDICAL JOURNAL.)

It was moved, seconded, and unanimously carried that the supplemental report of the Committee on Medical Economics to the House of Delegates be approved.

Report of the Medical Service Association of Pennsylvania

DR. J. ARTHUR DAUGHERTY: As MSAP grows, it finds an increasing problem arising in the enrollment of subscribers. In cooperating with Blue Cross, we are confronted with the question of paying for osteopathic service and cannot answer it. Under our enabling act we are not permitted to pay anyone except a doctor of medicine.

DR. PALMER: This is a very complicated problem. I know of no osteopathic hospital to which Blue Cross does not pay its insured hospital service obligations. They do not pay the osteopath. The Medical Practice Act was amended in 1941 by inserting a new section defining medicine and surgery and the healing arts. In Philadelphia there are doctors of medicine accommodating osteopaths by signing commitments to mental institutions for them.

After free discussion, it was the consensus that this question be held in abeyance until a legal opinion is received from our attorneys.

Report from Councilor Hogan

Dr. Hogan read his report addressed to Chairman Deckard under date of September 30 (see p. r.).

It was moved, seconded, and unanimously carried that Councilor Hogan's excellent report be received and that the Board of Trustees postpone discussion until after the Wednesday meeting of the House of Delegates.

New Business

Secretary Donaldson read a communication received from the Committee on Child Health recommending an increase in the training period for rotating internships devoted to pediatrics (see p. r.).

DR. HESS: I think that the State Board of Medical Education and Licensure sets up the rules and regulations which are required for a rotating internship.

It was moved, seconded, and unanimously carried that the communication from the Committee on Child Health be referred to the State Board of Medical Education and Licensure without comment from the Board of Trustees.

Correspondence

Secretary Donaldson read a communication from the Princeton University Press and said, "Inasmuch as we are so much interested in Dr. Benjamin Rush this year, many members might enjoy an opportunity to purchase this book, *The Autobiography of Benjamin Rush*, published by the non-profit Princeton University Press. Should we give them the privilege of using our address system?"

It was moved, seconded, and unanimously carried that the Princeton University Press be given the privilege of using the State Society's mailing list to inform members of the MSSP regarding their publication of a book about Benjamin Rush.

DR. PETRY: There is something that I should like to say to this board. I have served on the State Advisory Hospital Council, which is charged with determining the eligibility and the distribution of the Federal Hill-Burton contributions to hospitals.

The council recently met to discuss the Hill-Burton allocations for the first two years. It appears that there are certain areas in the State of Pennsylvania which have a high priority rating for small hospital facilities essentially as health centers and from which no applications have come. Notably in that group are some in the northwestern corner of the State. At the meeting in which the allocations were made, I learned that information concerning this was sent to existing hospitals, but that no effort has been made to contact the communities which have no hospitals. Should I communicate with the medical societies of those counties to apprise them of the fact that they are eligible and hold high priority if they wish to take steps locally to participate in the distribution of funds? Nine million dollars was approved to flow into this state in the next two years on applications which are already on file. Pennsylvania can proceed immediately.

It was moved, seconded, and unanimously carried that Dr. Petry be given the authority to send out a communication to the secretaries of the county societies regarding the availability of funds for construction facilities under the Hill-Burton bill, this letter to be sent by him as an individual.

DR. PETRY: In some larger communities where two hospitals exist, if they both make application and an award is made to one, the priority of that district immediately dips tremendously and the other hospital is frozen out. I have taken the stand that the State Hospital Advisory Council has no right to determine the relative standing of two applicant hospitals in the same community. The decision should be referred back to the community for arbitration.

(It was the consensus that Dr. Petry had assumed the correct stand on this question.)

SECRETARY DONALDSON: We received a communication from the family of Dr. McAlister expressing their appreciation of the flowers sent as an expression of sympathy at the time of his death.

DR. GAGION: I should like to make as a matter of record a vote of welcome to this Board meeting to a

former Board member who gave splendid service over a period of ten years.

It was moved, seconded, and unanimously carried that a vote of welcome be given to Dr. Laurrie D. Sargent, former chairman of the Board of Trustees.

It was moved, seconded, and unanimously carried that the meeting be adjourned until the luncheon meeting on Oct. 4, 1948.

The meeting adjourned at 11 p.m.

PARK A. DECKARD, *Chairman*,
WALTER F. DONALDSON, *Secretary-Treasurer*.

Oct. 5, 1948

A regular meeting of the Board of Trustees of The Medical Society of the State of Pennsylvania was held Tuesday morning, Oct. 5, 1948, in the Bellevue-Stratford Hotel, Philadelphia. While the meeting started at approximately 9:45 a.m., the stenographer was not called in to take official minutes until 10:45 a.m.

Officers in attendance were: Drs. Hugh M. Miller (1st), John J. Sweeney (2d), Francis J. Conahan (3d), Charles V. Hogan (4th), Park A. Deckard, chairman (5th), Joseph S. Brown (6th), George S. Klump (7th), Herman H. Walker (8th), Frank A. Lorenzo (9th), James L. Whitehill (10th), Leard R. Altemus (11th), Thomas R. Gagon (12th), Elmer Hess, president, Gilson Colby Engel, president-elect, and Walter F. Donaldson, secretary-treasurer.

Others present were: Dr. C. L. Palmer, chairman of Committee on Public Health Legislation, and Mr. Lester H. Perry, executive secretary.

The following motion was passed, following discussion on the questions submitted by the Columbia County Medical Society (resolution appended):

It was moved, seconded, and unanimously carried that the chairman of the Board of Trustees report back to the House of Delegates the receipt of the resolution from Columbia County Medical Society, advising that the subject, including the A.M.A. resolution referred to, is under investigation by the trustees to be reported back at the next session of the House of Delegates.

RESOLUTION

WHEREAS, The American Medical Association has condemned by formal resolution the practice of medicine by closed staff institutions which employ physicians on a salary basis exploiting their services, and which thereby do practice medicine as institutions, the Columbia County Medical Society of the State of Pennsylvania hereby urges the adoption by The Medical Society of the State of Pennsylvania of a similar resolution so that such institutions as exist in this state might be informed that their practices are opposed to the efforts and policies of organized medicine and not contributory to the public weal; therefore, be it

Resolved, That whereas the American Medical Association has condemned by formal resolution the practice of medicine by closed staff institutions which employ physicians on a salary basis exploiting their services, and which thereby do practice medicine as institutions, The Medical Society of the State of Pennsylvania reaffirms its endorsement of the policies of the American Medical Association in condemnation of institutions engaging in such practices.

Respectfully submitted,

JOSEPH V. M. ROSS, Delegate,
G. PAUL MOSER, President,
JESSE G. FEAR, Secretary,
Columbia County Medical Society.

Discussion Regarding Proposed National Blue Cross-Blue Shield Insurance Plan

MR. PERRY: The Executive Committee of the MSAP referred these Blue Cross-Blue Shield merger proposals to this Board asking that you study them and advise the MSAP before October 6 of your approval or disapproval. I have had copies made and distributed of the statement referred to by Mr. Hendricks (see pages 273-274, December PENNSYLVANIA MEDICAL JOURNAL for quotations from statement and from comments made by Mr. Hendricks). MSAP looks to this Board for advice.

The point made in this A.M.A. Council report is that a proposal of this moment should not be voted on by representatives of medical service plans until it has first been taken upon by the House of Delegates of the A.M.A.

Over many years there have been a number of conferences and meetings with Blue Cross to try to solve this problem of national enrollment and reciprocal relations between these plans. The final result that they arrived at, Blue Shield getting into the picture in this planning about a year ago, has just been crystallized within the past few weeks. I think it is an important problem, but I don't think that a delay from October 23 to the first week in December is going to be too vital one way or the other and I do feel that the medical profession of the country should understand exactly what this is and be given the opportunity to express its opinion.

DR. GAGION: Then you don't see any need for this Board to be hasty in advising representatives of MSAP before the French Lick conference?

MR. PERRY: I think that it is important to tell the MSAP, which has looked to you for advice, just what you think—either it is all right to go ahead at French Lick, or without prejudging the merits of the plan itself you think they should wait until after further study by the House of Delegates of the American Medical Association. If the board of MSAP followed the advice of this board and so instructed their delegates, then their delegates would have to vote "no" at the forthcoming meeting at French Lick.

DR. ENGEL: The problem here is on a national level to serve the public. We have been on the negative side long enough. I think this whole situation resolves itself to a very pointed question. We were told that the representatives of the doctors on the proposed board would elect the Blue Shield part of that board. The Blue Cross groups would elect for their part. There are doctors in hospital administration, so doctors have a predominance. We should stop bickering over a problem like this.

DR. KLUMP: We weren't at the moment discussing the divisions of this proposal, but I agree with every word you said. If you have read the A.M.A. Council's comment on this subject, you can't help but feel that it ends up on an emotional plea. There is no objective approach in it.

It was moved and seconded that the Board of Trustees endorse the spirit of a national setup to correlate all approved service plans to become available to all people; further, in view of the short time this board has had to digest the specific proposals, it will defer for further study final action on the problem; further, that a copy of this motion be referred to the American Medical Association.

DR. ENGEL: MSAP representatives will go to the French Lick meeting. Supposing a majority of the Blue Shield-Blue Cross plans voted in favor of this specific proposal. What will Pennsylvania's position be with the public if the majority of the plans vote in favor of this, and we are listed with those who didn't vote or those who voted "no"? We would have another problem on our hands.

MR. PERRY: There is not going to be unanimous approval of this proposal by Blue Cross. There is a difference of opinion not only in Blue Shield but in Blue Cross. The question we are getting clarified now is the one that has been on my mind all along. The Pennsylvania delegation at the French Lick meeting will not have enough influence to change the character of what we are voting on. If the spirit of the French Lick meeting is the same as it was at Los Angeles, where the majority wanted a definite decision one way or the other, then the vote will be on these proposals and not on the general principle. If the vote is on the general principle, how do we vote? I would take it that we vote "no."

DR. ENGEL: You wouldn't vote according to this recommendation.

MR. PERRY: If the vote is on these proposals, then we are listed as not voting.

DR. KLUMP: May I ask why we are deferring a "yes" or "no" decision in our suggestion to the Medical Service Association Board? Are we delaying our decision to wait for the A.M.A., or because we are afraid of these proposals?

DR. GAGION: I want to have a better conception in my mind as to exactly what we are approving or disapproving.

DR. KLUMP: I have it here in outline form. Presently existent are Blue Cross plans and Blue Shield plans, also the Blue Cross Commission and the Blue Shield Commission. This much discussed proposal is made only for legal reasons.

Decision on 1949 Dues

After discussion, it was moved, seconded, and unanimously carried that the Board of Trustees recommend to the House of Delegates that the 1949 dues of The Medical Society of the State of Pennsylvania remain the same as last year—\$15, one dollar to be allotted to the Medical Benevolence Fund and two dollars to the Educational Fund.

It was moved, seconded, and unanimously carried that the meeting be adjourned, the Board to reconvene Oct. 6, 1948, at 1 p.m.

The meeting adjourned at 11:45 a.m.

PARK A. DECKARD, *Chairman*,
WALTER F. DONALDSON, *Secretary-Treasurer*.

Oct. 6, 1948

A meeting of the Board of Trustees of The Medical Society of the State of Pennsylvania was held Wednesday, Oct. 6, 1948, in the Bellevue-Stratford Hotel, Philadelphia.

Members in attendance were: Drs. Hugh M. Miller (1st), Francis J. Conahan (3d), Charles V. Hogan (4th), Park A. Deckard (5th), Joseph S. Brown (6th), George S. Klump (7th), Herman H. Walker (8th), James L. Whitehill (10th), Leard R. Altemus (11th), and Thomas H. Gagon (12th).

Officers and newly elected Board members present were: Drs. Gilson Colby Engel, president; Walter F. Donaldson, secretary-treasurer; E. Roger Samuel, president-elect; Elmer Hess, past president; Harold B. Gardner, first vice-president; and James Z. Appel, councilor, Fifth District.

Others present were: Drs. C. L. Palmer, chairman of Committee on Public Health Legislation; Howard K. Petry, chairman of Committee on Public Relations; Louis W. Jones, chairman of Committee on Medical Economics; Mr. Lester H. Perry, executive secretary; and Mr. Thomas Hendricks, secretary of A.M.A. Council on Medical Service.

The meeting was called to order by Chairman Deckard at 1 p.m.

Unfinished Business

DR. GAGION: Concerning Associated Medical Care Plans, I was given some information this morning that I wish to have clarified. The "Joint Commission" was to have three A.M.A. members elected to it. The first three elected from the A.M.A. never attended the meetings.

MR. THOMAS HENDRICKS: The information is only partially correct. There was only one regularly called commission meeting at which there was no representative from the A.M.A. There have been eight or ten meetings since that time. The proposed constitution and by-laws of this organization calls for a board of the AMCP Commission of thirty members, of which six are to come from the A.M.A. This subject of naming the six members was presented to the A.M.A. Council on Medical Service on September 30. It was the feeling of the A.M.A. Council that the AMCP Commission should be integrated into the organization of American medicine. At that time they instructed the men who are members of the Council to appear before the AMCP Commission. That viewpoint was recommended for consideration in the proposed constitution and by-laws of the new commission.

The belief of the Council on Medical Service of the A.M.A. that the Council should not be integrated into AMCP but that AMCP should be integrated into American medicine was passed upon by the Commission of AMCP. The question now goes to the several plans for their vote. Members of the A.M.A. Council attending these meetings time after time asked the AMCP Commission members to speak not only to the Council but to the Board of Trustees of the A.M.A. concerning this matter. I believe that every member of AMCP is cognizant of the desires and recommendations of the Council on Medical Service of the A.M.A., and of the Board of Trustees.

DR. GAGION: We have no right to publish evidence of dissensions in opinions after we arrive at an action.

It was moved, seconded, and unanimously carried that the former action be rescinded and that from now on we publish in THE PENNSYLVANIA MEDICAL JOURNAL only the recorded actions of the Board.

DR. KLUMP: Would you interpret that to mean that the desire of a trustee to have his recorded vote published in the JOURNAL should be denied?

DR. GAGION: With a recorded request that vote should be published.

DR. WHITEHILL: The resolution we adopted yesterday did not entirely satisfy the MSAP board. They

wanted a "yes" or "no" answer. So they asked me if I would read this resolution at our meeting today. (Read resolution proposed by MSAP.)

It was moved, seconded, and unanimously carried that the Board should stand by its original resolution of Oct. 5, 1948.

Chapter V, Section 7, of the Constitution and By-laws

DR. GAGION: Yesterday the House of Delegates gave us a new constitution and by-laws and in Chapter V, Section 7, the phraseology reads:

"At the first meeting of the Board of Trustees and Councilors after the annual session of this Society, it shall organize by electing a chairman."

I should like to have this Board go on record and interpret the words "a chairman." Does it mean that any member could become chairman of this Board, or does it mean a chairman chosen from its own members? As this reads, all you need is "a chairman."

PRESIDENT-ELECT E. ROGER SAMUEL: I brought that subject up in the House of Delegates yesterday. The interpretation as given to me by Dr. Borzell is that The Medical Society of the State of Pennsylvania is incorporated under the state laws of Pennsylvania and its Board of Trustees are the incorporated trustees; therefore, under the state laws, it is necessary for you to elect as chairman one of your own members.

It was moved, seconded, and unanimously carried that the Board go on record as interpreting the first sentence of Section 7, Chapter V, of the By-laws, which ends with the phrase "electing a chairman," to mean a chairman from its own membership.

DR. HOGAN: This Board has yet to consider my report on the complaint against Montour County Medical Society.

It was moved and seconded that the Board of Trustees accept and approve the report of Councilor Hogan and that the Board sit as a judicial council on this question at its first stated meeting following the reorganization of the Board.

DR. KLUMP: I still am not entirely convinced of what we are going to consider. No specific charges have been made that have come through proper channels.

After free discussion, the previous motion was withdrawn.

DR. HOGAN: I originally gave my recommendation under Chapter III, Section 3, of the old By-laws.

It was moved, seconded, and unanimously carried that the Board follow the procedure outlined in Chapter III, Section 3, of the old By-laws:

"The censors of each district shall consider every case of appeal from the decision of a component county medical society by a member who has been censured, suspended, or expelled, provided that the appeal is made within three months after the censure, suspension, or expulsion. They shall report in writing their decision thereon to the county medical society, and also to the councilors of this Society. They shall consider and dispose of all questions affecting the principles of medical ethics that may be referred to them either by a component county medical society or by this Society. The decision of the censors in every case must be signed by a majority of the Board. In case a district contains an even number of censors, and a tie vote re-

sults, the councilor for that district shall cast the deciding vote. Any appeal or judicial question arising in a district comprised of less than three county societies shall be referred directly to the judicial council of this Society."

Further Unfinished Business

DR. CONAHAN: How should we handle a situation in which an applicant is refused membership in the medical society of his county?

SECRETARY DONALDSON: He may proceed under Chapter VIII, Section 3, of the new By-laws as follows:

"Any *doctor of medicine* who may feel aggrieved by the action of a component county medical society in refusing him membership shall have the right to appeal to the censors of the councilor district for their decision."

Introduction of New Officers and Trustees

CHAIRMAN DECKARD: I have a very pleasant duty to perform, that of presenting the new president-elect, Dr. E. Roger Samuel, and the first vice-president, Dr. Harold B. Gardner.

Dr. Deckard then presented Dr. James Z. Appel, the new trustee and councilor for the Fifth District, and welcomed back to the Board, Dr. Charles V. Hogan, Fourth District, and Dr. Joseph S. Brown, Sixth District.

Election of Chairman

Dr. Deckard then called for nominations for a chairman of the 1948-49 Board of Trustees.

Dr. Walker nominated Dr. Lorenzo as chairman. Seconded by Dr. Gagon.

It was moved, seconded, and unanimously carried that the nominations be closed and that Dr. Lorenzo be declared elected chairman of the Board of Trustees for the ensuing year.

Dr. Whitehill nominated Dr. George S. Klump as vice-chairman. Seconded by Dr. Gagon.

It was moved, seconded, and unanimously carried that the nominations for vice-chairman be closed and that Dr. Klump be declared elected vice-chairman of the Board of Trustees for the ensuing year.

DR. GAGON: Chairman Deckard, every member of this Board joins me in thanking you for all the fine things you have done for this organization; in appreciating the fairness with which you have presided over our Board of Trustees during the last two years, and in re-expressing the hope that we may long enjoy your interest and support in our problems.

Dr. Deckard was given a rising vote of thanks by the Board.

DR. DECKARD: For ten years I have enjoyed every meeting and association with you and take with me many fond memories and cherished friendships. I thank you all for your fine support.

In the absence of Chairman Lorenzo, Vice-chairman Klump presided for the remainder of the meeting.

VICE-CHAIRMAN KLUMP: President Engel requests the privilege of the floor because he must keep a previous engagement. So we will depart from the order of business.

PRESIDENT ENGEL: I want to ask your permission to do something in line with the policy of sensitizing new

officers and employing their talents. Dr. Harold B. Gardner is first vice-president. The House of Delegates has approved the proposal that he attend your Board meetings and become familiar with policies and activities. I have promised to appoint Dr. Robert L. Schaefer, who is second vice-president, as an ex officio member of the Committee on Public Health Legislation; Dr. John W. Barr, third vice-president, as an ex officio member of the Committee on Medical Economics; and Dr. Louise Gloeckner, fourth vice-president, as an ex officio member of the Committee on Public Relations. By thus serving they will each in a real sense participate in the administration of the Society.

It was moved, seconded, and unanimously carried that these appointments be approved.

PRESIDENT ENGEL: For your consideration and confirmation of my appointees to the Committees on Public Relations, Medical Economics, and Public Health Legislation, Secretary-Treasurer Donaldson will read the appointments. Dr. Palmer will again head the Public Health Legislation Committee which consists of appointees recommended by each member of this Board.

Election of Editor

Dr. Altemus nominated Dr. Walter F. Donaldson as editor. Seconded by Dr. Walker.

It was moved, seconded, and unanimously carried that the nominations be closed and that Dr. Walter F. Donaldson be declared elected editor of THE PENNSYLVANIA MEDICAL JOURNAL for the ensuing year.

Election of Executive Secretary

Dr. Whitehill nominated Mr. Lester H. Perry as executive secretary. Seconded by Dr. Miller.

It was moved, seconded, and unanimously carried that the nominations be closed and that Mr. Lester H. Perry be declared elected executive secretary for the ensuing year.

Election of Convention Manager

Dr. Altemus nominated Mr. A. H. Stewart, Jr., as convention manager. Seconded by Dr. Walker.

It was moved, seconded, and unanimously carried that the nominations be closed and that Mr. A. H. Stewart, Jr., be declared elected convention manager.

Election of Legal Counsel

Dr. Hogan nominated Mr. Philip H. Strubing, of the firm of Evans, Bayard and Frick, of Philadelphia, as legal counselor. Seconded by Dr. Whitehill.

It was moved, seconded, and unanimously carried that the nominations be closed and that Mr. Philip H. Strubing be declared elected legal counselor for the ensuing year.

In each of the above selections the honorarium or salary recommended by the Finance Committee was unanimously approved by the Board.

Election of Advisory Council on Medical Service

It was moved, seconded, and unanimously carried that the Advisory Committee on Medical Service of the Board of Trustees be composed of the chairmen of the Committees on Public Relations, Medical Economics, and Public Health Legislation, together with Dr. Frank R. Hanlon, of Wilkes-Barre; Dr. John Davis Paul, of Philadelphia; Dr. Alfred E. Chadwick, of Beaver; Dr. John J. Sweeney, representing the Board of Trustees, and the president, president-elect, and secretary-treasurer.

Appointment of Committee on Public Health Legislation

DR. PALMER: Dr. Deckard would be glad to serve on the committee in some capacity, and I would like to have him. I feel that he should be given the office of vice-chairman of the Committee on Public Health Legislation so that he can be active in the work.

It was moved, seconded, and unanimously carried that Dr. Park A. Deckard be appointed vice-chairman of the Committee on Public Health Legislation.

Dr. Conahan, Third Councilor District, then proposed the name of Dr. William J. Corcoran, of Scranton.

Dr. Whitehill, Tenth Councilor District, proposed the name of Dr. Wilbur E. Flannery, of New Castle.

Inasmuch as these changes were acceptable to Dr. Palmer, it was moved, seconded, and unanimously carried that Dr. William J. Corcoran, of Scranton, representing the Third District, and Dr. Wilbur E. Flannery, of New Castle, representing the Tenth District, be appointed to serve on the Committee on Public Health Legislation.

Appointment of Committee on Medical Economics:

Louis W. Jones, Wilkes-Barre, chairman; Dudley P. Walker, Bethlehem; John T. Farrell, Jr., Philadelphia; LaRue M. Hoffman, Williamsport; Norman T. Ochsenhirt, Pittsburgh; Thomas W. McCreary, Rochester; Edgar W. Meiser, Lancaster, and ex officio, John W. Barr, Johnstown.

Appointment of Committee on Public Relations:

Howard K. Petry, Harrisburg, chairman; Allen W. Cowley, Harrisburg; Archibald Laird, Wellsboro; J. Hart Toland, Philadelphia; Leo H. Crip, Pittsburgh; James M. Mayhew, Greensburg; Frederic B. Davies, Scranton; J. Van S. Donaldson, Butler; Samuel B. Hadden, Philadelphia, and ex officio, Louise C. Gloeckner, Conshohocken.

It was moved, seconded, and unanimously carried that the personnel of the Committees on Medical Economics and Public Relations be accepted as read.

It was moved, seconded, and unanimously carried that the honorarium of Mr. James H. Thompson be raised to \$1,000 per year, to be charged against the budget of the Committee on Public Health Legislation.

Discussion of the Budget

Dr. Petry presented the budget of the Committee on Public Relations and explained it in detail.

It was moved, seconded, and unanimously carried that the twelve months' budget of \$50,000 as proposed for the Committee on Public Relations be approved.

After further discussion, it was moved, seconded, and unanimously carried that the proposed total twelve months' budget of \$273,690 be adopted.

Appointment of Board Committees:

Finance: James L. Whitehill, chairman, Herman H. Walker, and James Z. Appel.

Library: George S. Klump, chairman, and Joseph S. Brown.

Building Maintenance: Francis J. Conahan, chairman, Hugh M. Miller, and John J. Sweeney.

Publication: Thomas R. Gagon, Chairman, Leard R. Altemus, and Charles V. Hogan.

Medical Benevolence: E. Roger Samuel, chairman, Francis J. Conahan, treasurer, Laurie D. Sargent, and Walter F. Donaldson, secretary.

It was moved, seconded, and unanimously carried that the Board committees be approved as submitted.

Election of Committee on Educational Fund

It was moved, seconded, and unanimously carried that the election of this committee be deferred until the next regular meeting of the Board, same to appear in the agenda under "unfinished business."

Time of Next Meeting

It was moved, seconded, and unanimously carried that the next meeting of the Board of Trustees be held as follows: Dinner meeting, Thursday evening, Dec. 16, 1948, at 6:30 p.m.; meeting, Friday morning, Dec. 17, 1948, at 9 a.m.

The meeting was adjourned at 4:50 p.m.

PARK A. DECKARD, *Retiring Chairman*,
FRANK A. LORENZO, *Chairman*,

WALTER F. DONALDSON, *Secretary-Treasurer*.

CHANGES IN MEMBERSHIP OF COUNTY SOCIETIES

New (48) and Reinstated (8) Members

ALLEGHENY COUNTY: Robert C. Beswick, Frederick P. Franke, Bernard Kline, John R. Orie, and Robert A. Rydze, Pittsburgh.

ARMSTRONG COUNTY: Donald H. Schumaker, Leechburg.

BEAVER COUNTY: John W. Colavincenzo, New Brighton; Everett O. Sheets, Beaver Falls.

BERKS COUNTY: William F. Finzer, Reiffton; William H. Keffer, Reading.

BRADFORD COUNTY: Peter P. Mayock, Jr., Sayre.

BUTLER COUNTY: Paul DeMerit, Chicora; David E. Imbrie, George Kulick, and Michael Kulick, Butler.

CLEARFIELD COUNTY: Nathaniel Yingling, Clearfield.

CUMBERLAND COUNTY: Charles M. Reddig, Carlisle.

DAUPHIN COUNTY: Vaun Archie Newell, Harrisburg.

DELAWARE COUNTY: Paul A. Loefflad, Upper Darby.

ERIE COUNTY: James Elmer Croop, Waterford; Robert B. Dugan, George John Dusckas, Williams C. Kinsey, Carl B. Lininger, William J. Logue, Roland E. Miller, Michael V. Sivak, Wilbur S. Wallace, and William D. Weber, Erie. (Reinstated) John E. Donovan, Erie.

FAYETTE COUNTY: Jay H. Daniels, Connellsville; Edwin J. Kamons, Uniontown; Anthony W. Moats, Jr., Fairchance.

LACKAWANNA COUNTY: Edgar L. Dimmick, Dunmore; John J. Gaffney, Throop; Robert L. Hickok, Philadelphia. (R) William A. O'Hara, Olyphant; Russell D. Rodham, Scranton.

LANCASTER COUNTY: Charles R. Beitell, Jr., Holtwood; Oscar Davis and Henry J. Glah, Jr., Lancaster; David E. Krusen, Paradise. (R) Russell P. Stoner, Marietta.

LEBANON COUNTY: John A. Bamberger, Annville; Meyer Perchonock, Lebanon.

McKEAN COUNTY: Bernard S. Bretherick, Port Allegany.

MONTGOMERY COUNTY: Franklin C. Kelton, Ambler; Arthur F. Mann, Pottstown; Thomas W. Richards, Willow Grove; Ralph V. Santo, Philadelphia; Chester G. Thomas, Norristown.

NORTHUMBERLAND COUNTY: (R) Clark B. Zimmermann, Lewisburg.

SOMERSET COUNTY: (R) Thomas L. McCullough, Springfield, Mo.

WESTMORELAND COUNTY: Vincent A. Kehm, Herminie. (R) Joseph F. Lipinski, New Kensington; Lawrence W. McGough, Trafford.

Resignations (12), Transfers (14), Deaths (22)

ALLEGHENY COUNTY: *Transfers*—Richard C. Allsopp, Evans City, to Butler County Society; Harry W. Bowman, Bethlehem, to Northampton County Society; Michael E. Farah, New Kensington, to Westmoreland County Society; Louis J. Kowalski, Harrisburg, to Dauphin County Society. *Deaths*—George J. Kastlin, Pittsburgh (Univ. Pa. '24), December 31, aged 48; Edward M. Iland, Coraopolis (Univ. Pgh. '96), January 14, aged 78; William T. Mitchell, Pittsburgh (Johns Hopkins Univ. '16), January 29, aged 58.

ARMSTRONG COUNTY: *Transfer*—Violet M. Hemminger, Somerset, to Somerset County Society. *Death*—William H. Nix, Worthington (Jeff. Med. Coll. '05), January 10, aged 73.

BERKS COUNTY: *Transfer*—John E. Barsby, Quakertown, to Bucks County Society. *Death*—George R. Hetrick, Birdsboro (Jeff. Med. Coll. '23), January 25, aged 55. *Resignation*—Robert C. Prall, Montclair, N. J.

BUCKS COUNTY: *Resignation*—George A. Enion, Philadelphia.

CUMBERLAND COUNTY: *Death*—Joseph L. Dougherty, Mechanicsburg (Med.-Chi. Coll. '10), December 31, aged 63.

DAUPHIN COUNTY: *Transfer*—Charles F. Taylor, Lebanon, to Lebanon County Society. *Resignation*—T. Eugene Andes, Martinsburg, W. Va. *Death*—Paul C. Walter, Harrisburg (Johns Hopkins Univ. '23), November 26, aged 51.

ERIE COUNTY: *Death*—J. Frank Rutherford, Hastings (Coll. P. & S., Baltimore, '92), January 14, aged 82.

FAYETTE COUNTY: *Resignations*—Gerald M. DeWoody, West Palm Beach, Fla.; Warren D. Leslie, Wheeling, W. Va.

FRANKLIN COUNTY: *Transfers*—John P. Manges, Bethlehem, to Northampton County Society; Sarah I. Morris, Harrisburg, to Dauphin County Society.

JEFFERSON COUNTY: *Death*—William M. McCormick, Falls Creek (Jeff. Med. Coll. '31), October, 1948, aged 43.

LACKAWANNA COUNTY: *Death*—William E. Keller, Scranton (Univ. Pa. '92), December 29, aged 76.

LANCASTER COUNTY: *Transfer*—Samuel S. Barr, Lebanon, to Lebanon County Society. *Death*—Amos B.

Schnader, Terre Hill (Jeff. Med. Coll. '03), January 19, aged 73.

LEHIGH COUNTY: *Death*—Mark A. Baush, Allentown (Jeff. Med. Coll. '23), January 3, aged 52.

LUZERNE COUNTY: *Death*—Gideon L. Howell, Trucksville (Univ. Pa. '12), January 13, aged 63.

LYCOMING COUNTY: *Resignation*—William H. Eyster, Jr., Rochester, Minn.

MONTGOMERY COUNTY: *Transfer*—William F. Hanišek, Easton, to Northampton County Society.

NORTHAMPTON COUNTY: *Transfers*—Edward J. Ford, Lancaster, to Lancaster County Society; Rupert E. Kelly, Ridgway, to Elk County Society.

NORTHUMBERLAND COUNTY: *Transfer*—Robert A. Houston, Annville, to Lebanon County Society.

PHILADELPHIA COUNTY: *Transfers*—Thomas S. Armstrong, Jr., Carlisle, to Cumberland County Society; John W. Bieri, Camp Hill, to Dauphin County Society; Joseph A. DeCaro, Chester, to Delaware County Society; Herbert P. MacNeal, Carlisle, to Cumberland County Society. *Deaths*—Basil R. Beltran, Philadelphia (Med.-Chi. Coll. '12), January 20, aged 59; George MacIntire Ferguson, Philadelphia (Jeff. Med. Coll. '99), January 18, aged 74; George Nelson Richmond, Philadelphia (Univ. Pa. '95), January 9, aged 79; Maurice Silverman, Philadelphia (Jeff. Med. Coll. '24), January 20, aged 49; Maurice T. Sloane, Philadelphia (Med.-Chi. Coll. '14), January 15, aged 57; Charles J. Swalm, Philadelphia (Univ. Pa. '06), January 1, aged 64; Abel E. West, Philadelphia (Leonard Med. Coll. '08), January 9, aged 73.

SOMERSET COUNTY: *Death*—Walter F. Johnson, New York City (Jeff. Med. Coll. '24), July 13, aged 48.

TIOGA COUNTY: *Resignation*—Claude S. Johnson, Clinton, N. Y.

WARREN COUNTY: *Death*—Edwin S. Africa, Warren (Hahn. Med. Coll. '07), December 30, aged 69.

YORK COUNTY: *Resignation*—Stuart Rizika, Baltimore, Md.

CONTRIBUTIONS TO MEDICAL BENEVOLENCE FUND

The Committee on Medical Benevolence makes grateful acknowledgment of the following contributions to the fund. These have also been previously acknowledged individually.

Woman's Auxiliary, Lackawanna County ...	\$486.00
Woman's Auxiliary, Montgomery County, in memory of Dr. C. J. Swalm	5.00
Woman's Auxiliary, Berks County, in memory of Drs. C. J. Swalm and W. B. Odenatt ...	15.00
Woman's Auxiliary, Lehigh County, in memory of Dr. Mark A. Baush	10.00
Woman's Auxiliary, Butler County, in memory of Mrs. L. R. Hazlett	5.00
Dr. C. T. Buckingham, Franklin County	50.00
Previously reported	221.68

Total contributions since 1948 report \$792.68

VETERAN REPAYS LOAN

Veterans' Loan Fund MSSP,
8104 Jenkins Arcade,
Pittsburgh, Pa.

I am enclosing check for \$300 as payment in full of
non-interest-bearing loan obtained through you in 1945.

With appreciation, I am,

_____, M.D.

Feb. 12, 1949

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has
been received since Dec. 31, 1948. Figures in first col-
umn indicate county society numbers; second column,
State Society numbers.

Jan. 3	Delaware	94-120	1422-1448	\$405.00
	Schuylkill	159-161	10510-10512	37.50
	York	87-94	1449-1456	120.00
	Franklin	1-12	1457-1468	180.00
6	Bucks	52-57	1469-1474	90.00
	Northampton	1, 5-103	1475-1574	1,500.00
7	Franklin	13-29	1575-1591	255.00
	Montgomery	221-246	1592-1617	390.00
10	Philadelphia	3182-1-40	1618-1657	600.00
	Lackawanna	1-78	1658-1735	1,170.00
	Berks	4-93	1736-1825	1,350.00
	Bradford	50	10513	15.00
	Bradford	1-14	1826-1839	210.00
	York	95-104	1840-1849	150.00
11	Lebanon	1-3	1850-1852	45.00
	Delaware	121-136,		
		142-160	1853-1887	525.00
12	Northumberland	1-26	1888-1913	390.00
	Dauphin	2	1914	15.00
	Juniata	1-7	1915-1921	105.00
	York	105-123	1922-1940	285.00
13	Columbia	3-36	1941-1974	510.00
	Lawrence	1-28	1975-2002	420.00
14	Lackawanna	277	10514	15.00
	Lackawanna	79-107	2003-2031	435.00
	Lebanon	4-12	2032-2040	135.00
	Clinton	1-9	2041-2049	135.00
15	Franklin	30-39	2050-2059	150.00
	Bucks	58-63	2060-2065	90.00
17	Westmoreland	207	10515	15.00
	Westmoreland	3-8	2066-2071	90.00
	Indiana	1-10	2072-2081	150.00
	Delaware	161-180	2082-2101	300.00
	Armstrong	1-22	2102-2123	330.00
18	Cumberland	1-24	2124-2147	360.00
	Clarion	1-20	2148-2167	300.00
19	Berks	94-162	2168-2236	1,035.00
20	Lackawanna	278	10516	15.00
	Lackawanna	108-130	2237-2259	345.00
	Somerset	1-12	2260-2271	180.00
	York	124-134	2272-2282	165.00
	Franklin	40-55	2283-2298	240.00
	Montour	1-27	2299-2325	405.00
	Fayette	1-3	2326-2328	45.00
	Beaver	1-3	2329-2330	30.00
21	Northampton	104-142	2331-2369	585.00
	Warren	10-24	2370-2384	225.00
	Indiana	11-22	2385-2396	180.00

Jan. 21	Westmoreland	208	10517	\$15.00
	Westmoreland	9-94	2397-2482	1,290.00
24	Fayette	4-47	2483-2526	660.00
	Butler	1-32, 34-41	2527-2566	600.00
	Lancaster	(1948)	10518	15.00
	Berks	163-179	2567-2583	255.00
	Northampton	143-154	2584-2595	180.00
	Lawrence	29-46, 48-49	2596-2615	300.00
	McKean	1-7	2616-2622	105.00
	Columbia	37	2623	15.00
25	Lackawanna	131-143	2624-2636	195.00
	Montgomery	247-270	2637-2660	360.00
	Somerset	13-14	2661-2662	30.00
	Cumberland	25-28	2663-2666	60.00
	Delaware	181-190	2667-2676	150.00
26	Westmoreland	95-108	2677-2690	210.00
	Bucks	64-69	2691-2696	90.00
27	Indiana	23-26	2697-2700	60.00
	Dauphin	3-38, 40-53,		
		55-61, 63-102,		
		151-213	2701-2860	2,400.00
28	Clinton	10-22	2861-2873	195.00
	Clearfield	1-28	2874-2901	420.00
	Allegheny	3, 951-1080,		
		1082-1286	2902-3236	5,025.00

ARE YOU USING THE PACKAGE
LIBRARY SERVICE?

Are you taking advantage of the facilities
offered by the package library service of The
Medical Society of the State of Pennsylvania?
There are, at the present time, over 97,000 re-
prints and tear sheets from current periodicals
filed in the library for your use.

Prior to 1944 the average yearly number of
requests was approximately 350. However, from
1944 to 1948 inclusive, there has been a con-
tinuous increase in borrowers. A total of 1192
requests were received during 1948, an increase
of 293 requests over the total for 1947.

One hundred and sixteen requests were filled
from January 1 to January 31 covering the fol-
lowing subjects:

Raynaud's disease	Chronic pericarditis
Tay-Sachs disease	Regional enteritis
Harelip	Seborrheic dermatitis
Cleft palate	Blood transfusions
Vivisection	Enuresis
Paget's disease	Undulant fever (2)
Migraine	Muscular contraction
Nervous disorders	Diseases of the spleen
Child health and care	Whooping cough
Simmonds' disease	Trench foot
Genital prolapse	Hypothyroidism
Histamine	Varicose veins
Ringworm of the scalp	Pneumoconiosis
Group practice	Electromyography
Wood's light	Treatment of leukemia
Electrocardiography	Enuresis in children
Pellagra	Chronic pancreatitis

Ulcerative stomatitis	Porphyria
Tendon injuries	Anoxia
Skin tumors	Medical service
Gout	Sutures
Radioactive iodine	Social psychiatry
Rh factor	Specialty boards
Histoplasmosis	Ophthalmology
Animal experimentation	Medical ethics
Group psychotherapy	Maternal mortality
Hysterectomy	Obstetrics
Cerebral hemorrhage	Adaptation syndrome
Hypertension	Tuberculosis therapy
Paralysis agitans	Medical education
Parkinson's disease	Poliomyelitis
Liver diseases	Nervousness
Kidney diseases	Thigh amputation
Tumors of the lung	The modern hospital
Modern drugs	Anemia
Rice diet (2)	Premarital laws
Carcinoma of the colon	Liver function tests
Perforated peptic ulcers	
Sex education in children (2)	
Use of radioactive iodine in hyperthyroidism	
Fluorine and dental caries	
Socialized medicine (6)	
Carcinoma of the gallbladder	

Tumors of the small intestine
 Penicillin aerosol treatment in sinusitis
 Vitamin E in heart disease (3)
 Absence of the gallbladder
 Desmoid tumors of the stomach
 Cancer of the breast (2)
 Public health in Pennsylvania
 Use of heparin and dicumarol
 Intestinal obstruction due to adhesions
 Carcinoma of the thyroid
 Polyostotic fibrous dysplasia
 Surgical treatment of scoliosis
 Heart disease and pregnancy
 Use of nitrogen mustard in Hodgkin's disease
 Treatment of the common cold
 Pennsylvania workmen's compensation
 Treatment of herpes zoster
 Use of intravenous ether in vascular diseases
 Gold therapy in arthritis
 Polycystic disease of the kidney
 Treatment of carcinoma of the larynx
 Pregnancy diagnosis (2)
 Amputation of extremities
 Allergy in otolaryngology
 Pennsylvania Psychiatric Society
 Veterans Administration

AMERICAN LEGION OPPOSES SOCIALIZED MEDICINE

Resolution No. 453

SUBJECT: OPPOSE SOCIALIZED MEDICINE

Recommended by the Committee on Rehabilitation and
Approved by the National Convention

WHEREAS, The American Legion has consistently opposed all efforts to socialize medicine in the United States as evidenced by the resolution adopted in 1945 and reiterated in 1946, and

WHEREAS, There is still persistent and constant effort being made to enact socialized medicine legislation for the alleged benefit of all the people of the United States, and

WHEREAS, Compulsory health insurance would result in a general loss of our high standards of health care which now exist and would deprive us of a large measure of our personal liberty and would also increase the burden of bureaucracy, and

WHEREAS, Government control of medical care would add an enormous tax burden to the American people, including hundreds of thousands of our disabled veterans of both wars, and widows and orphans of our deceased veterans, and

WHEREAS, The American Legion takes pride in our program of improving the standard of medical care within the Veterans Administration and other contract institutions, which has now done much to elevate the standard of care in all hospitals, and

WHEREAS, It is still our conviction that any compulsory health insurance plan—political medicine—destroys the essential personal relationship between patient and the doctor of his choice and increases Govern-

ment supervision and control of our private lives and is in full substance and effect—the planned economy of a collectivist nature—and,

WHEREAS, The Communists have proclaimed "socialized medicine is the keystone to the arch of the socialistic state," and

WHEREAS, Any plan of compulsory health insurance would have the tendency to lower the standard medical care that is now guaranteed our veterans and would also deprive the citizen of the right to select the quality of medical care that he can afford, and this, we believe, is contrary to the fundamental rights of the individual, and

Now therefore be it resolved by The American Legion in convention assembled in Miami, Florida, this 18th, 19th, 20th and 21st of October, 1948, that we are still unalterably opposed to all efforts and movements to enforce socialized medicine upon the American people.

(Sponsored and recommended
by the Department of Illinois)

MATERNAL DEATHS BY COUNTIES

On page 606, this issue, will be found a listing of "Deaths from Selected Causes in Pennsylvania, October, 1948." The column "Maternal Deaths" totals 12, divided by counties as follows: Blair and Butler, 2 each; Allegheny, Erie, Fayette, Lackawanna, Northumberland, Philadelphia, Schuylkill, and Westmoreland, 1 each. It is important that the causes for these deaths were determined and discussed by members of the medical societies in the counties where such deaths occurred.

1948 Was Year of Proud Achievement for Medical Service Association of Pennsylvania

Operations and activities of the Medical Service Association of Pennsylvania during the twelve months ended Dec. 31, 1948, showed substantial development and growth.

At the close of 1948 there were 353,643 Blue Shield subscribers enrolled in the association as compared to 130,380 at the end of 1947—an increase of 223,263. Based on the third quarter report of the Blue Shield Commission, MSAP's 1948 enrollment record will compare with other plans as follows: (1) among plans having 200,000 or more members—the highest percentage of enrollment increase, 171 per cent; (2) in number of subscribers enrolled—third largest in the country, exceeded only by the million-member plans in New York City and Michigan.

Assets reached a new high of \$1,021,005.57, increasing \$641,441.98 during 1948.

The cost of physicians' services incurred and deferred maternity cases during 1948 totaled \$1,669,514.50, which was \$1,079,562.50 more than in 1947. During 1948 the number of physicians' services incurred and deferred maternity cases was 30,240 as compared to 9980 during the preceding twelve months—an increase of 20,260.

The number of participating physicians on Dec. 31, 1948, stood at 7094, compared to 6415 a year ago.

The association's earned income in 1948 was \$2,210,038.08. During the year 75.5 per cent went for physicians' services and deferred maternity cases; 13.7 per cent for administration; 9.7 per cent for reserves; and 1.1 per cent for miscellaneous items.

The agreements in force at the close of 1948 represented an annual income of \$3,289,438.20—an increase of \$2,188,164.60.

Balance Sheet—December 31, 1948

ASSETS		LIABILITIES	
Bonds	\$163,377.21	Prepaid subscription fees	\$154,385.65
Cash—on hand and in bank	309,047.57	Reserves:	
Cash—in transit	335,724.32	Reported but unpaid physicians' services	20,388.50
Interest-bearing deposits	200,000.00	Unreported physicians' services ...	277,000.00
Accrued interest	177.78	Processing reports of unreported and unpaid physicians' services ..	15,000.00
Prepaid expenses	12,635.64	Deferred maternity cases	259,614.00
Admitted assets	\$1,020,962.52	Contingencies	294,574.37
		Liabilities and reserves	\$1,020,962.52

TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the co-operation of the Pennsylvania Tuberculosis Society
and The Medical Society of the State of Pennsylvania

THE decreasing incidence of tuberculosis in the United States has been accompanied by changes in the epidemiology of the disease which are of interest and concern to all physicians. Primary tuberculosis among adults, once relatively rare, is now increasing and in doing so presents new problems for clinicians and public health workers.

PRIMARY INFECTION AND PROGRESSIVE TUBERCULOSIS

In the pathogenesis of progressive tuberculosis, pulmonary or extrapulmonary, it has been a general assumption that there are mainly two separate danger periods: the first, at the time directly following primary infection; another, dependent on a secondary exogenous infection or an endogenous exacerbation of lesions formed during the primary infection and separated by a period of latency from the primary infection. Primary infection in early childhood exacts a certain toll of mortality from disseminated tuberculosis, miliary or otherwise, from meningitis and from direct extension from the primary complex. This is generally accepted and seems well substantiated by the early peak in tuberculosis mortality before the age of five. Whether this hazard from the primary infection exists only during childhood or continues throughout life is difficult to know.

The problem becomes more urgent, of course, with the decrease of childhood infection and the concurrent increase of primary infections in adults. Other questions are whether or not progressive pulmonary tuberculosis in adults is in a significant proportion of cases the direct consequence of primary infection, and, if so, whether or not primary progressive pulmonary tuberculosis in the adult can be differentiated clinically and roentgenologically from that disease which is caused by a secondary (endogenous or exogenous) infection in the presence of a healed primary complex.

In an impressive series of reports from the Scandinavian countries, the relation between primary infection and progressive pulmonary tuberculosis in adults has been studied. Complete

unanimity of opinion does not exist, but most, if not all, contemporary Scandinavian authors now agree that:

(1) Primary infection occurs frequently after the age of 18 or 20.

(2) Primary infection in adults is much more frequently accompanied by clinical symptoms, such as grip-like symptoms, fever and malaise, than is usually recognized in this country.

(3) Primary infection in adults is frequently associated, particularly in young women, with erythema nodosum (in Sweden, erythema nodosum is reportable as tuberculosis), with exudative pleurisy, and with parenchymal changes in the lung demonstrable by x-ray examination.

(4) A large proportion of all cases of "genuine" (reinfection type) tuberculosis is caused directly by primary infection.

(5) While primary infection can be diagnosed with certainty only by tuberculin conversion, erythema nodosum and certain roentgenologic changes should strongly suggest the diagnosis.

Whether or not the Scandinavian observations are representative for conditions in the United States is not known because an insufficient number of studies concerned with this problem have been published here.

It is known that erythema nodosum in association with primary tuberculosis is rare in this country. The shift of tuberculin conversion to higher age groups is as well known here as in Scandinavia. For the rest, there is little evidence for or against the Scandinavian conclusions. According to a few reports, a diagnostic differentiation between primary and secondary tuberculosis

is impossible without tuberculin tests proving recent conversion. This should not imply an absence of differences. Competent observers state that essentially the same anatomical differences exist in adults between primary and post-primary tuberculosis as in children. Clinical symptoms and objective signs of disease seem to be observed, in the early period following conversion, more frequently in Scandinavia than in the United States. It is uncertain whether this difference is in facts or in interpretation.

Most mass surveys in the United States have been made without tuberculin tests, and few have repeatedly examined the same persons. Serial tuberculin tests and repeated filming are necessary for disclosing the relation between primary infection and progressive tuberculosis. It is hoped that the large study on nurses, now being carried on under the joint auspices of the National Tuberculosis Association and the U. S. Public Health Service, will provide material suitable for analysis from a pathogenetic point of view.

It should be obvious that pathogenetic knowledge is not of academic interest only—it is unavoidably the foundation for all anti-tuberculosis work and will determine the effectiveness of such work.

It is possible that what is true in Scandinavia is not true in the United States. *Tuberculosis changes with time and place.* Every country must investigate its local epidemiologic conditions; none can accept, without proof, the findings in some other region.

BCG vaccination is the logical consequence of the epidemiologic situation in Scandinavia. If it should prove to be true for the United States that a large proportion of progressive tuberculosis in adults develops independently of a second exogenous infection, our present strategy of anti-tuberculosis work would need fundamental reforms.

Primary Infection and Progressive Tuberculosis, Editorial, Max Pinner, M.D., The American Review of Tuberculosis, October, 1947.

CAMPAIGN TO SPEED MEDICAL RESEARCH

Uniting in a simultaneous effort throughout the United States, 99 national scientific and civic organizations will seek to speed medical research through a campaign announced today by Dr. Anton J. Carlson, president of the National Society for Medical Research. The campaign, which is to be directed against research bans erected by the antivivisection cult, comes at a time when legislative battles on the "vivisection" question are raging in many states.

"The purpose of our national educational effort," Dr. Carlson stated in his announcement, "is to eliminate the paradoxical misunderstanding which makes some people support vast appropriations for medical research on one hand and oppose the work which is done with the money on the other hand.

"These people simply do not understand," Dr. Carlson explained, "that all medical science depends upon the study of living creatures—their body functions, their dysfunctions or diseases, and the effect of various treatments upon them. In other words, all of medical science is based upon 'vivisection,' which is defined by the antivivisection cult as experimentation with living creatures.

"Persons can oppose the study of life for the purpose of learning how to protect life if they want to," Dr. Carlson stated, "but we would like to so clarify the issue that persons who really want medical research to continue are not working to defeat their own interests through misunderstanding."

Dr. Carlson explained that most national magazines,

many advertisers, and several thousand clubs, associations, and colleges are cooperating in this attempt to clarify the meaning of the one word "vivisection" through a cooperative public educational effort to take place during the month of March.

Organizations cooperating in the attempt to clarify the vital role of experimentation in medical progress include: American Dental Association, American Diabetes Association, American Medical Association, American National Red Cross, American Public Health Association, American Veterinary Medical Association, Association of American Medical Colleges, National Research Council, National Foundation for Infantile Paralysis, National Science Teachers Association, and United States Junior Chamber of Commerce.

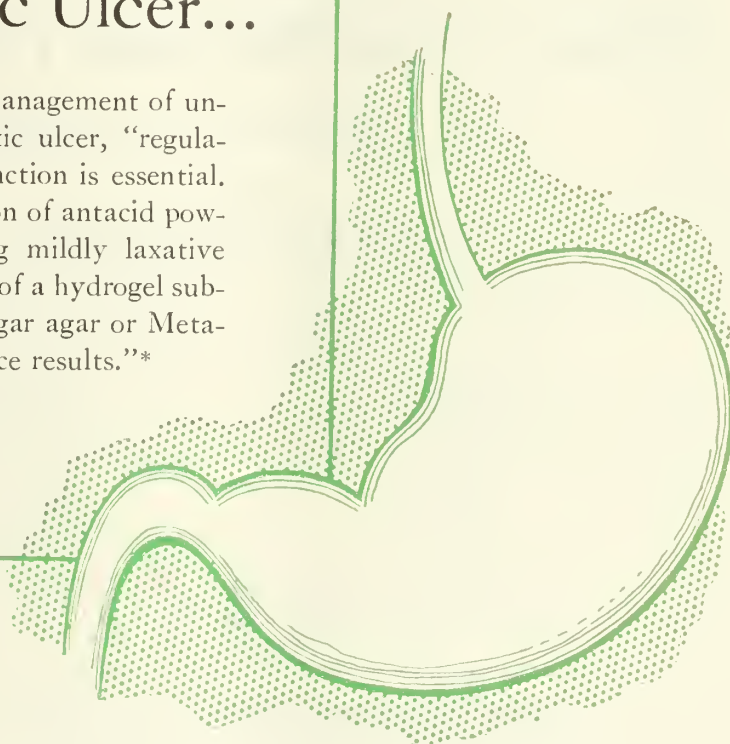
1949 SCIENTIFIC EXHIBIT APPLICATIONS AVAILABLE

The forms for applying for space in the Scientific Exhibit of the 99th Annual Session which will be held at the Hotel William Penn, Pittsburgh, Sept. 26 to 29, 1949, may be secured from Elwyn L. Heller, M.D., Chairman, Committee on Scientific Exhibits, Presbyterian Hospital, Pittsburgh 13, Pa.

Completed application forms must be returned to the committee by May 1 to receive consideration.

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*Gerendasy, J.: Modern Treatment of Peptic Ulcer, J. M. Soc. New Jersey 43:84 (March) 1946.

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"A CALL TO ARMS"



The practice of medicine in the United States, based upon the concepts of free enterprise and individual initiative, is threatened by a revolutionary change.

Indeed, our American way of life is in jeopardy if the plans from Washington reach a successful culmination, for the attack on American medicine is but the entering wedge for a socialistic form of government.

If we believe that the future progress of medicine depends upon the maintenance of that democratic system which has already led to a standard of medical care and public health far superior to that which prevails in any other land, we must then accept the challenge and battle for what we believe is to the best interests of the people.

Mr. Harold Stassen recently emphasized the obligation of the individual in promoting his own health and welfare. He also made it clear that once a situation is reached in which government takes away private initiative, a very definite threat to our individual freedom results. History has shown that once the government takes over the responsibility of the individual, the arrangement becomes a permanent one.

No government has ever controlled billions of dollars for the direct payment to physicians for the medical services provided by them without ultimately controlling and dictating the services rendered. It is not possible to socialize the means of paying for medical care without simultaneously socializing the quality and quantity of the product of medical care.

Whether medical care is supplied as it is now by private enterprise, or is furnished by some government agency, our people are going to pay for it. One of our biggest jobs is combating the people's notion that Federal medicine is "free medicine."

If the public at large really understood the Social Security Administration plans, I am sure they would reject the proposals.

It is therefore our obligation and our job to inform the public, by every means at our command, regarding the various aspects of state socialism. We can perform an invaluable service to our country if we devote the coming year largely to the study of social security and other "welfare" programs.

When the women of America are awakened to the effect that these programs would have on their homes, their children, their savings, and even upon their religious freedom, they will rise up in wrath and shout the story from the house-tops.

It is our duty to awaken these women. Each of us in our daily contacts with friends is an ambassador of the entire American medical profession. We must become truth missionaries among our friends, explaining at every opportunity the issues that are even more vital to their welfare than to our own. We must not hesitate to solicit the active aid of every possible friend in the work of preserving the conditions of practice that will enable the physician to serve the people with a high quality of medical care. We must feel confident that once the people learn the facts about compulsory health insurance—once they understand the advantages of private medical care as supplemented by voluntary plans of insured sickness service—they will reject the proposal for a politically dominated compulsory medical care system.

As mentioned by your president in her program for 1948-49, we must continue to carry on "the established Auxiliary activities . . . however, because of the recent onslaught on the medical profession . . . the public relations program should be pointed up and the mechanics of Auxiliary operation should be geared for more effective action."

We should lose no opportunity to disseminate knowledge and material exposing the fallacy of a compulsory sickness insurance program.

We must inform and stimulate lay organizations such as leagues of women voters, church groups, other women's auxiliaries, and any other group whose activities mold public opinion.



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It will not be easy to counteract the false publicity issued by Federal bureaus at Washington. However, if we are sincere when we say that we oppose state socialism in the United States, we can make our opposition prevail.

This is everybody's job. It is not a task for your national officers alone—not an assignment for your state or county officers alone—but it is a "Call to Arms" for each and every member of the Auxiliary. Working actively we can be of tremendous importance in educating the public.

Dr. Sensenich, the A.M.A. president, has said, "Miserably deteriorating medical processes have spread almost throughout the world. Within a year, we may either have won our freedom or miserably lost it to the politicians."

Whether we have that freedom or not may in a large measure depend upon the individual efforts of each and every Auxiliary member. The American Medical Association has placed great confidence in us in the past. Now is the time to prove that we have been worthy of that confidence. American medicine is at the crossroads. Never before has an informed public been so vital to our cause. Let us arise as one and spread the gospel of American medicine and the dangers of compulsory insurance under government control. Let us by every word, every deed, and every act place the facts before the public so that we will continue to merit the confidence placed in us by the A.M.A. and so that we will truly be an "Auxiliary" in deeds as well as in name.

(Mrs. David B.) KATHERINE B. ALLMAN,
President-elect,
Woman's Auxiliary to the American
Medical Association.

INTRODUCING THE BOARD MEMBERS

Committee Chairmen

Archives: Mrs. Walter Orthner, state president 1943-44, has also served the state as publicity chairman and councilor of the Sixth District. In Huntingdon County she has been chairman of various committees and president. Before her marriage, Mrs. Orthner was secretary to an attorney in Philadelphia. She is a past president of the Huntingdon Civic Club and the Music Club; past secretary of the Huntingdon County Federation of Woman's Clubs; director of the local Tuberculosis Society and American Cancer Society; and a member of the Juniata League and J. C. Blair Memorial Hospital Auxiliary. Her hobbies are handwork of all kinds and demitasse collecting.

Benevolence: Mrs. Charles H. Silvis, president of Westmoreland County 1945-46, formerly taught music in Claridge, Pa., and is now teaching piano. She is co-director of choral work at the Irwin Woman's Club,

member of the P.T.A., and a teacher in the Lutheran Sunday School. The Silvis' have one girl, age eight. Mrs. Silvis finds time for music, painting, and golf.

By-Laws: Mrs. Edward H. Bedrossian, an active member and past president of Delaware County, taught school and in 1935-36 was a volunteer orthoptist at St. Christopher's Hospital for Children. She is vice-president and health chairman of the Woman's Club of Drexel Hill. Her sons, E. Howard and Robert Haig Bedrossian, are physicians and her daughter, Doris Lydia, has her B.S. in dietetics.

Clippings: Mrs. William T. Hunt, Jr., Merion, a member of Philadelphia County, is a past president of Huntingdon County Auxiliary. She was formerly state benevolence chairman. She had done social service and kindergarten work at the Bedford Street Mission, Philadelphia. Her memberships include the memorial and social service committees of Jefferson Hospital, Auxiliary of Home for Incurables, and church organizations. She is also a past president of the Children's Service Club of Huntingdon. Her main hobby is travel, having jaunted about in Europe, Bermuda, and Canada. The Hunts have two girls, ages thirteen and ten.

Convention: Mrs. Jay G. Linn, state auxiliary president 1946-47, has also been councilor of the Tenth District and corresponding secretary. She has served Allegheny County as president and in other offices. She is now president of the Woman's Fortnightly Review of Mt. Lebanon and a director of the Woman's Club. Her hobbies are people and travel, and she has visited Mexico, most of the Caribbean Islands, British Guiana, Canada, Alaska, Cuba, Guatemala, Venezuela, and all but two of the United States. The Linns have two married daughters and a son who is an ophthalmologist.

Finance: Mrs. S. Dale Spotts, chairman of public relations in 1944-47 for the Woman's Auxiliary to the American Medical Association, is a past president of Philadelphia County. She was a teacher and psychologist at the Psychological Clinic, University of Pennsylvania, and a former board member of the Philadelphia Branch, American Association of University Women. A daughter is a sophomore at Northwestern University. Mrs. Spotts collects dolls, specializing in those representing different states in the United States, and first editions.

Hygia: Mrs. Otto C. Reiche served as president 1946-47 of the Hazelton Branch, Luzerne County. She had been a nurse and operating room supervisor at Long Island College Hospital, Brooklyn, N. Y. In Weatherly she has served on the executive board of the Visiting Nurses' Association since 1945 and is on the executive board of the Cancer Society, having conducted the campaign for the past two years. Her hobby is antiques. The Reiches' two sons are attending preparatory school.

Legislation: Mrs. Albert F. Doyle, currently public relations chairman and cooperating actively with the Cambria County Medical Society, taught English and history in Patton Junior High School, kindergarten in Johnstown, and was a supervisor of Johnstown playgrounds. She is a member of the board of directors of the Johnstown Branch, American Association of University Women, and program chairman of the Meadowvale School Mothers' Club. Dr. and Mrs. Doyle have two daughters, Susan and Karen, ages six and four.

National Bulletin: Mrs. Archibald Laird, a past president of Tioga County and very active in Wells-

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boro, was last year's president of the Forum and is now president of the P.T.A.; den mother to thirteen Cub Scouts; treasurer of the Community Concert Association; counselor of Wellsboro Junior Musician's Club; and a member of the D.A.R., Wednesday Morning Musicales, and the Eastern Star. She has visited the British Isles and has traveled from Maine to California. Collecting dolls and buttons are her hobbies. The Lairds have three sons, eleven, ten, and two, and a daughter, seven.

Necrology: Mrs. Harry B. Jones, a member of Beaver County, has also been public relations chairman for the state. A former teacher in Aliquippa, last year she was president of the Woman's Club of Aliquippa, and is at present treasurer of the Southwestern District of the P.T.A. Dr. and Mrs. Jones have a son fourteen years of age.

Nominations: Mrs. Rufus M. Bierly of Luzerne County (at present a "pleased onlooker") is our immediate past state president and was state program chairman, 1944-46. Before her marriage she taught English in Canton High School and public speaking and dramatics in Wilkes-Barre High School. She is a past president of the West Pittston Woman's Club, and at present head of the drama group of the Presbyterian Church, on the nominating committee of the Lackawanna Presbyterial Society, and a member of the Pittston Hospital Auxiliary and P.T.A. Her hobbies are books, plays (directing, acting, and reading), and music. She has traveled in Europe. On Oct. 19, 1948, she had the honor of helping celebrate her mother and father's fifty-fifth wedding anniversary. A son, Louis, is fifteen, and a daughter, Sally, is eleven.



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Postwar Planning: Mrs. Frederic B. Davies, a former dietitian and home economics teacher, is an active member in Lackawanna County. She is a member of the Scranton Century Club and Waverly Woman's Club. The Davies have one daughter, Nancy Elizabeth, twelve years of age.

Program: Mrs. Norman K. Beals, a past president of Venango County, is an outstanding community leader in Franklin, active in the P.T.A., Federation of Woman's Clubs, First Baptist Church, and Hospital Auxiliary. Her hobby is "raising my family and making their interests and hobbies mine." The Beals' have six children, five sons and a daughter. She states: "I was born in Lisbon, Portugal, and my parents brought me to the United States when I was nine years old. I speak, read, and write Portuguese and understand Spanish; established three missions among Portuguese people in Rhode Island and was pastor for five years of the Calvary Baptist Church in Lansdale, R. I.; traveled through twenty states and Mexico on preaching and evangelistic tours; eight years ago organized an Americanization school, through which over one hundred foreign people have become American citizens."

Public Relations: Mrs. John V. Foster, Jr., an active member of Dauphin County, was former program chairman for the state. She was a teacher of home economics. At present she is a member of the boards of the Harrisburg Child Welfare Association, Community Chest, and Pennsylvania State College Home Economics Alumni Association. She states: "My home is my greatest hobby; cooking." The Fosters have one girl, ten, and one boy, seven.

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Publicity: Mrs. Daniel H. Bee, a past president of Indiana County, has been Ninth District councilor. She was formerly head of the commercial departments of Coplay and Swarthmore High Schools. Last year she was president of the Indiana Junior Woman's Civic Club and at present is a member of the advisory health council of Indiana School District, Community Chest board, Hospital Auxiliary, Eastern Star, Republican Council of Women, and Alpha Sigma Tau Sorority, and a teacher in the Sunday School and Bible School of the First Methodist Church. Her hobby is boating on the Allegheny River. The Bees have one daughter, Mary Susan, age seven.

A.M.A. 98TH ANNUAL SESSION

Haddon Hall will be the headquarters for the annual meeting of the Woman's Auxiliary to the American Medical Association, which will be held in Atlantic City, N. J., June 6 to 10, 1949.

Requests for reservations should be sent at once to Dr. Robert A. Bradley, Chairman, Subcommittee on Hotels, 16 Central Pier, Atlantic City, N. J.

COUNTY NEWS

Auxiliary work and interest are increasing throughout the State as shown by reports from seventeen counties.

Christmas programs highlighted the activities at the close of 1948. On November 23 *Allegheny*, after hearing Mrs. Paul C. Craig's inspiring message, had Mrs. R. S. Stoner, an authority on table decorations, demonstrate various ways of making holiday decorations for doors, mantels, tables, and most any nook or corner. *Delaware* held a Christmas party December 16 at the Swarthmore Woman's Club. Santa Claus arrived at the home of Mrs. Francis L. Larkin, Uniontown, December 9, to distribute small gift items donated by local merchants to *Fayette* members; other gifts were exchanged. *Indiana* was entertained by the medical society with a dinner at the Indiana Country Club. Gifts were brought and given to the Child Welfare Services for distribution. In the Century Club, December 8, *Lackawanna* was entertained by Mrs. Shirley Ives Ritzel with a group of Christmas selections. Mrs. Walter Dickman gave a short reading. *Northampton* exchanged gifts, sang carols, and was entertained by Mrs. Stroub, guest soloist, and her accompanist, Mrs. Kleckner. At *Philadelphia's* Christmas bazaar, Miss Marcella Decray was the guest harpist. Christmas carols were sung. Mrs. William J. Jacoby, Fourth District councilor, spoke at a supper meeting in Frackville, *Schuylkill*, when the North-of-the-Mountain Auxiliary entertained the South-of-the-Mountain Auxiliary. Carols were sung and Christmas gifts were exchanged. *Warren* entertained their husbands at the Woman's Club with a dinner and a pleasant evening of music and games.

At the home of Mrs. John K. Covey, Bellefonte, Bernice Durgin Flegal, M.D., spoke to *Centre* on rheumatic fever. *Clinton* held a buffet supper and house-

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warming for Dr. and Mrs. Edward E. Hoberman on January 26, with the doctors as their guests. *Dauphin* held a luncheon meeting at the Penn-Harris Hotel, Harrisburg, January 14, and heard a fine talk by Hamblen C. Eaton, M.D., Harrisburg State Hospital, on "Some Aspects of Medical Research." Mr. Roy Jansen, publicity assistant to the Public Relations Committee, MSSP, showed two stimulating movies. Mrs. Clarence E. Moore explained the MSAP and Mrs. Gilbert L. Dailey told of happenings in the legislative field. Mrs. Drury Hinton, president-elect of the State Auxiliary, spoke at *Delaware's* January 13 luncheon meeting at the Inglenook Tea Room, Swarthmore. *Fayette* met January 6 at the Annette Nurses Home, Uniontown Hospital, when Mrs. Robert Steele spoke on the "Rediscovery of America" and reviewed three plays current on Broadway, "Knickerbocker Holiday," "The Patriots," and "Abe Lincoln in Illinois."

Harold F. Moffitt, M.D., Altoona, spoke to *Huntingdon* February 10, at the Nurses Home, on the problem of cancer. Dr. Moffitt is a member of the Cancer Commission of the State Medical Society and of the Board of Directors of the Pennsylvania Division of the American Cancer Society. Guests included members of the county medical society, the dentists and pharmacists of the county and their wives, and the nurses of the county. *Indiana* held a covered dish supper at the home of Mrs. Thomas W. Kredel, at which time Miss Nettie Bealor, Directress of Nursing, Indiana Hospital, spoke on the future of nursing. Mrs. Edward E. Reiss addressed *Mifflin* on animal experimentation at the February 11 luncheon at Green Gables Hotel, Lewistown. Mrs. Paul C. Craig discussed the auxiliary program with *Philadelphia* on January 11. Mrs. George E. Pfahler showed movies of "A Trip to Williamsburg and Return." An interesting article on socialized medicine in Great Britain was read at *Schuylkill's* January meeting at the home of Mrs. Allen Wesley Hildreth, Pottsville.

C. L. Palmer, M.D., chairman of the Committee on Public Health Legislation, MSSP, requested the signing of petitions concerning proper animal experimentation. *Delaware*, *Lebanon*, *Mifflin*, *Northampton*, *Northumberland*, and *Schuylkill* have distributed these petitions to their members. Mrs. Drury Hinton spoke at *Northampton* on this subject and the group assumed the responsibility for 1700 signatures. On January 14 Mrs. W. Horace Means read a script on the doctors' stand on the antivivisection legislation over Station WLBR, *Lebanon*. *Indiana* secured C. H. William Ruhe, M.D., assistant professor of physiology and pharmacology, School of Medicine, University of Pittsburgh, as

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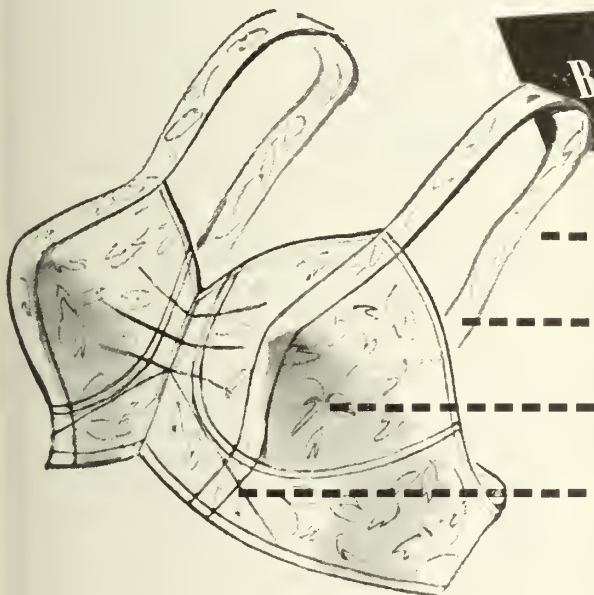
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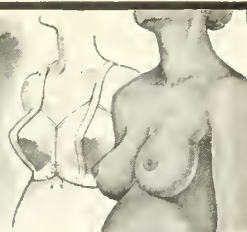
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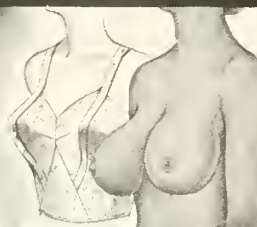
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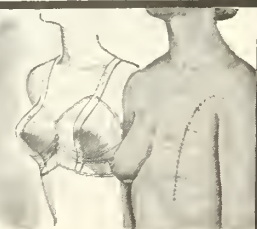
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Surgery of Colon and Rectum, one week, starting March 7, April 11.
Esophageal surgery, one week, starting June 13.
Thoracic Surgery, one week, starting June 20.
Breast and Thyroid Surgery, one week, starting June 27.
- GYNECOLOGY**—Intensive Course, two weeks, starting March 21, April 18, June 20.
Vaginal Approach to Pelvic Surgery, one week, starting April 4, May 16.
- OBSTETRICS**—Intensive Course, two weeks, starting March 7, April 4.
- MEDICINE**—Intensive Course, two weeks, starting April 4.
Electrocardiography and Heart Disease, four weeks, starting March 16.
Personal Course in Gastroscopy, two weeks, starting March 7, May 16.
Diagnosis and Treatment of Congenital Malformation of Heart, two weeks, starting June 13.
- PEDIATRICS**—Intensive Course, two weeks, starting April 4.
- DERMATOLOGY**—Formal Course, two weeks, starting May 2.
- CYSTOSCOPY**—Ten Day Practical Course every two weeks.
- UROLOGY**—Intensive Course, two weeks, starting April 18.

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a speaker on animal experimentation for the Junior Woman's Civic Club.

Lebanon is sponsoring a health poster contest, with Mrs. C. Ray Bell, Mrs. Harold A. Krohn, Mrs. John F. Loehle, Mrs. Herbert C. McClelland, and Mrs. F. Allen Rutherford in charge. *Northampton* is assisting in the contest sponsored by the Northampton County Medical Society.

Some of the auxiliaries are reporting new members. *Allegheny* reported twenty-seven new members to November 23. *Indiana* added to its roll Mrs. H. Curtis Long and Mrs. Ross Rumbaugh. In December *Lackawanna* introduced Mrs. Frank A. Bridgett, Mrs. Eugene Agnone, Mrs. George A. Clark, Miss Rose Comerford, Mrs. Harold H. Klein, Mrs. Joseph D. Moylan, Mrs. John C. Sanner, and Miss Agnes Sirgany. Mrs. Karl W. Hahn and Mrs. Paul B. Kreitz, Bethlehem, were welcomed at *Northampton*. *Philadelphia* held a luncheon honoring new members, who were presented with corsages and name-plates. Mrs. Glen Schwalm and Mrs. Ivan Schwalm, Valley View, joined *Schuylkill*.

Thoughts are turning to benevolence and other contributions. *Clinton* has contributed \$75 to benevolence. Mrs. Leslie E. Morgan and Mrs. Walter A. Redel, *Lackawanna* fund captains, announced a total of \$485 collected. *Lebanon* is collecting money at each meeting for use in a project; in November, flowers were auctioned and bridge tallies were sold. *Philadelphia's* Christmas bazaar was well attended. A prize was given to the best decorated table, a house furnishing booth. The money realized will be given to the benevolence fund. Other donations have been: *Delaware*, \$25 to the Camp and Hospital Branch of Red Cross; *Fayette*, a \$15 Tuberculosis Bond; *Indiana*, \$15 to Indiana County Child Welfare Services; *Northampton*, \$5 to Easton Red Cross and \$5 to Bethlehem Red Cross; *Schuylkill*, an orphan boy and girl in the county were outfitted with clothing by a Pottsville member; *Warren*,



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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

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Delaware is volunteering to make cancer dressings. Members are to meet in small groups at suitable times in the different communities to make them. While the work is going on, a member is to read aloud articles pertinent to medical legislation. This will help to inform and to educate along these lines. Discussions will follow. Warren held a work bee for the Warren General Hospital, January 18, at the Y.W.C.A.

Fayette appointed a committee to select the best name submitted by the county members for the State Newsletter. Mrs. David F. Sennett has secured a gavel for Fayette made from cherry wood over one hundred years old that had been taken from the old Laurel Hill Presbyterian Church. Two plates will be attached, one bearing the name and date of the founding of the auxiliary and one bearing the name and date of the founding of the church.

NEW HORIZONS AND CURRENT PROBLEMS IN PHYSICAL MEDICINE

Progress is being made in both basic and clinical research in physical medicine. We should be proud of the efforts of the investigators who are advancing the knowledge pertaining to our field. We are progressing so rapidly that it seems worth while to pause for a minute to survey the possibilities of our specialty.

Let us examine for a minute some of our opportunities for cooperative work with our colleagues in other specialties. Take, for instance, orthopedics; it is a recognized fact that the success of many surgical procedures is assured only by the intelligent and effective use of physical therapy and occupational therapy after surgery. In neuromedicine and neurosurgery we provide numerous diagnostic and therapeutic measures which are extremely valuable in the over-all care of patients with neurologic disorders. In internal medicine, the physiatrist provides a valuable service to the internist, from the point of view of diagnosis and treatment. His assistance is especially valuable for disorders of the soma, such as arthritis, fibrositis, arteriosclerosis, and post-febrile convalescence. Hydrotherapy, electroshock therapy, and therapeutic exercises are invaluable in the treatment of neurosis and psychoneurosis by the psychiatrist. These are some of the tools of physical medicine. Early ambulation, bed exercises, and specific remedial exercises have proven to be of great value for speeding up the recovery of postsurgical patients.

More important than the service to other specialties are the potentialities of the intrinsic activities of physical medicine itself. For instance, let us consider some of the special interests of the physiatrist.

Anterior Poliomyelitis.—Almost the entire treatment, aside from general medical and nursing care during the acute and convalescent stages, is in the field of physical medicine. The evaluation of abnormalities of the skeletal muscular system, the treatment by hot pack therapy, therapeutic exercises, gait training, and the non-surgical aspects of physical rehabilitation are entirely physical medicine. Postoperative care of the patients with poliomyelitis is also largely within our sphere.

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feet are disorders with which our specialty deals. The sooner the orthopedic surgeon recognizes that physical medicine has developed into a specialty and that the physiatrist is willing and anxious to work with him, the better it will be for everyone—physiatrist, orthopedist, and patient.

Arthritis.—Our most capable observers agree that physical medicine has much to offer the arthritic patient in the restoration of the function of muscles and joints.

Fever Therapy.—Fever therapy is still useful in the treatment of chorea, eye abnormalities, and arthritis. It is possible that in the future there will be an increased demand for this type of therapy when the synergistic aspects of hyperthermia and drugs are better understood.

Geriatrics.—Life expectancy has increased twenty years during the past decade and geriatrics is developing into a specialty. Experience has shown that physical medicine in the form of physical therapy, occupational therapy, and physical rehabilitation is the most effective form of therapeutics to offer this large group of patients.

Neuromuscular Disorders.—Next to nonsurgical orthopedics the most important branch of physical medicine is that of dealing with the diagnosis and treatment of neuromuscular disorders.

Electrodiagnosis reveals information regarding the irritability of the peripheral nerves and skeletal muscles. It includes diagnostic tests such as the reaction of degeneration, chronaxia measurements, strength-duration curves, galvanic-tetanus ratios, estimations of neurotization and maturation times. These determinations provide information which is indispensable to neurologists, neurosurgeons, and orthopedists.

The treatment of such neuromuscular disorders as anterior poliomyelitis, cerebral palsy, multiple sclerosis, progressive muscular atrophy, syringomyelia, amyotrophic lateral sclerosis, and parkinsonism has been markedly improved by the utilization of such procedures. Advances in muscle re-education are making the use of surgery and mechanical aids, such as splints or braces, unnecessary in the treatment of cerebral palsy.

Rehabilitation.—The principle advocated by some of the leaders in the field of rehabilitation is, apparently, "make the most of what is left." This concept is inadequate. It should be, first, secure maximal functional



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¹ McLester, J. S.: Nutrition and Diet in Health and Disease, ed. 4, Philadelphia and London, W. B. Saunders Company, 1943.

² Kunde, M. M.: The Role of Hormones in the Treatment of Obesity, Ann. Int. Med. 28:971 (May) 1948.

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recovery of damaged parts and, second, make the most of what is left. I urge that physical medicine adopt this policy in dealing with the plan of operation of rehabilitation centers.

Let us emphasize three principles in our code of rehabilitation—the three C's of rehabilitation—courage, confidence, and competence.—Abstracted by ALBERT A. MARTUCCI, M.D., from paper by O. Leonard Huddleston, M.D., Ph.D., read at the twenty-sixth annual session of the American Congress of Physical Medicine, Washington, D. C., Sept. 8, 1948.

RESPONSIBILITY IS YOURS

You may remember the day that you took the Oath of Hippocrates; but you probably don't. You may remember what the Oath imparts, but probably not. You might have a copy of it, but again you probably haven't.

You may think this all makes little difference; but you may be wrong—dead wrong. The public hasn't forgotten the Oath. They know it very well, at least its ideals and intent if not the words. This little scrap of thinking is the one that centuries ago placed your profession on a higher plane than most human endeavors ever go.

Medical education has brought scientific skill to the patient's door, but just as important is the interpretation of the Hippocratic Oath to that patient.

Intentionally or unintentionally, misconceptions appear, such as—a doctor cannot refuse to make a call—a doctor must answer an emergency, etc.—interpretation

is necessary and essential on an individual basis even in the middle of the night.

When the phone rings at 3 a.m. you curse the day that Hippocrates was born, but comes the dawn and reason, you are proud of your heritage and the respect that it accords you. It matters not if ten million people are cared for; if one goes without aid the people are unhappy. The public is not interested in your personal health, but only in your being the instrument of their faith in the profession. Some doctors (none in Wichita, I hope) are convincing them that emergencies must come on schedule and that it isn't "cricket" to get sick at home. We don't really believe this, but their actions are speaking louder than our thoughts.

Many of my lay friends tell me that you can't get a doctor out at night. One person even printed such an affront. You don't believe that this is true; but if the people think so, it might as well be so. The régime in Washington will not force socialized medicine down our throats, but the people can and may do so. Yours is the responsibility, not the Sedgwick County Medical Society, not the Kansas Medical Society, not the A.M.A., not a political party.

You still have a chance to get into the act before the curtain goes down. Play your part with zeal. Pray that the audience will recognize your part, and also recognize you as an essential to the American way of living, and the heritage that is ours.

Me! I'm going to get three copies of the Oath of Hippocrates, place one in my waiting room for all to see, one under the glass of my office desk, and last but not least, one on the night table, printed in luminous paint. Will you join me?—D. P. T., *Wichita, Kansas Medical Bulletin*, Jan. 4, 1949.

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MEDICAL NEWS

Future Meeting Calendar

AMERICAN COLLEGE OF PHYSICIANS—New York, March 28 to April 1, 1949.

INDUSTRIAL PHYSICIANS AND SURGEONS OF THE UNITED STATES AND CANADA—Detroit, Mich., April 2-9, 1949.

PHILADELPHIA COUNTY MEDICAL SOCIETY POSTGRADUATE INSTITUTE—Philadelphia, April 5-8, 1949.

PENNSYLVANIA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY—Harrisburg, April 22-24, 1949.

REGIONAL CONFERENCE ON PREMEDICAL EDUCATION—Syracuse, N. Y., May 6-7, 1949.

AMERICAN GOITER ASSOCIATION—Madison, Wis., May 26-28, 1949.

INTERNATIONAL CONGRESS ON RHEUMATIC DISEASES—New York City, May 30-June 3, 1949.

Engagements

MISS SHEILA HOPKINS, of Wynnewood, to Thomas M. McMillan, 3d, M.D., son of Dr. and Mrs. Thomas M. McMillan, of Philadelphia.

MISS ANTOINETTE VIRGINIA HUSIK, daughter of Dr. and Mrs. David N. Husik, to Mr. Gideon A. Frankil, all of Philadelphia.

MISS MARY LEE MCKINNEY, daughter of Dr. and Mrs. Walter B. McKinney, of Blue Bell, to Mr. William C. Lowry, 3d, of Philadelphia.

MISS REITA ELAINE HANDMAKER, of Altoona, to Irwin L. Simkins, M.D., of Johnstown, son of Dr. and Mrs. James J. Simkins, of Philadelphia.

MISS DENISE THERESE SULLIVAN, daughter of Dr. and Mrs. Dennis T. Sullivan, of Lansdowne, to Mr. John Paul Jones, of San Francisco, Calif.

Marriages

MISS GLORIA JEANNETTE PEZZILLO to James J. Traitz, M.D., both of Philadelphia, February 26.

MISS HEDVAH RAY COHEN, of Philadelphia, to M. Price Margolies, M.D., son of Dr. and Mrs. Michael Margolies, of Coatesville, February 13.

MISS SARAH ADAMS SKILLERN, daughter of Dr. and Mrs. Samuel R. Skillern, of Cynwyd, to Mr. Richard Brooke Jarrett, of Philadelphia, February 18.

MISS FRANCES NEALL REPPLIER, daughter of Dr. and Mrs. Sidney J. Repplier, of Philadelphia, to Mr. Lyman R. Hanson, Jr., of Los Angeles, Calif., February 25.

Deaths

○Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

○Edmund F. Hanlon, Hazleton; Jefferson Medical College of Philadelphia, 1927; aged 45; died Feb. 16, 1949, following a heart attack. Dr. Hanlon was one of seven brothers who followed their father in the medical profession. During World War II, he served with the Army Air Forces. Surviving, in addition to his widow and one son, are his mother and the following brothers: Drs. Frank and Paul, both of Wilkes-Barre; Dr. Clement, of Bethlehem; Drs. George and David, both of Rochester, Minn., and Robert, a student at Jefferson Medical College.

○Eugene Rush, Philadelphia; Jefferson Medical College of Philadelphia, 1914; aged 60; died Feb. 19,

1949. Dr. Rush was chief of pediatrics at Mount Sinai Hospital and a member of its board of directors. He was also attending pediatrician at the Jewish Seaside Home for Invalids, Atlantic City, and at the Philadelphia Foster Home for Hebrew Orphans. He was a member of the American Academy of Pediatrics. During World War I, he was a first lieutenant in the Army Medical Corps. Surviving are his widow, a son, and three brothers and sisters.

○Clair E. Robison, Altoona; Jefferson Medical College of Philadelphia, 1903; aged 69; died Jan. 27, 1949. Dr. Robison was a member of the Altoona Hospital staff and served a term as chief of its medical staff. He was a past president of the Blair County Medical Society. He is survived by his mother, two daughters, and one son.

○Thomas S. Stewart, Philadelphia; University of Pennsylvania School of Medicine, 1901; aged 72; died Feb. 19, 1949. Dr. Stewart, who had retired from the practice of medicine, was curator of the Microscopical Section of the Academy of Natural Sciences. He was a member of the American Roentgen Ray Society.

Harry H. Lott, Philadelphia; Jefferson Medical College of Philadelphia, 1907; aged 69; died Feb. 5, 1949, at Lake Worth, Fla. Dr. Lott, who retired three years ago, was a former professor of laryngology at Jefferson. He served as a major in the Army Medical Corps during World War I. A son survives.

Joseph W. Roberts, Philadelphia; Howard University College of Medicine, Washington, D. C., 1907; aged 69; died Feb. 10, 1949. He was a member of the staff of the Mercy and Douglas Hospitals. His widow and a son survive.

○William M. McCormick, Falls Creek; Jefferson Medical College of Philadelphia, 1931; aged 43; died in October, 1948. He was a member of the Radiological Society of North America and the American College of Radiology.

○Walter F. Johnson, New York City; Jefferson Medical College of Philadelphia, 1924; aged 49; died July 13, 1948. Dr. Johnson was a member of Somerset County Medical Society.

○William H. Nix, Worthington; Jefferson Medical College of Philadelphia, 1905; aged 73; died Jan. 10, 1949. He was an affiliate member of Armstrong County Medical Society.

Ignatius L. J. Fitzpatrick, Philadelphia; Medico-Chirurgical College of Philadelphia, 1901; aged 70; died Feb. 16, 1949.

○William T. Mitchell, Pittsburgh; Johns Hopkins University School of Medicine, 1916; aged 58; died Jan. 29, 1949.

○Edward M. Iland, Coraopolis; University of Pittsburgh School of Medicine, 1896; aged 77; died Jan. 14, 1949.

○Ella B. Custer, Philadelphia; Woman's Medical College of Pennsylvania, 1883; aged 87; died Nov. 8, 1948.

○Edwin S. Africa, Warren; Hahnemann Medical College and Hospital of Philadelphia, 1907; aged 69; died Dec. 30, 1948.

○Mark A. Baush, Allentown; Jefferson Medical College of Philadelphia, 1923; aged 51; died Jan. 3, 1949.

Miscellaneous

ANNOUNCEMENT HAS BEEN MADE THAT THE 1950 decennial meeting of the United States Pharmacopoeial Convention will be held May 9 and 10, 1950, at the Hotel Statler, Washington, D. C.

THE WOMAN'S MEDICAL COLLEGE OF PENNSYLVANIA celebrated its Founders' Day, marking the ninety-ninth year of its charter, on the evening of March 11. Thirteen faculty members who have served the College for twenty-five years were given service citations.

ELLIOTT P. JOSLIN, M.D., emeritus professor of medicine of the Harvard University School of Medicine, will discuss "The Future Diabetic" at the Hahnemann Medical College, Philadelphia, on April 4. This is the third annual lecture given by the Phi Delta Epsilon Fraternity. All physicians, students, and interested persons are invited.

THE NINETIETH MEETING OF THE READING EYE, EAR, NOSE AND THROAT SOCIETY was held on February 16. This was the fifth annual joint meeting of the Diplomates Association of Berks County Physicians and the Reading Eye, Ear, Nose and Throat Society. The

speaker was Stephen S. Hudack, M.D., of New York City, who discussed "Restoration of Joints with Articular Replacement and Changing Concepts in the Mechanism of Bone Healing."

AT THE INVITATION OF DR. WILLIAM G. LEAMAN, professor of medicine at Woman's Medical College, Philadelphia, a symposium on "The Future of Medical Practice in America" was held in January in the auditorium of the College. Participating with Dr. Leaman were Mr. William F. Irwin, executive secretary of Philadelphia County Medical Society, and Dr. Richard H. Shryock, professor of history at the University of Pennsylvania, who acted as moderator for the discussion.

THE AMERICAN BOARD OF OPHTHALMOLOGY wishes to announce that it does not evaluate, approve, or disapprove any ophthalmic residency toward fulfilling the requirements for candidates for board examinations. Any candidate who qualifies for the board examination and completes the prerequisites as outlined in the booklet of information will be accepted. A copy of this booklet can be obtained from the Secretary of the American Board of Ophthalmology, 56 Ivie Road, Cape Cottage, Maine.

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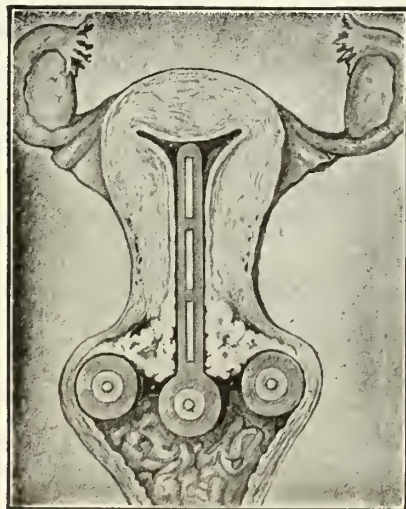
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PUBLICATION OF THE NATIONAL REPORT ON THE FINDINGS of the recently completed two and one-half-year study of child health services will be marked by a dinner on April 2 in New York City, according to an announcement of Warren R. Sisson, M.D., president of the American Academy of Pediatrics. A nationally known layman and an outstanding authority in medicine and public health are being invited to be guest speakers. The two-volume report which is now on the press is being published by the Commonwealth Fund of New York.

A REGULAR MONTHLY MEETING OF THE PENNSYLVANIA ACADEMY OF PHYSICAL MEDICINE was held January 20 at the Philadelphia General Hospital. Pascal S. Lucchesi, M.D., medical director and superintendent of the hospital, spoke on the importance of rehabilitation in that hospital, and Albert A. Martucci, M.D., chief of the Physical Medicine and Rehabilitation Division at the same hospital, spoke on "Orientation and Management of Rehabilitation Centers." An interesting array of cases was presented by Drs. Charles A. Furey, Jr., and Francis X. Sweeney. This was followed by a film demonstration on rehabilitation and a general discussion.

TELEVISION IN NATURAL COLOR FOR THE TEACHING OF SURGERY AND MEDICINE to medical students will have a pioneer demonstration at the American Medical Association meeting in Atlantic City, June 6 to 10. The University of Pennsylvania School of Medicine in collaboration with Smith, Kline and French Laboratories will televise actual operations and diagnostic procedures from the Atlantic City Hospital to Convention Hall. The presentation will be similar to the one presented at the Centennial Celebration Session of The Medical So-

ciety of the State of Pennsylvania last October. However, the natural color reproduction is an innovation in medical television.

NORRIS W. VAUX, M.D., Secretary of Health, announces that two physicians will be appointed to serve as chiefs of divisions in the Bureau of Maternal and Child Health. These are key positions and it is essential that the vacancies be filled in the near future.

Both of these are full-time administrative positions, with headquarters in Harrisburg.

Consideration will be given to applications by physicians who are licensed or who are eligible for licensure to practice medicine in the Commonwealth of Pennsylvania.

Physicians who are interested in public health work of this type should write to Paul Dodds, M.D., Director, Bureau of Maternal and Child Health, Pennsylvania Department of Health, Harrisburg.

A THIRD REGIONAL CONFERENCE ON PROBLEMS OF PRE-MEDICAL EDUCATION is being sponsored by Alpha Epsilon Delta, national premedical honor society, in cooperation with Syracuse University, at Syracuse on May 6 and 7, 1949. Students and faculty representatives from colleges and medical schools of New York and Pennsylvania are invited to meet at the Onandago Hotel for two days of informal discussion of current problems in this field. Arrangements for the conference are under the direction of Dr. Hugh E. Setterfield, professor of anatomy, School of Medicine, Ohio State University, and national president of Alpha Epsilon Delta, with the assistance of Dr. Eric H. Faigle, associate dean, College of Arts and Sciences, Syracuse University, national vice-president of Alpha Epsilon Delta, and the New York Beta Chapter at Syracuse University.

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THE PENNSYLVANIA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY will meet April 22, 23, and 24 at the Penn-Harris Hotel, Harrisburg. Among the speakers who will present papers at this meeting will be Drs. Albert D. Ruedemann, Cleveland, Ohio, John R. Lindsay, Chicago, Ill., Ralph O. Rychener, Memphis, Tenn., Carlton S. Nash, Rochester, N. Y., Jay G. Linn, Pittsburgh, Arno E. Town, New York City, and George M. Coates, Philadelphia. In addition to formal presentations, the program will include a round table discussion on "Headaches" which will present representatives of all major specialties. There will be a study club to discuss "Cataract Problems."

The incumbent officers are: president, James J. Monahan, Shenandoah; president-elect, Daniel S. DeStio, Pittsburgh; and secretary, Benjamin F. Souders, Reading.

THE INDUSTRIAL PHYSICIANS AND SURGEONS OF THE UNITED STATES AND CANADA will hold their thirty-fourth annual meeting at Detroit, Mich., April 2 to 9, with headquarters at the Book-Cadillac and Statler Hotels. Participating groups are the American Conference of Governmental Industrial Hygienists, American Industrial Hygiene Association, American Association of Industrial Dentists, and American Association of Industrial Nurses.

The week-long program is featured by (1) surgical clinics at the Henry Ford and Harper Hospitals, (2) scientific sessions on such timely subjects as the problems created by atomic radiation, cardiovascular diseases among the employed, alcoholism in industry, and toxicities of industrial substances such as beryllium, agricultural chemicals, and rare metals, and (3) special sessions for physicians in steel manufacturing and heavy industry, in rubber, petroleum, and chemicals in coal mining and metal mining.

SURVIVAL RATES FOR RHEUMATIC FEVER PATIENTS COMPUTED

A child with rheumatic fever has one chance out of two to live to the age of 40, report May G. Wilson, M.D., and Rose Lubschez, M.A., in a recent issue of *The Journal of the American Medical Association*.

The two researchers from the New York Hospital and the Department of Pediatrics of Cornell University Medical College, New York, base their conclusion on a study of 1042 children having the disease who were under medical supervision during a period of thirty years.

Within this time, 226 patients died, about 75 per cent from rheumatic heart disease and 10 per cent from subacute bacterial endocarditis.

The incidence of subacute bacterial endocarditis in the entire group was 2.2 per cent. Cardiac involvement was present in every patient at last observation.

Ninety per cent of the patients who were 21 to 42 years of age were able to carry on their normal activities without circulatory symptoms.

A child has four chances out of five to survive fifteen years after the onset of the disease, three chances out of four to live twenty years, and two chances out of three to survive thirty years, the study shows.

The over-all death rate was 14.7 per thousand per year. The highest death rates occurred between the ages of one and four years (33.2 per thousand) and 10 to 14 years (16.3 per thousand).

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Annual Meeting of

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FRIDAY, APRIL 22

12:00 Noon Luncheon of Executive Committee and guests, Parlor D

SCIENTIFIC MEETING—Ballroom

- 2:00 p.m. *Medical Treatment of Early Cataract*
Albert D. Ruedemann, M.D., Detroit
- 3:00 p.m. *Vertigo: Differential Diagnosis and Treatment*
John R. Lindsay, M.D., Chicago
- 4:00 p.m. *External Diseases of the Eye—Diagnosis and Treatment*
Ralph O. Rychener, M.D., Memphis
- 5:00 p.m. Meeting of the Committee on Conservation of Hearing, Parlor B
- 8:00 p.m. Round table discussion and smoker—Ballroom
Subject: *Headache* — Moderator: Matthew S. Ersner, M.D.
Otology — George M. Coates, M.D., Philadelphia
Ophthalmology — John Dunbar, M.D., Pittsburgh
Internal Medicine — Philip Retew, M.D., Reading
Neuropsychiatry — Howard K. Petry, M.D., Harrisburg

MOTION PICTURES

- "The Function of the Ear in Health and Disease"
By H. G. Kobrak, M.D.
- "Cataract Closure with a Corneoscleral Suture Combined with Large Sliding Conjunctival Flap From Above"
By Philip H. Decker, M.D.

SATURDAY, APRIL 23

- 9:00 a.m. *Functional Diseases of the Nose*
C. Stewart Nash, M.D., Rochester, N. Y.
- 10:00 a.m. *Beta Ray Uses in Ophthalmology*
A. D. Ruedemann, M.D., Detroit
- 11:00 a.m. *Eustachian Tube Obstruction, Early Diagnosis and Management*
John R. Lindsay, M.D., Chicago
- 12:00 Noon *Study Club*—Subject—*Cataract Problems*
Discussers: Albert D. Ruedemann, M.D., Ralph O. Rychener, M.D., and Arno Town, M.D.

- 1:30 p.m. *External Diseases of the Eye—Treatment and Diagnosis*
Ralph O. Rychener, M.D., Memphis
- 2:30 p.m. *History of Otorhinology*
George M. Coates, M.D., Philadelphia, Guest of Honor
- 2:45 p.m. *Allergy in Otology; Practical Points*
Lewis T. Buckman, M.D., Wilkes-Barre
- 3:00 p.m. *Anticoagulants in Ophthalmology*
Jay G. Linn, M.D., Pittsburgh
- 3:15 p.m. *Laryngotracheobronchitis*
John R. Simpson, M.D., Pittsburgh
- 3:30 p.m. Discussion of papers by Drs. Buckman, Linn, and Simpson
- 4:00 p.m. *Economics of Ophthalmology*
Ralph Pino, M.D., Detroit
- 5:00 p.m. Business meeting

SUNDAY, APRIL 24

- 10:00 a.m. *The Otology Consultant in Compensation and Liability Actions*
C. Stewart Nash, M.D., Rochester, N. Y.
- 11:00 a.m. *Diagnosis and Prognosis in Hypertension by Retinal Examination*
Arno Town, M.D., Philadelphia
- 12:00 Noon *Recent Advances in Chemotherapeutics*
Harrison F. Flippin, M.D., Philadelphia
- 1:00 p.m. *Installation of Officers*

SOCIAL EVENTS

FRIDAY, APRIL 22

- 4:30 p.m. *Tea for Ladies*—Governor's Room

SATURDAY, APRIL 23

- 12:30 p.m. *Luncheon-Bridge for Ladies*—Harrisburg Country Club
- 7:00 p.m. *Cocktail Hour*
- 8:00 p.m. *Dinner-Dance* (dress optional)
Music and Entertainment by Ira Bowman and Orchestra

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BOOK REVIEWS

MIDWIFERY. By ten teachers. Under the direction of CLIFFORD WHITE, M.D., B.S. (Lond.), F.R.C.P. (Lond.), F.R.C.S. (Eng.), F.R.C.O.G. Edited by Clifford White, Frank Cook, and William Gilliat. Eighth edition. 560 pages with 217 illustrations. Baltimore: The Williams & Wilkins Company, 1948. Price, \$6.00.

It is difficult to properly evaluate the purpose of this book. It is too large for a synopsis, but not detailed enough for the specialist or even an adequate textbook for the student. However, it is well printed, written, organized, and illustrated.

The sections on anatomy and physiology are adequate, but such an important subject as prenatal care is covered in merely seven pages. Many new and proven advances in obstetrics are not covered, such as early ambulation, proper fluid and electrolytic balance in the treatment of toxemias, endocrine treatment, threatened abortion, the use of a fine catgut rather than silkworm gut or stout catgut for the repair of episiotomies, extraperitoneal cesarean section, and the treatment of phlebotrombosis and thrombophlebitis. On the other hand, some methods of treatment recommended by this book have proved to be valueless or even harmful, such as the recommended use of vaginal packing in the treatment of placenta praevia. The errors of omission spoil what otherwise might have been a good textbook.

RECENT ADVANCES IN OBSTETRICS AND GYNECOLOGY. By ALECK W. BOURNE, M.A., M.B., B.Ch. (Camb.), F.R.C.S. (Eng.), F.R.C.O.G., Obstetric Surgeon to St. Mary's Hospital; Consulting Obstetric Surgeon, Queen Charlotte's Hospital; Consulting Surgeon, Samaritan Hospital for Women; Late Examiner to the University of Cambridge and the Conjoint Board; and LESLIE H. WILLIAMS, M.D., M.S. (Lond.), F.R.C.S. (Eng.), F.R.C.O.G., Obstetric Surgeon to In-Patients, St. Mary's Hospital; Consulting Obstetric Surgeon to Queen Charlotte's Hospital, The Jewish Maternity Hospital, and the Nelson Hospital; Surgeon to In-Patients, Samaritan Hospital for Women; Examiner in Midwifery and Gynecology to the University of London; Late Examiner to the Universities of Cambridge, Durham, and Wales and to the Conjoint Board. Seventh edition. 326 pages with 85 illustrations. Philadelphia: The Blakiston Company, 1948. Price, \$6.00.

The seventh edition of this book contains modifications of all previous chapters and the addition of six new chapters. The authors have been wise in the choice of subjects which are of greatest interest at the present time. Many of these subjects are well covered and many others in a most excellent manner.

Chapter one, concerning nutrition, is a well-written review of the modern concepts of nutrition during pregnancy. The second chapter concerns weight changes and water metabolism and should be reviewed by all who practice obstetrics. Other chapters include: The Anemias of Pregnancy, Anesthesia and Analgesia in Obstetrics, The Use of Penicillin in Obstetrics, Lactation, Hemorrhagic Disease of the Newborn, Erythroblastosis and Radiology in Obstetrics.

Part two is concerned with the following gynecologic subjects: Cancer of the Cervix Uteri, Stress Incontinence, Sympathectomy, Penicillin in Gynecology, Radiologic Diagnosis and X-ray Therapy. As in the case of previous editions, this is a well-written, well-organized, and well-printed book—worthwhile reading for all who do obstetrics and gynecology.

PSYCHODYNAMICS AND THE ALLERGIC PATIENT. By HAROLD A. ABRAMSON, M.D., with a panel discussion. 81 pages with 7 figures. St. Paul and Minneapolis: Bruce Publishing Company, 1948. Price, \$2.50.

This book, an official publication of the American College of Allergists, represents the first step in the co-ordination of organizational allergy and psychodynamics. The object is to focus on the importance of emotional factors in the routine therapy of the allergic patient by both the allergist and the general practitioner.

Besides two articles by the author, it records the first panel discussion on the role of psychodynamics and the allergic patient, arranged by allergists under the auspices of the American College of Allergists at its third annual meeting held in Atlantic City, N. J., June 8, 1947.

Among the invited psychiatrists attending the meeting were Drs. O. Spurgeon English, Frank Fremont-Smith, J. A. P. Millet, Sandor Rado, and Edward Weiss. By bringing together authorities in the field of psychiatry and authorities interested in the immunologic aspects of the problem involved in treating the allergic patient, it was possible to take this first step in the consideration of the co-ordination of the disciplines of applied immunology and of psychodynamics on the same program in a constructive way.

A chapter on the psychosomatic aspects of hay fever and asthma prior to 1900, by the author, is a chronologic history revealing that even in their relatively primitive therapy our medical ancestors not only recognized the syndromes of hypersensitivity corresponding to what is now on an immunologic basis but also stressed the relationship between the psyche and allergic diseases in no uncertain way. This chapter contains many suggestions for historical exploration in the field of psychodynamics in connection with allergic syndromes.

The author's article on "Psychodynamics and the Allergic Patient" brings forth convincing evidence of the inadequacy of the histamine theory of allergy and the importance of emotional factors. The author feels that it is necessary to be specific in characterizing motivation by specific psychomotive forces and in other cases, neuromotive forces. The term motive force is not sufficiently specific to emphasize the primary role of the psyche which contains unmeasurable quantities. Various case records are given which classify allergic syndromes into those in which immunologic factors are definitely always present and those in which immunologic factors have not been proven.

All students of allergy and psychiatry will be stimulated by this free discussion of controversial questions.

CONTROL OF PAIN IN CHILDBIRTH. Anesthesia, Analgesia, and Amnesia. By CLIFFORD B. LULL, M.D., F.A.C.S., F.I.C.S., Director, Division of Obstetrics and Gynecology, Philadelphia Lying-in Unit, Pennsylvania Hospital; and ROBERT A. HINGSON, M.D., F.I.C.S., F.A.C.A., F.I.C.A., Associate Professor of Obstetrics; Anesthesiologist, Department of Obstetrics, Johns Hopkins University and Hospital; Surgeon, United States Public Health Service. With an introduction by Norris W. Vaux, M.D., Consulting Obstetrician and Gynecologist, Philadelphia Lying-in Unit of Pennsylvania Hospital; Professor Emeritus of Obstetrics, Jefferson Medical College. Third edition, revised and enlarged. Philadelphia: J. B. Lippincott Company, 1948. Price, \$12.00.

This book is an encyclopedia of all methods of analgesia, anesthesia, and amnesia used in obstetrics. The first 130 pages discuss completely the anatomic and physiopharmacologic aspects of all drugs used in obstetrics.

The second part gives in detail the various techniques of pain relief during labor and delivery. This third edition brings up to date the previous editions and is a "must" as a reference book for all obstetricians. It is excellently printed, written, and illustrated.

THE SKIN DISEASES. By JAMES MARSHALL, M.D., B.S., M.R.C.S., L.R.C.P. First edition, with 355 pages. London: The Macmillan Company, 1948. Price, \$7.50.

This book, bearing its refreshing title, is introduced by the author as a companion to his manual "The Venereal Diseases." He intended it apparently for non-dermatologists and students and it serves that purpose very well. It is comparative in size and scope to the short Sutton and Sutton, Tobias' dermatologic text, and Warren's excellent manual.

It is lavishly illustrated for a book of its size and the photographs are excellent, particularly the colored plates. Every important skin disease has a characteristic picture accompanying the description. Those in the chapters on syphilis are particularly good.

It is pleasant to read a dermatologic text in which no strenuous attempt is made at classification. In this book diseases are presented in logical order; in some instances generic grouping is quite adequately done, but it is not carried too far. Examples of the latter are the chapters on Diseases Due to Viruses, Vitamin Deficiency Diseases, and Diseases of the Cutaneous Appendages. Another happy instance is the inclusion of pruritus, neurodermatitis, dyshidrosis, and prurigo in one chapter.

A section on syphilis is included and the author states in his preface that "syphilis is one of the most important

of skin diseases and that dermatology and syphilology are inseparable." The descriptive chapters of the disease are very well done, but one criticism seems to be indicated. The reviewer believes that no one should attempt to be brief and sketchy when writing of the treatment, and that the pitfalls should be stressed rather than specific schedules. To the author's credit, he does state that "every case of late syphilis should be assessed individually." But he says very little as to why this is so, or of the danger of highly spirocheticidal drugs carelessly used in late syphilis with asymptomatic visceral and central nervous system involvement.

Many recent advances in dermatologic therapy are covered—the specific value of vitamin D₂ in lupus vulgaris, the use of sulfonamides in lymphopathia venereum and in actinomycosis, the treatment of dermatoses due to metals and their salts with BAL (British anti-lewisite), the management of parasitic infestations with DDT, and the various uses of the antihistaminics.

This manual is a useful addition to the growing list of dermatologic texts. It is certainly to be recommended to the non-specialist who is planning to add a dermatologic volume to his library.

ANA PUBLIC RELATIONS WORKSHOP. A Manual of Practical Public Relations Techniques for the Guidance of the National Membership of the American Nurses' Association. 32 pages and 39 illustrations. American Nurses' Association, 1790 Broadway, New York 19, N. Y. Price, \$2.50.

This manual was prepared for the ANA by Edward L. Bernays, noted counsel on public relations, and is now being distributed throughout the country among district and state nurses' associations with a total membership of some 166,000 professional nurses. It is believed to be one of the most comprehensive and useful works of its kind compiled in recent years. It can be of great help to all professional organizations in whatever field; for that reason, it has wide general interest.

SCHOOL DAYS

School days are once more just around the corner for the 1107 members of The Medical Society of the State of Pennsylvania enrolled in the 1948-1949 program of the Graduate Education Institute.

Spring sessions will begin the week of April 3 in each of the ten centers. Check your calendar now with the dates listed for your center.

Tuesday, April 5, 12, 19, 26 and May 3

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Wednesday, April 6, 13, 20, 27 and May 4

ERIE

WASHINGTON

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Thursday, April 7, 14, 21, 28 and May 5

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The manual is a clear, simple, thorough, highly practical exposition of public relations techniques, illustrated with 39 charts and photographs. It sets forth in direct, readable fashion how most effectively to utilize the press, radio and television, movies, direct mail, public meetings, and other media of communication so as to give ideas and factual information the widest possible circulation among the public.

This manual is a practical how-to book prepared by experts for groups which want to utilize the manifold techniques of modern public relations on a day-to-day basis. Such techniques today are of direct and vital importance.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

ESSENTIALS OF GYNECOLOGIC ENDOCRINOLOGY. (With Sections on the Male). By GARDNER M. RILEY, Ph.D., Assistant Professor of Obstetrics and Gynecology, University of Michigan Medical School. Ann Arbor, Michigan: Caduceus Press, 1948. Price, \$3.00.

DEEP MASSAGE AND MANIPULATION ILLUSTRATED. By JAMES CYRIAX, M.D., B.Ch. (Cantab.), Physician to the Department of Physical Medicine, St. Thomas's Hospital, London. Third edition. New York: Paul B. Hoeber, Inc., Medical Book Department of Harper and Brothers, 1948. Price, \$5.00.

THE BUSINESS SIDE OF MEDICAL PRACTICE. By THEODORE WIPRUD, Executive Director and Secretary of The Medical Society of the District of Columbia and Managing Editor of the *Medical Annals of the District of Columbia*. Second edition. Illustrated. Philadelphia: W. B. Saunders Company, 1949. Price, \$3.50.

OBSTETRIC ANALGESIA AND ANESTHESIA. Their Effects upon Labor and the Child. By FRANKLIN F. SNYDER, M.D., Associate Professor of Obstetrics and Associate Professor of Anatomy, Harvard Medical School. Illustrated. Philadelphia: W. B. Saunders Company, 1949. Price, \$6.50.

MAYO CLINIC DIET MANUAL. By the Committee on Dietetics of the Mayo Clinic. Philadelphia: W. B. Saunders Company, 1949. Price, \$4.00.

BLOOD TRANSFUSION. By ELMER L. DEGOWIN, M.D., Associate Professor of Internal Medicine, State University of Iowa; Director, Blood Transfusion Service, University Hospitals; Member of the Com-

mittee on Blood and Blood Derivatives, National Research Council; Member of the Advisory Board for Health Services, American National Red Cross; Secretary of the Subcommittee on Blood Substitutes, National Research Council, 1940-1945; ROBERT C. HARDIN, M.D., Assistant Professor of Internal Medicine, State University of Iowa; formerly Senior Consultant in Blood Transfusion and Shock in the European Theater of Operations, U. S. Army, and Commanding Officer of the ETO Blood Bank; and JOHN B. ELSEVER, M.D., Senior Surgeon, U. S. Public Health Service; Chief, Professional Standards, Hospital Division, U.S.P.H.S.; Director of the Syracuse University Blood Transfusion Service, 1940-1942; Technical Director of the Blood Plasma Section, Medical Division, U. S. Office of Civilian Defense, 1942-1944; Director of the Civilian Blood Donor Service and Associate National Medical Director, The American Red Cross, 1944-1946. Illustrated with 200 diagrammatic drawings. Philadelphia: W. B. Saunders Company, 1949. Price, \$9.00.

YOUR CHILD OR MINE. The Story of the Cerebral-Palsied Child. By MARY LOUISE HART BURTON, in collaboration with Sage Holter Jennings. New York: Coward-McCann, Inc., 1949. Price, \$1.25.

CLINICAL ASPECTS AND TREATMENT OF SURGICAL INFECTIONS. By FRANK LAMONT MELENEY, M.D., F.A.C.S., Associate Professor of Clinical Surgery, College of Physicians and Surgeons, Columbia University; Associate Visiting Surgeon, Presbyterian Hospital, New York City. With a foreword by Allen O. Whipple, M.D. Illustrated. Philadelphia: W. B. Saunders Company, 1949. Price, \$12.00.

SOCIAL MEDICINE. Its Derivations and Objectives. The New York Academy of Medicine Institute on Social Medicine, 1947. Edited by IAGO GALDSTON, M.D. New York: The Commonwealth Fund, 1949. Price, \$2.75.

CLINICAL CASE-TAKING GUIDES FOR THE STUDY OF PATIENTS. History-taking and Physical Examination or Semiology of Disease in the Various Systems. By GEORGE R. HERRMANN, M.D., Ph.D., Professor of Medicine, University of Texas. Fourth edition. St. Louis: The C. V. Mosby Company, 1949. Price, \$3.50.

INTRODUCTION TO PHYSIOLOGIC AND PATHOLOGIC CHEMISTRY. With Laboratory Experiments. By L. EARLE ARNOW, Ph.G., B.S., Ph.D., M.B., M.D., Director of Research, Medical Research Division, Sharp & Dohme, Inc., Glenolden, Pa.; Professor of Chemistry, Bryn Mawr College Summer School of Nursing, Bryn Mawr, Pa., 1941-1943, 1945; formerly Assistant Professor of Phys-



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iologic Chemistry, University of Minnesota Medical School, and Lecturer in Physiologic Chemistry to students enrolled in the University of Minnesota School of Nursing, Minneapolis. With an introduction by Katharine J. Densford, R.N., B.A., M.A., D.Sc., Professor of Nursing and Director of the School of Nursing, University of Minnesota, Minneapolis. Third edition. St. Louis: The C. V. Mosby Company, 1949. Price, \$4.00.

ORAL ANATOMY. By HARRY SICHER, M.D., Professor of Anatomy and Histology, Loyola University School of Dentistry, Chicago College of Dental Surgery. With 310 text illustrations including 24 in color. St. Louis: The C. V. Mosby Company, 1949. Price, \$15.00.

CAMPBELL'S OPERATIVE ORTHOPEDICS. Editor, J. S. SPEED, M.D., Associate Editor, HUGH SMITH, M.D., Memphis, Tenn. Second edition, with 1141 illustrations including 2 color plates. Volumes I and II. St. Louis: The C. V. Mosby Company, 1949. Price, \$30.00.

PSYCHODYNAMICS AND THE ALLERGIC PATIENT. By HAROLD A. ABRAMSON, M.D., F.A.C.A., Associate Physician for Allergy, Mount Sinai Hospital, New York City; Consulting Physician for Allergy, Sea View Hospital, Staten Island, N. Y.; Assistant Professor of Physiology, Columbia University, New York City. Panel discussion by Rudolf L. Baier, M.D., Ethan Allan Brown, M.D., Hal M. Davison, M.D., O. Spurgeon English, M.D., Frank Fremont-Smith, M.D., J. A. P. Millet, M.D., M. Murray Peshkin, M.D., Homer E. Prince, M.D., Sandor Rado, M.D., and Edward Weiss, M.D. An official publication of the American College of Allergists. St. Paul and Minneapolis: The Bruce Publishing Company, 1948. Price, \$2.50.

A PEOPLE'S PARTNERSHIP

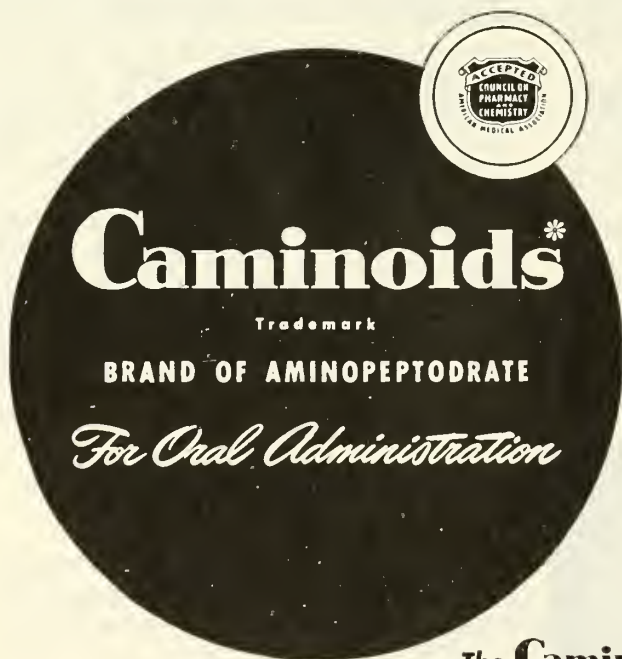
Community safeguards depend upon a united people. Especially in time of disaster, efficient functioning is necessary if lives are to be saved and the injured and homeless given practical aid. That is why an organization such as the American National Red Cross is necessary. Haphazard planning won't do. People must know where to turn, how to coordinate their efforts to help.

The Red Cross was able to coordinate the services of civic groups last year when more than 300 disasters struck in widely separated communities. Vanport, Ore., New Orleans, La., Coatesville, Ind., Greensboro, N. C., Bonne Terre, Mo., are many miles apart, but in each case the peculiar catastrophe that attacked these places was met by organized response.

All Red Cross work is divided between community volunteers and a full-time staff. Whether the work is educational and preventive, such as first aid, water safety, accident prevention, home nursing, and nutrition, or remedial, such as aid to veterans, servicemen, and civilians, both hospitalized and able-bodied, the Red Cross counts on community cooperation.

The growing Red Cross National Blood Program particularly demonstrates the need for partnership that makes service possible. So far approximately 64,000 persons have offered to donate blood in this peacetime program, and blood has been distributed to more than 350 hospitals.

Let us continue to have faith in this people's partnership to the end that we will contribute our money, our time, and our moral support to make the 1949 Red Cross fund campaign a success. The month of solicitation is March. The service is year-round.



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Subdural Hematoma in Infants

Jerome F. Grunnagle



Beware ! "A Doctor Draft"

An Editorial



A Bright New Scientific Program for a Bright New Century

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A Stimulating Conference

Officers' Department

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APRIL, 1949

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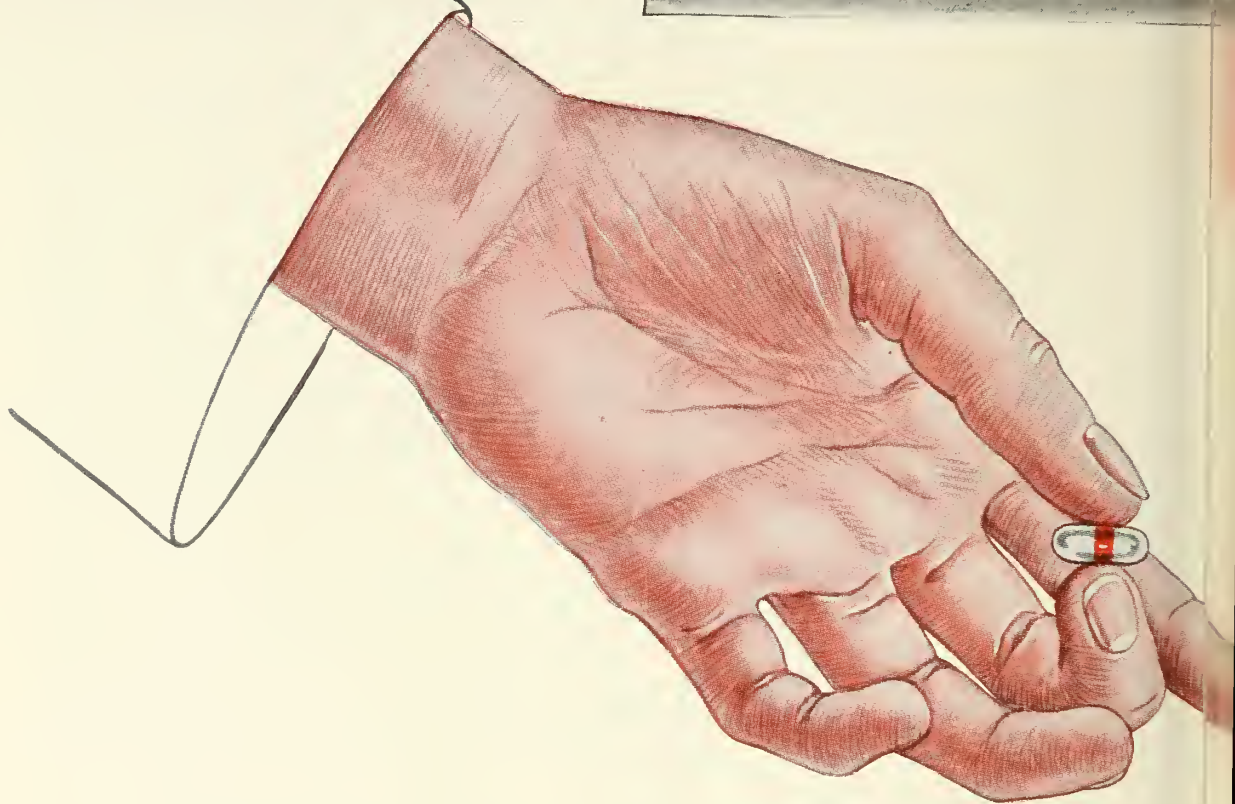
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*Magladery, J.: Therapeutic Conference, The Treatment of Epilepsy.
Bull. Johns Hopkins Hosp., 82:609, (June) 1948.

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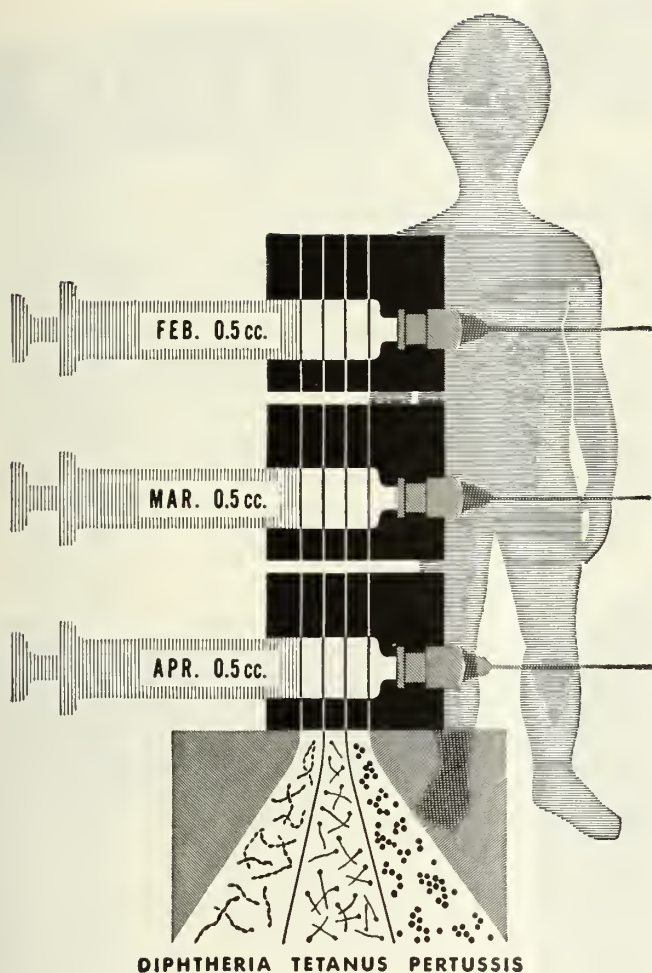
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Cambria	Francis T. Carney, Johnstown	Warren F. White, Johnstown	Monthly
Carbon	Marvin Evans, Lansford	John L. Bond, Lehighton	Bimonthly
Centre	William L. Welch, State College	Hiram T. Dale, State College	Monthly
Chester	Alfred L. Chicote, Phoenixville	Francis Jacobs, West Chester	Monthly
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Clinton	William C. Long, Jr., Lock Haven	David W. Thomas, Lock Haven	Monthly
Columbia	G. Paul Moser, Bloomsburg	Jesse G. Fear, Berwick	Monthly
Crawford	John P. Hobson, Cambridge Springs	Robert G. Pett, Meadville	Monthly
Cumberland ...	E. Blaine Hays, Carlisle	Richard R. Spahr, Mechanicsburg	Bimonthly
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Delaware	Walter E. Wentz, Jr., Media	Walter E. Egbert, Chester	Monthly
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† Except June, July, and August

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*Provides an excellent and convenient high
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QUAKER MAID is made only from pure corn syrup, granulated sugar syrup and refiners syrup.

The unusually high calorie value supplies a generous proportion of the total calories supplied in the feeding supplement.

Each bottle of QUAKER MAID syrup is

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QUAKER MAID syrup is economical because it is distributed only in areas that can be reached without adding high freight rates to the selling price. This results in considerable savings for your patients.

ANALYSIS	
Moisture	23.20
Solids by drying (Vacuum 70°C.)	87.84
by Refraction	86.80
Ash	0.72
Chlorides as Sodium Chloride	0.18
Sugars, Before Inversion	33.21
As Invert	32.13
As Dextrose	39.13
Sugars, After Inversion	37.66
As Invert	4.50
As Dextrose	66.3
Sucrose	
Glucose	
(211°V)	
Total Sugars after Prolonged Acid	68.3
Inversion (Includes Dextrines)	65.9
As Invert Sugar	25.4
As Dextrose	144
Dextrins (calc.)	
Calories, per fluid ounce (calc.)	

Terry Burns of Philadelphia is another "Quaker Maid Baby" whose formula contained Quaker Maid Syrup exclusively as a carbohydrate supplement.

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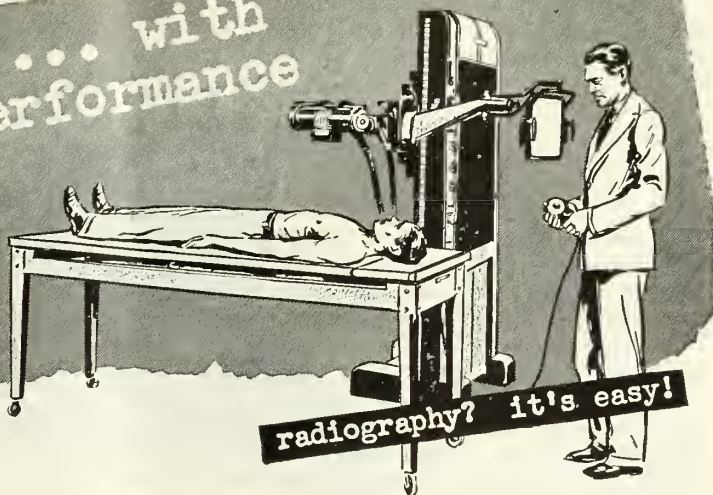
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modest cost ... with
excellent performance



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PICKER
combination
x-ray apparatus

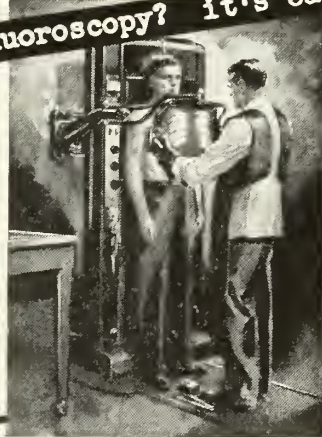
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LETTERS

Syrup of Urethane

GENTLEMEN:

Our attention has been called to a press release just issued by the Food and Drug Administration with regard to Syrup of Urethane manufactured by Marvin R. Thompson, Inc., Stamford, Conn.

The release, which was dated March 8, follows:

"The Federal Security Administration's Food and Drug Administration is making seizure of Syrup of Urethane. This is a cough syrup manufactured by Marvin R. Thompson, Inc., Stamford, Conn. Physicians, pharmacists, and consumers are warned that the administration of urethane in the quantity recommended on the label may cause a dangerous lowering of the white blood cell count. This leaves the patient more liable to infection from disease germs. Individuals suffering from coughs are likely to have accompanying infections.

"While urethane came into use as a sedative about a century ago, recent medical studies clearly demonstrate its potential danger when used as directed in the labeling of this syrup. However, when use of urethane is discontinued, the white blood cell count ordinarily returns to normal in a short time.

"More than 2300 gallons of Syrup of Urethane have been distributed in about 34,000 packages ranging in size from ½ oz. physician's samples to one gallon bottles. The product has gone throughout the country to physicians, wholesale druggists, and retail pharmacists.

"When seizure actions were commenced, the manufacturers started to recall Syrup of Urethane from the market. The manner and extent of distribution are such that neither the manufacturer nor federal, state, and local health offices will be able to locate all bottles promptly."

The office of the Council on Pharmacy and Chemistry urges you to bring this matter to the attention of the members of your society, association, or staff.

COUNCIL ON PHARMACY AND CHEMISTRY,
American Medical Association,
Chicago, Ill.

Brother's Keeper

GENTLEMEN:

Enclosed find check for \$50 for special assessment of American Medical Association. My assessment has already been paid and this will take care of some who cannot or will not pay their assessment.

_____, M.D.
Pennsylvania.

American Academy of Neurology

GENTLEMEN:

I would like to announce the establishment of the American Academy of Neurology, whose purpose it is to further and encourage the practice of clinical neurology and to stimulate teaching and research in neurology and allied sciences.

Active membership in the Academy is open to every physician who has been certified in neurology or in both neurology and psychiatry. Junior membership is avail-

able to physicians presently engaged in postgraduate studies in neurology or who are awaiting certification in neurology. In addition, there is an associate membership for those who are not certified in neurology but whose interests are in fields related to neurology. It is hoped that because of the unrestricted membership this association will be representative of the entire neurologic specialty and will offer an organ of expression for many of the younger men in the field. The American Academy of Neurology at present has 500 members. The first business meeting was held in Chicago in June, 1948.

The first scientific meeting will be held at the French Lick Springs Hotel, French Lick Springs, Ind., on Wednesday, Thursday, and Friday, June 1, 2, and 3, 1949. Dr. Dave B. Ruskin, of the Caro State Hospital, Caro, Mich., is in charge of the scientific program.

The present executive council consists of Dr. A. B. Baker, Minneapolis, president; Dr. Pearce Bailey, Washington, D. C., vice-president; Dr. Joe R. Brown, Minneapolis, secretary-treasurer; Dr. Frederic Lewey, Philadelphia, Dr. William A. Smith, Atlanta, Dr. J. M. Nielsen, Los Angeles, and Dr. A. L. Sahs, Iowa, Board of Trustees. Communications to the Academy should be addressed to Dr. Joe R. Brown, 19 Millard Hall, University of Minnesota, Minneapolis 14, Minn.

A. B. BAKER, M.D., *President*,
American Academy of Neurology,
Minneapolis 14, Minn.

Associate Member Pays

GENTLEMEN:

I am a little tardy with my A.M.A. assessment enclosed which I read was for active members only; however, it is doing my part to protect the rising generations of future medicos and for the upholding of the prestige of our profession.

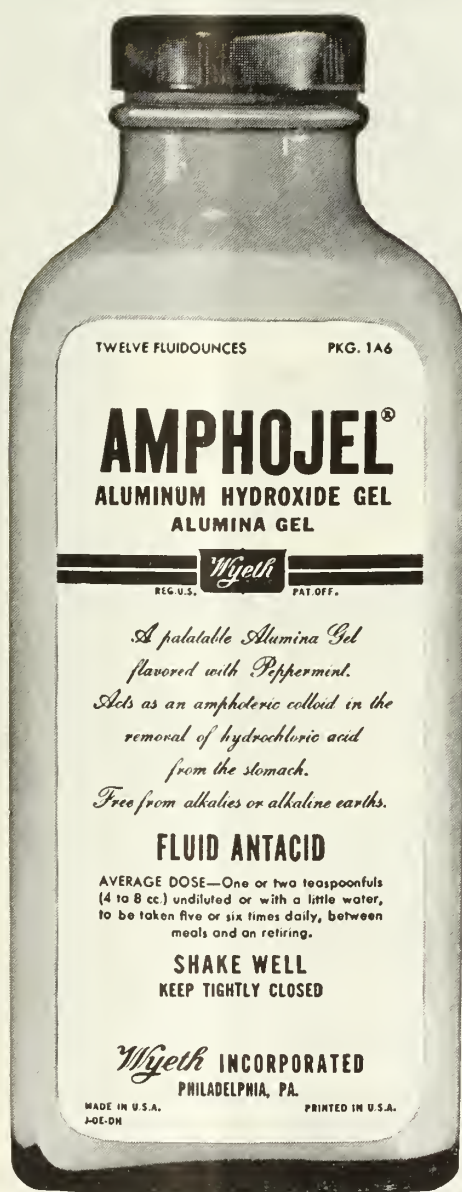
Associate Member,
_____, Pa.

New Board

GENTLEMEN:

As you know, the American Board of Preventive Medicine and Public Health, Inc., was approved by the Advisory Board for Medical Specialties and by the Council on Medical Education and Hospitals of the American Medical Association at their meeting on February 6. The American Board of Preventive Medicine and Public Health, Inc., therefore is prepared to accept applications for examination for certification in this specialty.

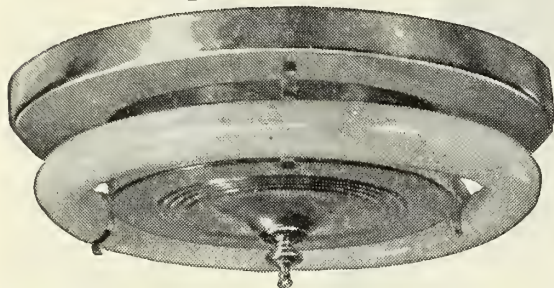
The requirements for certification include general qualifications, such as moral and ethical standing in the profession, adequate training in medicine, internship in an approved hospital, and licensure to practice medicine in the United States. Eligibility for examination also requires that the new applicant have special training and experience in preventive medicine and public health of at least six years following internship. This must include special academic training, or its equivalent, and field training or residency meeting the standards set up by the board.



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Applications may also be received for the Founders Group, who may be excused from examination. The by-laws authorize a Founders Group made up of practitioners of preventive medicine and public health who have attained unquestioned eminence in the field. The Founders Group presumably will include persons having attained eminence as indicated by academic appointments at the level of professor or associate professor of preventive medicine and public health, or who have held positions of eminence and responsibility for a period of not less than ten years in this field.

ERNEST L. STEBBINS, M.D., *Secretary-Treasurer*,
 American Board of Preventive Medicine and
 Public Health, Inc.,
 615 N. Wolfe St.,
 Baltimore 5, Md.

Clinical Eye Conference

GENTLEMEN:

Will you be good enough to insert the following notice of a meeting in one of the forthcoming issues of the PENNSYLVANIA MEDICAL JOURNAL?

"The first annual clinical conference of the Wills Hospital will be held in Philadelphia on Friday and Saturday, May 6 and 7, 1949.

"The program will be made up of members of the staff of the hospital and of ex-resident physicians. It will consist of lectures throughout both days with an evening session on Friday, May 6. A long list of eye operations will be scheduled throughout the two days.

"Among the authors of papers to be delivered are:

"Dr. James S. Shipman—'Some Practical Facts Regarding Retinal Surgery with a Report of Results in More Than Four Hundred Unselected and Consecutive Cases.'

"Dr. Edmund B. Spaeth—'The Surgical Correction of Ptosis, Congenital and Acquired, When Complicated by Other Oculomotor Situations.'

"Dr. John S. McGavie—'Causes of Failure in the Surgical Treatment of Glaucoma.'

"Dr. Wilfred E. Fry—'Integrated and Non-integrated Enucleations with Respect to Implantation.'

"Dr. Louis Lehrfeld—'Study of End Results of Glaucoma at The Wills Hospital, 1936 to 1948.'

"Dr. Bernard C. Gettes—'Dibutyl Sulfate, a Comparative Study of Its Cycloplegic Effects.'

"Dr. Irving H. Leopold—'Further Studies of the Chemical and Immunologic Properties of Human Tears.'

"Dr. Isaac S. Tassman—'Experimental Studies with Physiologic Glue for Use in the Eyes.'

"Dr. Joseph V. Klauder and Dr. George P. Meyer—'Diagnosis of Syphilitic Primary Optic Atrophy in the Pre-atrophic Stage.'

"Dr. Joseph W. Hallett—'The Optics of Cylinder Magnification.'

"Dr. Cecil O'Brien, of the University of Iowa, and Dr. Arthur J. Bedell, of Albany, N. Y., will also read papers, the titles as yet unselected.

"The Wills Hospital Society of ex-Resident Physicians will hold its annual meeting at the conclusion of this conference."

CARROLL R. MULLEN, M.D.,
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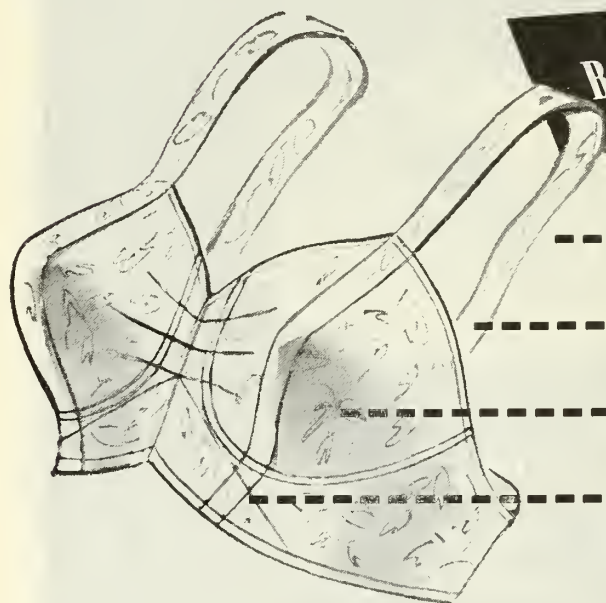
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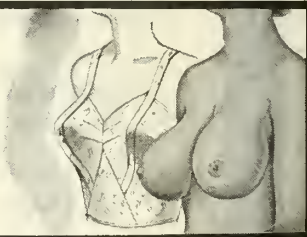
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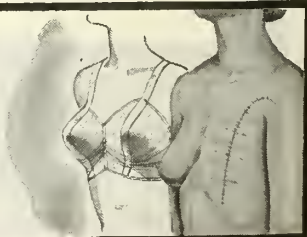
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Physiologic Mechanisms of Psychosomatic Phenomena

STEWART WOLF, M.D., THOMAS H. HOLMES, M.D., HELEN GOODELL, B.Sc.,
and HAROLD G. WOLFF, M.D.

New York, N. Y.



Dr. Stewart Wolf

IN MAN'S earlier days, it was felt that none of the circumstances in or about him were predictable. The winds and the rains and the visitations of plagues were thought to occur as expressions of capitious whims of the gods. Since then, we have learned

of more and more phenomena that they are indeed predictable and, in fact, obey strictly certain laws which are expressible in mathematical formulae. The mechanisms of all these phenomena are thus rendered amenable to experimental study. In our day, experimental medicine is dominating the medical field and the magic is slowly being purged from medicine. We are still inclined, however, to make a distinction between the "science" of medicine, which has to do with an understanding of chemical and electrical equilibria in the machinery of the body, and the "art" of medicine, which has to do with man's attitudes, aspirations, frustrations, and resentments, which are known to upset these equilibria. Now, if they are known to upset the equilibria, they must enter in some way into the mass-action equation of homeostasis. Thus, the only justification for speaking of them as an art and distinguishing that from science would be that we

know very little about their mechanisms. We can be sure, however, that the behavior of the integrated organism, man's personality and his reactions, are subject to natural laws and are as accessible through experimentation as were the mechanisms of his respiration and heart beat.

My thesis, then, is to present something of what is known concerning the physiology of psychosomatic phenomena. Newer concepts of disease propose that bodily changes in illness occur as part of the attempt of the human organism to deal with threats to its integrity, influences which tend to disturb its homeostatic equilibrium. The rales we hear in pneumonia, for example, and the consolidation come not so much from activities of the pneumococci as they do from attempts of the body to deal with these microbes. Lately, now that the novelty is wearing off Pasteur's epoch-making discoveries, we realize again that bacteria are not the only foes to man's organismal integrity. Neither are "ice nor snow nor heat nor gloom of night," nor chemical poisons nor bullets nor other physical traumata, but so also are unsympathetic wives, bosses, and mothers-in-law. Hans Selye¹ and others^{2, 3, 4} have demonstrated the invalidity of our older concepts that specific lesions are caused by correspondingly specific etiologic agents. On the other hand, defensive reactions (or disease) on the part of the bodily tissues are largely non-specific and monotonous, and occur in similar fashion to a variety of apparently unrelated noxious stimuli.

Presented as part of a Symposium on Psychosomatic Medicine at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 4, 1948.

Dr. Wolf is assistant professor of medicine at Cornell University Medical College, and is in charge of Medicine A, the psychosomatic clinic of the Department of Medicine at New York Hospital.

Our language attests to an ancient awareness that problems of interpersonal adjustment may give rise to bodily disorders: "he makes me sick to my stomach," "my job is a headache," "he makes my blood boil or run cold." Recently, opportunities have been afforded to study some of these effects, let us call them psychosomatic phenomena, quantitatively and to assess their significance and possible implications as regard health and disease.

The experimental method is apparently still the most profitable way to study the biologic laws which underlie the mechanisms responsible for health or disease. An experiment requires that a subject of appropriate nature be exposed to the action of measurable forces and that the results be capable of observation and measurement. The study of diseases and bodily disorders affecting human beings is most satisfactorily pursued by way of experiments on humans. An understanding of psychosomatic phenomena virtually requires a human subject.

The reactions of humans to symbolic stimuli (i.e., words, experiences, and events which have, in addition to their direct action, an effect through their interpretation by the subject) have been observed by numerous investigators. The experiments fall short of the ideal often because the symbols are inadequately evaluated by the experimenter. This is usually because the experimenter's interpretation of an event is imputed to the subject.

An example of these phenomena is provided by an experience from our own laboratory.⁵ During the course of Mittelman and Wolf's observations on "cold hands," it became customary to expect a sharp drop in the subject's finger temperature during the reading of "And Sudden Death," by J. C. Furnas, an especially graphic account of the violent deaths which fol-

low automobile accidents. One mild-looking young woman of 18 failed to display more than a slight fall in finger temperature while reading the account. Accordingly, she was given a piece of supposedly "neutral" literature in the form of President Roosevelt's address at the dedication of the Jersey City Medical Center. As she read, her finger temperature dropped off precipitously. Later it was learned that she had been a regular reader of the sensational press and was unimpressed by "And Sudden Death," while the reading of the Roosevelt speech reminded her of serious strife in her own home concerning the President. The family had been destitute shortly before his accession to the presidency and afterwards her father and brothers found substantial government jobs. In the face of this they disapproved of Roosevelt and planned to vote against him. The girl considered this base ingratitude to their "benefactor" and frequently left the dinner table when the President's name came up for discussion. Thus the reading of his speech aroused in her much more anguish than did the description of motor car accidents.

Comment. This experiment supports the cliché that "one man's meat is another man's poison." It is important to bear this in mind constantly when evaluating experiments which concern psychosomatic phenomena. In animal experiments, however, this error is of course nearly inevitable. In human experimentation it can be avoided only by a familiarity with the subject and his reaction patterns. Unfortunately, workers who have accorded adequate attention to this aspect of the experiment have exercised less care in matters of standardization of procedure and measurement of changes at the end-organ. On the other hand, those whose techniques of observation have been the most meticulous and highly developed have often interpreted too generally the character of the stimuli applied.

Method. In attempting to deal with these difficulties and shortcomings, the following general method was utilized: A disease or bodily disorder was considered capable of approach when some stage in its mechanism or manifestations which came and went with variations in its presence or severity could be measured and recorded. Subjects with the disorder in question were then studied with reference to their life history, including illnesses and patterns of response to various events. They were then followed from day to day, while observations were made on mood, general effectiveness, attitudes, experiences, and specific symptomatology, together



Fig. 1. Life chart correlating nasal and gastric disturbances with life situations. The black bars at the right indicate the occurrence, duration, and intensity of troublesome symptoms.

with the measurements of the bodily function in question.

In addition to observing these long-term experiments of nature, short-term experiments were engaged in, in which during a control period of relative relaxation and security, and in the absence of disturbance in the measured function, an interview was undertaken in which a topic of significant conflict was introduced.

In all of these experiments, artificial attempts to distress the subject were avoided and naturally occurring problems and conflicts were utilized as they came up in day-to-day living. Three techniques were resorted to chiefly. They may best be illustrated by describing our exploration of nasal disorders.⁶

Observations.

(1) Correlation of illness with events, attitudes, and emotions.

The first step was to establish a correlation between nasal difficulty and periods of stress in the life situation. This is illustrated graphically in Fig. 1, which was constructed from the history of a physician ill for many years with peptic ulcer and sinusitis. The events in his life, attitudes, and feeling states were correlated in point of time with the periods of most severe illness as he recalled them.

He had had no nose complaints before his first year in medical school. He had been a "well-behaved child." He had had no serious emotional conflicts as evidenced by temper tantrums, nor illnesses other than the usual exanthemata of childhood. His mother "favored him," but his father was unnecessarily strict and harsh because

he said he did not want his son to be "pampered." He stood in awe of his father. As a boy, he did well in school and college and was praised for his good behavior.

During his first year in medical school he found the course in anatomy distasteful and difficult and he was in conflict as to whether or not he had rightly chosen his career. He continued, however, and graduated from medical school confident that with his special advantages of education, background, and social position, and the assets of his personality and fine training, "success" would easily be his, and he would soon "have the world at his feet."

When he began his internship, it was his belief that the head nurse of the ward, whom he described as a "sour old spinster," was immediately antagonistic to his youthful enthusiasms and thwarted him at every turn. He resented her stern, inelastic attitude and her lack of appreciation of his assets. As he continued his internship, he found other individuals who were similarly unsympathetic to him. It became an increasingly exhausting experience to combat them. He "burned with resentment" toward these women who would not favor him, and he felt blocked in a situation which he could not master. He said, "I was gradually becoming less and less the person I had thought I was." In his bitterness he believed that the first unsympathetic nurse he had encountered had ruined his life by robbing him of his youthful enthusiasms, hopes, and aspirations. It was in such a setting that he began having, in 1926, recurrent, acute, and sometimes incapacitating attacks of sinusitis and almost continuous nasal obstruction. These

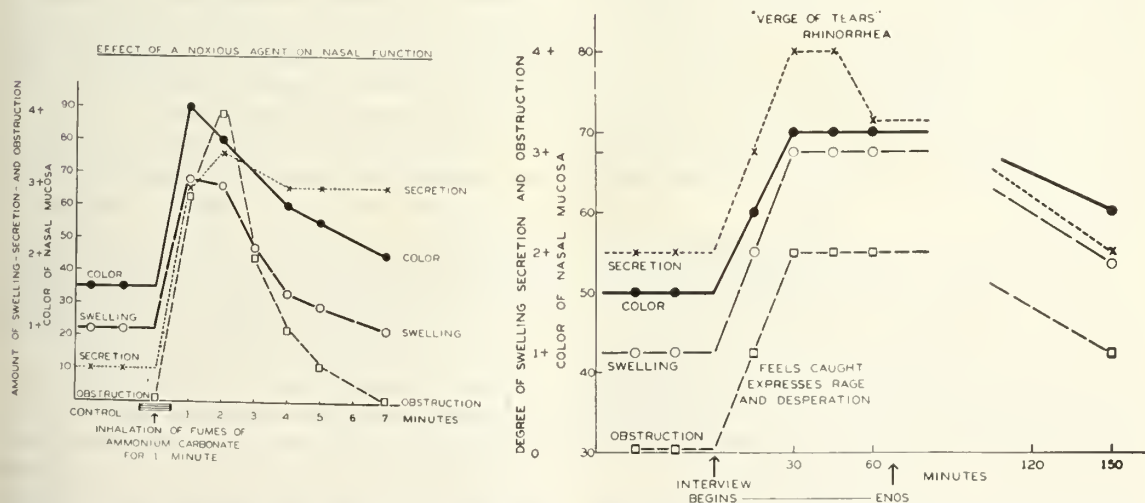


Fig. 2. (A) Hyperemia with swelling, hypersecretion, and obstruction of the nose following inhalation of noxious chemical agent, ammonium carbonate.

(B) Experimentally induced hyperemia, swelling, hypersecretion, and obstruction in the nose during an interview in which the subject experienced rage and desperation.

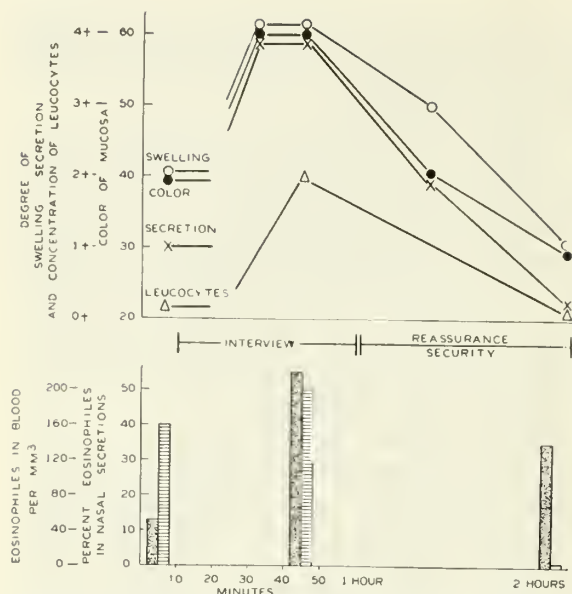


Fig. 3. Eosinophil and neutrophil reaction in the nasal cavities, accompanying feelings of resentment, frustration, humiliation, and guilt. (Stippled bars represent number of eosinophils in circulating blood.)

complaints have continued with fluctuations in severity up to the present time.

The subject was married in 1929 and his emotional relationships with his wife were unsatisfactory almost from the beginning of their marriage. His son was born in 1931, and from then on his "fundamental interest" was this boy. After the birth of his daughter in 1935, he said that he "inwardly burned with resentment and anger" because of his wife's harshness toward and rejection of the boy. "I used to bottle up my resentments, but the turmoil inside was terrible. It would last for days and weeks." He began having stomach pains in 1935 and his sinusitis was more troublesome than ever. In an effort to regain his health he gave up his practice during one summer and rested in the mountains. During the winters he spent week-ends in the country away from his family. This expedient afforded relief from his nose and stomach symptoms.

In a setting of extreme resentment and feeling of futility he had a prolonged attack of sinusitis in the fall of 1940, and when the sinusitis was most acute in December, he had his first hemorrhage from a duodenal ulcer. His domestic tension remained unchanged, and his feelings of resentment were unresolved. In October, 1942, an acute attack of sinusitis again preceded a second hemorrhage from his duodenal ulcer.

In August, 1943, the subject was divorced from his wife. At that time he was befriended by a colleague to whom he frequently went for

advice. During the subsequent eighteen months he had considerable improvement in his attitudes, and his attacks of sinusitis were less frequent and of shorter duration. The important emotional prop provided by his colleague was withdrawn by the accidental death of the man in December, 1944. The patient, nevertheless, felt optimistic about himself and well able to carry on his activities without restriction or direction. With an air of defiance of his former nose and stomach difficulties, he had a very gay holiday season, accepting many invitations to parties which entailed drinking many cocktails, smoking a great deal, and getting little sleep and relaxation. In spite of his generally improved attitude he became fatigued, tense, and anxious and developed an acute attack of sinusitis and hematemeses.

Comment. When data such as these are gathered from a patient's recollection of his past history, they are scarcely reliable. Moreover, inferences are further limited by the lack of objective evidence of nasal changes. Although numerous correlations of this type were possible among 100 subjects with chronic vasomotor rhinitis who were studied, much more useful data were gathered from day-to-day observations of these subjects over a period of months and years with the aid of diaries on the one hand and direct observation of the nasal structures on the other.

(2) Variations in appearance of the nasal structures.

Variations in appearance of the nasal septum and turbinates were viewed through an ordinary warmed nasal speculum inserted with care not to traumatize the tissues. Variations in color were expressed in figures ranging from 20 (pale) to 100 (red), according to a standardized Talquist hemoglobin scale. Roughly quantitative estimates of swelling, secretion, and obstruction were made in terms of 0 to 4 plus.

By means of this method it was possible not only repeatedly to observe the impact of day-to-day problems on the organism but actually to establish the relevance of certain conflicts by bringing them up for discussion during a period of experimental observation of the nasal membranes. Later, evidence that it was possible to establish such a relation will be presented.

It became desirable first to explore the psychologic background, the significance of the symbolization, and the biologic significance of this particular pattern of reaction; and second, to clarify the physiologic mechanism of the disturbance and its relation to symptoms and to structural disease. Since this discussion concerns pri-

marily physiologic mechanisms, the former approach will be sketched in only briefly, for purposes of perspective.

(3) Attitudes and behavior of rhinitis sufferers.

From an analysis of infantile responses, fantasy life, dreams and general attitudes and behavior among these 100 subjects, it was found that they dealt with the deprivation of parental love and support and other frustrations by shutting in their feelings and shutting out the world. They were defensive rather than offensive in their general orientation toward problems and challenges. They apparently felt that it was "nobler in the mind to suffer the slings and arrows of outrageous fortune than to take arms against a sea of troubles." Unlike patients with hypertension⁷ and peptic ulcer,⁸ they were usually unable to take decisive action.

Their reaction to social situations and challenges of day-to-day living was one of non-participation. They took in little and gave out little. With the idea that this "shutting-in, shutting-out" attitude in reaction to stress might be reflected in the respiratory passages by the pattern of nasal hyperfunction with shutting out and washing away noxious agents, an attempt was made to ascertain the biologic significance of these disturbances by exposing a group of subjects to a series of graded threats to the integrity and welfare of the organism.

(4) Reactions of the nasal membranes to noxious stimuli.

A. The first of these consisted of noxious stimulation of the nose with fumes of ammonium carbonate. The expected reaction was observed, namely, after inhalation, sudden hyperemia, swelling of the nasal structures with hypersecretion and obstruction. Associated with these nasal changes there occurred lacrimation and spasm of the eyelids, as well as strenuous coughing. In Fig. 2A is shown sudden acceleration of all nasal functions.

Comment. This was obviously a reaction of defense on the part of the organism, an effort at shutting out, washing away, neutralizing, and ejection of the offending substance.

B. Another type of assault against the person arises from the inhalation of pollens to which he may be sensitive. Accordingly, a subject was studied in an attack of hay fever. Prior to the attack, the septum and turbinates were of comparatively pale color and of normal appearance. Immediately upon beginning to cut flowers in his

garden, however, the subject began to weep and sneeze. His membranes had become hyperemic, wet, and swollen.

Comment. This particular attack was an abortive one, but it was frequently observed that when the swelling of the membranes was sustained, the hyperemia subsided, leaving the membranes pale but still swollen, wet, and edematous-looking. This pale, swollen state is the usual appearance of the nose of the hay fever sufferer when he comes to the doctor's office for treatment. It is clear, however, that, as in the case of inhalation of irritating fumes, the hyperemia comes first. This thus appears to be another instance of the defensive bodily reaction of shutting out and washing away.

C. The next step was to inflict upon the experimental subject a non-specific threat, not directed at his respiratory passages. Accordingly, an intense headache was induced by constricting the head in a tight-fitting steel crown. This was a highly unpleasant experience, associated with feelings of apprehension on the part of the victim, and gave rise to the same reaction of defense as that described already for more specific threats to the nose.

D. The final step was to learn whether or not symbolic threats which did not involve the application of physical trauma would induce such a pattern of defense with nasal changes (Fig. 2B).

A sufferer from chronic rhinitis, whose nasal structures at the time of observation were normal, was forcibly reminded that he was caught in the toils of an unfavorable marriage, that his wife was using him for a meal ticket and giving

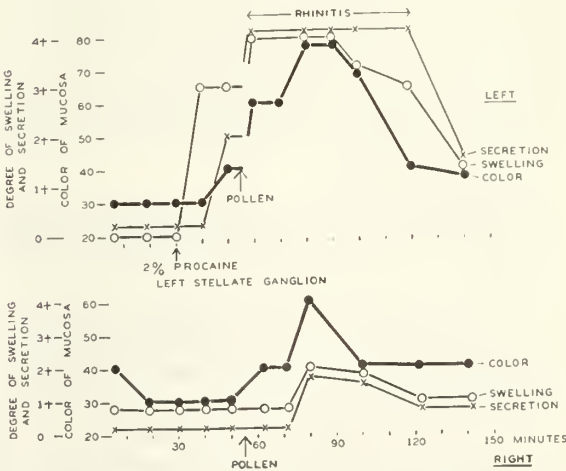


Fig. 4. Exaggerated reaction of nasal hyperfunction on side of temporarily blocked stellate ganglion following inhalation of pollen.

him nothing in return. He promptly began to display the same evidences of nasal hyperfunctioning as noted above and there was an almost complete obstruction to breathing. He described himself as being on the verge of tears although weeping did not occur. After the discussion was ended, the subject was reassured and diverted and after another hour the nasal functions returned toward normal.

Comment. The association of nasal hyperfunction to weeping was frequently observed. The fact that the tears pass into the nose through the nasolacrimal duct may be of some significance with regard to the nasal changes which accompany weeping, but it seems unlikely that the chemical composition of tears is sufficiently irritating to produce hyperemia and swelling and indeed the changes in the nose often occurred without actual lacrimation. Lacrimation, like nasal hypersecretion, serves to wash away particles and to dilute noxious agents. As if in answer to Tennyson's query,⁹ "Tears, idle tears, we know not what they mean," the origin of these phenomena may be related in some way to weeping in infancy and occur as part of a conditioned response. The individual may learn to adapt a physiologic pattern appropriate against noxae in the air about him to protect himself from other threats and to gain sympathy and support. As in dealing with noxious gases and dust, the infant may find the behavior pattern built around weeping an effective method of gaining succor from a hostile environment. As the individual grows older, he may perpetuate the weeping pattern as a way of life, despite the fact that it becomes progressively more ineffective and inappropriate as protection against symbolic threats and assaults. The complete weeping pattern, involving both the eye and the nose, often persists in females into adult life. In adult males, however, from the impact of cultural conditioning, the pattern becomes fragmented. While frank weeping is seldom manifest, hyperfunction in the nose may be readily evoked.

(5) Structural tissue changes and cellular reactions occurring as part of psychosomatic phenomena.

In an attempt to explore the characteristics of the tissue change and its mechanisms, a biopsy was made from the inferior turbinate of a sufferer from chronic rhinitis, first on one side during a control period of rest and relaxation, when the membranes were in an average state of activity, and again, from the opposite turbinate, at the height of a frustrating interview when the

patient was on the verge of tears. Both biopsies were made with the same technique and the same topical cocaine anesthesia. The first section showed an essentially normal mucosal structure with moderate round cell infiltration. The second revealed the mucous glands to be filled with secretion and the vascular and lymphatic channels to be prominent and dilated. The lighter stroma was indicative of edema.

The cellular reaction of the nasal tissues was also greatly modified by symbolic stimuli. When the nasal secretions of the same subject were collected and stained by an appropriately standardized technique before, during, and after the discussion of significant conflicts, it was found that nasal hyperfunction was accompanied by a marked eosinophilia, not only locally but in the peripheral blood as well (Fig. 3).

In this subject, as well as others, not only was an eosinophilic reaction observed in company with stress but a purulent response as well with the outpouring by the nasal membranes of polymorphonuclear leukocytes.

Other evidences of "organic" tissue changes in response to symbolic threats to the integrity or welfare of the organism were increased fragility of the membrane and lowered pain threshold accompanying sustained nasal hyperfunction. Ordinarily, when the membranes were in their average state, minor traumata with the nasal speculum were neither significantly painful nor productive of bleeding. Under circumstances of sustained hyperemia, however, the merest contact of speculum with turbinate was intensely painful and usually resulted in erosion and bleeding.

Comment. It appeared that transitory nasal hyperfunction from whatever cause could be well tolerated by the organism, but sustained engorgement of tissues with obstruction not only led to pain and discomfort but also predisposed to the development of polypi and the establishment of infection locally and in the paranasal sinuses.

(6) Neural mechanisms of the nasal reactions.

The neural mechanisms responsible for these changes appeared to include the parasympathetic branches of the third cranial nerve which reach the nose via the superficial petrosal nerve and the sphenopalatine ganglion. It was found that when the sympathetic supply of the nose was interrupted by procaine injection of the stellate ganglion the unopposed parasympathetic supply induced a state of moderate nasal hyperfunction. A membrane thus changed by partial denervation

was found to be even more reactive to noxious stimuli than usual (Fig. 4).

(7) Protective patterns involving other organs and organ systems.

Similar experimental techniques have been applied to the study of psychosomatic reactions involving other organs and organ systems^{10,18} and similar attempts have been made to formulate the findings into an integrated pattern.

Certain generalizations derive from these observations. The observed disturbances were not confined to one organ, so that the terms "organ neurosis" or "locus minoris resistentiae" could not be applied. The disturbances were more generalized into patterns of reaction, perhaps involving predominantly one organ but also manifest by characteristic changes in musculoskeletal function, attitudes, feelings, and general behavior. Moreover, the functional disturbances in each organ fell into not one but two categories, namely, hyperfunction on the one hand or hypofunction on the other. Generally speaking, hyperfunction was more ominous as regards local tissue damage and the development of "organic" disease. In the nose, hypofunction characterized by shrinkage and pallor of the membranes with widening of the air passages was seen to accompany sudden and abject fear, dejection, and hopelessness (Fig. 5).

The contrast of hypofunction and hyperfunction is perhaps most vividly seen in the stomach where our subject with a permanent gastric fistula offered a unique opportunity to observe directly the behavior of the gastric mucosa.

Hypofunction in the stomach associated with pallor of the membrane, hypomotility, low acid, and delayed emptying time is the well-known result of situations provocative of sudden and abject fear, disgust, dejection, and feelings of being overwhelmed. It is usually associated with facial pallor, weak voice, indecisiveness, and paucity of general bodily activity. This reaction was found to be characteristic of some individuals and was frequently seen among soldiers in the terrifying circumstances of combat. The symptoms associated with this condition were, chiefly, epigastric fullness, nausea, vomiting, and often diarrhea. The opposite gastric response, namely, hyperfunction associated with hyperemia, hyperacidity, and hypermotility, is less common but apparently more destructive of tissue. It was seen following situations productive of rage and hostility and was associated with tension, querulousness, and generally aggressive behavior. This type of reaction, too, was characteristic of some individ-

uals, chiefly those suffering from peptic ulcer. The associated symptoms, with or without ulceration, were mid-epigastric pain relieved by food or alkalis.

Contrasting patterns of hypo- or hyperfunctioning of organs occurring in response to symbolic stimuli have been identified also in studies of the pulse, blood pressure, skeletal muscle tension, salivary function, activity of the colon and urinary bladder and vaginal secretion.

General Discussion and Conclusions

In attempting to formulate this mass of data it becomes apparent that our old concepts concerning the occurrence of psychosomatic phenomena are too narrow. The notion fostered by Eppinger and Hess¹⁹ of imbalance or congenital defect in one division of the vegetative nervous system is obviously inadequate since, as pointed out above, more of the organism than that supplied by vegetative nerves is involved. Moreover, as also pointed out above, depending on the character, the same individual may display either sympathomimetic or parasympathomimetic changes in a given organ.

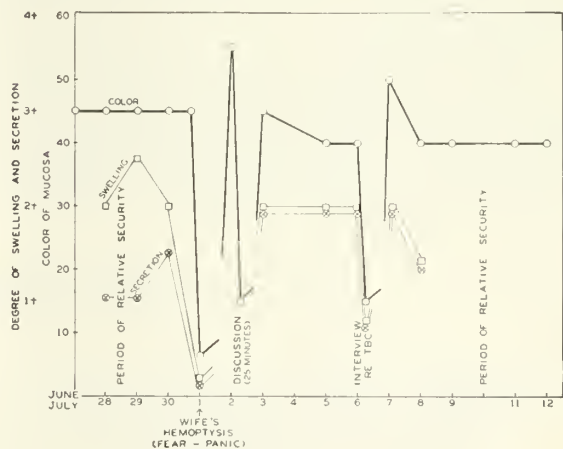


Fig. 5. Blanching of nasal membranes with wide air passages associated with fear and panic.

For the same reasons, the recently popular concept of organ inferiority is not applicable. There is more than just an organ involved and it may hyper-react at some times and hypo-react at others. Similarly, efforts to view these psychosomatic disturbances as symbolic acting out of repressed drives have not been fruitful in our hands. Viewed as integrated patterns of defense, however, psychosomatic phenomena take on more significance. Up until recently to think in teleologic terms was frowned upon and yet, as pointed out concerning hyperfunction in the

nose, the response of swelling, hypersecretion, and obstruction, often associated with lacrimation and blepharospasm, may be an appropriate and useful emergency defense reaction against irritant particles and noxious gases. The mechanism is invoked, however, against noxae not directed toward the air passages and often in response to symbolic threats arising out of difficulties in interpersonal relationship. The dangers of unduly prolonging this pattern, useful in an emergency, are obvious. Sustained obstruction in the nasal passages, as elsewhere in the body's ducts and cavities, may lead to infection. At such times we have found among patients not merely a pattern of shutting out in the nose but a general attitude of restraint, repression, and defense, together with a defensive behavior characterized by non-participation. Similar, but somewhat different, is the non-aggressive behavior of the patient with gastric hypofunction who is troubled with nausea and vomiting and rejects his food as well as the adverse situations in which he finds himself. "I'm sick of it," he might say. In contrast, the stomach of the subject with peptic ulcer is prepared for sustenance. His attitude and behavior are offensive and he sinks his teeth in problems and perhaps would like to devour his foe.

Evidence on these points and the general significance of the various bodily disturbances we have been able to measure is incomplete, but that these psychosomatic phenomena occur cannot be doubted and it seems probable that they have

considerable importance for the human organism.

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ARMY ANNOUNCES OPENING OF VALLEY FORGE HOSPITAL TO GRADUATE PROFESSIONAL EDUCATION PROGRAM

Beginning July 1, 1949, Valley Forge Army General Hospital, Phoenixville, Pa., will participate in the Graduate Professional Education Program, it was announced in March by Major General R. W. Bliss, the Surgeon General. This will bring the number of general hospitals participating in this program to nine, and will open a new source of training to young physicians interested in the Army Military Intern Program. The Army has extended an invitation to medical students to visit its training hospitals during the summer months. Valley Forge, located within 25 miles of Philadelphia, will make it possible for students in this area to inspect Army medical teaching facilities.

The Military Intern Program offers graduate professional training opportunities to selected graduates of medical schools approved by the American Medical As-

sociation. Successful candidates are assigned to Army general hospitals which have a great variety of clinical material. All participating hospitals are approved for such teaching by the Council on Medical Education and Hospitals of the American Medical Association.

Three hundred internships are available yearly. Appointments begin on July 1 of each year and terminate June 30 the following year. After receipt of their commissions as reserve first lieutenants, successful appointees are called to active duty with full pay and allowances. These young doctors selected from the top and middle thirds of their school classes receive a year's rotating internship and are indoctrinated in the military application of their training. They are offered the opportunity to apply for Regular Army Medical Corps commissions at the end of their internships.

As of March 14, 1949, there were 113 military interns on duty in Army training hospitals, with 232 new men selected to begin July 1, 1949. Of the 113 officers on duty, 73 have been offered residencies in Army general hospitals, and one in a civilian hospital under the Civilian Intern Program.

The Nature of the Emotional States that Disturb Bodily Function

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THE writer welcomes the opportunity to place before a medical group some description of the emotional states which disturb body function. There are many disturbances in physiologic functioning due to emotion, and yet the charge of emotional energy which is producing the change is subtly concealed, hard to isolate, and elusive to redirect or neutralize. The physician, therefore, needs to know these emotions and how to look for them with as much accuracy as he learns to enumerate the gram-positive cocci and how to bring them to view with a culture and staining process. To carry our analogy further, let us name a few of the most common emotions which act as pathogenic agents and then proceed to discuss their characteristics and means of isolation and recognition.

1. Anxiety (fear and worry).
2. Need for love (approval, appreciation, recognition).
3. Hostility (anger, hate, aggression).
4. Inferiority feelings.
5. Guilt.
6. Ambivalence.
7. Ambition (competition).
8. Envy.

Anxiety

Anxiety is one of the earliest emotions aroused and one of the most basic in the whole life history of man. Fear is its conscious representative, but the emotion of anxiety itself is largely unconscious. We have to use the word fear in order to describe its origin since anxiety arises predominantly out of two early life situations, namely, fear of physical harm, pain, or injury and fear of the loss of love. When the child is threatened with the loss of his mother's protective presence, he sustains uncomfortable sensations both in the mind and body, and in describing his reaction to this fear we say he fears a loss of love (meaning the loss of a friendly pres-

ence). Also as the child comes to suffer pain from falls, bumps, or punishment, he dreads its repetition. Its possibilities of repetition fill him with the same uncomfortable sensation and we call this sensation anxiety.

Anxiety has two components. One of them is psychic and distressing to the mind in varying degrees. The somatic component arises from the fact that once the anxiety threshold for the psyche has been reached there is an overflow of emotional energy through the autonomic nervous system to any or all parts of the body. People, in the ordinary course of life, who suffer from too much anxiety are people who in early life lacked the consistent supply of a reassuring friendly presence, or who were subjected to too many real pain-inflicting experiences or threats of them. This allows a dread or worry pattern to construct itself, and, as life becomes more complex, the number of things which threaten a deprivation of love and security or real physical distress increases. To a school child the teasing and exclusion by other children is a most painful loss of love and cause him to try to avoid that painful situation. A child who has not been properly helped to understand and accept minor discomfort may suffer acutely over a trip to the dentist. And so we see the beginning of morbid dread of a host of phenomena, such as dread of diseases like heart disease, cancer, tuberculosis, venereal disease, insanity, stroke, dread of being hospitalized, of being operated upon, of riding in a car in traffic, of being in a crowd and losing control of oneself, of not being a success, of losing caste in the eyes of others, of having something happen to loved ones, of inadvertently harming others, etc. The list could go on indefinitely.

Not only does the emotion of anxiety impair one's ability to enjoy life but it has more far-reaching effects. If one's energies are used up hoping that by dwelling upon the feared thing it can be averted, then there is little energy left for happy living. If this phenomenon goes on long

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enough and severely enough, the body physiology can no longer function properly and symptoms of illness will appear. These come through the mechanism we have already described of the conversion of emotional energy into somatic disturbances through the autonomic nervous system. We then have psychosomatic illness. But, in addition to somatic symptoms, the organism may utilize other mechanisms in its struggle with anxiety. It may overindulge in alcohol or drugs. It may accumulate large quantities of a sense of futility and depression of spirits. It may resort to bizarre behavior and false beliefs or even commit crimes in order to try to gain freedom from the distressing feeling which is so large a part of anxiety. It must be remembered all the time that relatively few people know they have anxiety. Recognition of its presence has escaped them while the symptom formed, the liquor was being drunk, the crime committed, or the delusion appearing. Here is where the physician needs to be the diagnostician and look for and identify the anxiety, and make the patient aware of its presence. This is the first step in understanding the cause of his trouble and preparing for the correction of it through acquiring new values and making new and more valuable personal relationships.

Need for Love

The need for love and its derivatives of approval, appreciation, and recognition is a most important emotional need. Sufficient gratification of this emotion is of great importance to health, both physical and mental. We are still living in a world which regards love as merely a luxury if not actually a sin. This is due, at least in part, to the fact that few people understand love very well; and many distort all forms of love with the suspicion that, if it is not held strongly in check, it will succumb to some organic sensual expression, either incestuous or licentious. Because of this attitude, love between parents and children is cramped and smothered, and it follows that love between husband and wife will have the same lack of wholesomeness and the whole cycle continues generation after generation. This leaves nearly everyone starved for love, appreciation, acceptance, approval, and in their emptiness they too get perverted physiologic activity, take to drugs and alcohol, try new love adventures, get divorces and remarry trying to find the cure for their love hunger.

Hostility

Like the need for love, hostility is also ubiquitous. Without spending too much time on the

philosophic origins of hostility, let us say simply that when the human organism fails to find conditions which keep him in a constant state of well-being, he experiences an unpleasant emotion accompanied by ideas of retaliation and the use of force to gain his ends, even of destruction of the person or thing which makes him uncomfortable or which thwarts him. This we call hostility. It is impossible to conceive of anyone in our society without any hostility, but certainly small amounts can be absorbed entirely satisfactorily. This is true especially if properly blended with the rest of the personality to produce wit or zestful, spicy conversation or if it results in a wholesome competition. "Get up and git" or "I'll show them" is an aggressive philosophy which contributes to progress individually and generally. But unfortunately for society a great deal of hostility does not take this form. It does not even find vent in occasional outbursts of anger, righteous or otherwise. It has to be held in because the child or adolescent does not feel that his environment will tolerate any show of hostility. He fears rejection or punishment, so his holding in results in repression—a "burying alive" process of which the mind is capable. The buried or repressed hostility builds up and the more it builds up the more labor the mind has to exert to keep it from reappearing. While this battle is going on there is much less energy available for friendly relations. In fact, the person having this internal struggle is guilty about his bad feeling and feels neither like loving nor that he deserves to be loved.

The results of this continual psychopathology may be various things, one example being the obsessive thought of such a person that he will harm somebody. However, we are more interested in where it expresses itself somatically. We discover that it goes in several directions to produce upper and lower gastro-intestinal symptoms and enuresis, into headache, a tic-like movement, probably into epilepsy and skin conditions, and plays a role in hypertension and gastro-intestinal disorders. Actually the discovery of these forces of which people are individually so unconscious was long ago noted by the general population when they observed that situations gave them "headaches," "made them sick," "itch for a fight," and "get their blood pressure up," over something frustrating. Since people are not proud about being irritable, disagreeable, unpleasantly aggressive, arrogant, demanding, tyrannical, or domineering, they remain remarkably unconscious of this emotion. But there are tremendous quantities of hostility latent in the human race producing not only serious social

problems but many individual symptoms of illness as well.

Inferiority Feelings

To many it might appear that feelings of inferiority could exist as a social phenomenon but not produce any medical implications. But feelings of inferiority are closely linked up with the basic emotions of love and hate. Obviously, the person having feelings of inferiority has not had enough acceptance and appreciation. This leaves a great hunger growing in him—a hunger which may stimulate the gastric physiology to function as if physiologic hunger existed. The false stimuli appearing at the wrong times and too continuously can give symptoms and actually produce a pathologic state of the tissue. Feelings of inferiority and the frustration which has produced them generate hostility also, so that combinations of emotions are at work along with feelings of inferiority.

Guilt

Guilt is a conscience reaction. It is an emotional distress reaction resulting from criticisms by the conscience, the conscience being a well-preserved memory pattern of what the parents thought was right and proper. The person holding guilt has reason to feel that he has not been or is not living up to expectations. This emotion can kill the joy of living and may cause the patient to live a life of excessive self-sacrifice which in the course of time produces physiologic disturbances. As an emotion its acts to block the reception of impulses emanating from others of love and approval. Starvation of the love needs can occur from guilt and the pathophysiology results in the way described earlier in the paper.

Ambivalence

Ambivalence is a term given to the condition of holding both love and hate reactions toward a person or the world in general. These impulses may be present practically continuously and show themselves rather subtly, or they may show themselves more superficially and plainly by a capricious change of mood and attitude in which

those associated with them are loved one hour or one day and hated and condemned the next. We see men, for instance, who protest how much they love their wives but never listen to their requests, their suggestions, never try to further their plans, and never help them in any tangible way. We see women who protest that they love their children but who never allow them to do anything they enjoy and never let them decide anything for themselves. This mixture of emotions, which has the descriptive term of ambivalence which portrays it as one emotion, can, like guilt, block off the benefits of direct, friendly, satisfying, and wholesome love relations.

Ambition (Envy, Competition)

The ambitious person does not necessarily have pathologic emotions, but he certainly runs the risk of being infected with envy or excessive competitiveness. These emotions tend to produce tension and the professional, financial, and social success of many people has been paid for at a high price, i.e., the price of tension, which is prone to express itself through the nervous system upon many parts of the body. The aggressive component inherent in these emotions plays a large role in conditions such as cardiovascular disease, migraine, hypertension, and to some degree, in many others. A successful person can have achieved his goal by a great ability and a friendly, easy-going manner, but he is in the minority. Ambition with its attitude of competition, and sometimes accompanied by envy, is all too often carried along as necessary equipment on the road to success. So it should be looked for and brought into consciousness if present.

We have tried to describe the nature of the most common and frequent emotions which produce disturbances in bodily function. Knowing them and being able to isolate them is one of the first steps toward neutralizing or redirecting them. As we said in the beginning, physicians should know them well as pathogenic agents and not merely as casual and innocuous phenomena.

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The Pennsylvania Department of Health desires the services of 25 young physicians from July 15 to 31, inclusive, at the newly created Camp for Underprivileged Boys at Indiantown Gap, Pa. Remuneration will be \$10 per day plus expenses and transportation. For further information, communicate with Norris W. Vaux, M.D., Secretary of Health, Commonwealth of Pennsylvania, Harrisburg, Pa.

The Psychosomatic Concept in General Medical Practice

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THE term "psychosomatic medicine" has become very popular—almost too popular, in a sense. Like the mental hygiene movement of twenty-five years ago, which popularized the subject of mental hygiene although not prepared to implement it, so does the same danger exist in the broadcasting of information regarding psychiatry and psychosomatic medicine. We create a demand that we are not prepared to meet.

The term psychosomatic is often criticized. It is referred to as a hyphenated term which is no better than all the other terms which have been used to try to bring together psychiatry and medicine, but I think it has served a useful purpose in many ways. It has caught the imagination of physicians and laymen alike, as no other term or phrase ever has before, and has aided in bringing about an amalgamation of medicine and psychiatry which I know all will admit is long overdue.

The psychosomatic concept is certainly not new in medicine. From days of antiquity, medicine has known there was some kind of relationship between feelings and sickness. But in the last one hundred years we have moved away from paying attention or giving respect to feelings as a cause of sickness and, following Virchow, have narrowed down our viewpoint to the organ and cell as the seat of disease. Many instruments of precision have been perfected to study these various changes within the body, and specialists have arisen who further divide the body into systems and organs and concentrate on the study of these changes with the various instruments of precision. Many of these so-called specialists became prominent by their exploitation of a particular instrument of precision. It might well be called the "machine age" in medicine—a period of laboratory ascendancy in which, undoubtedly, great discoveries have been made, particularly in the field of infectious disease, but the person in the body of the human being who is ill and his

feelings were almost entirely neglected. To a certain extent, that is still true today.

World War II did a great deal to change that, and this fascination with psychiatry stems largely, I think, from the impetus that was given to the development of the subject by military medicine, because almost every physician who served in World War II came back with a healthy respect for the emotions as factors that can make people sick, and placed them on an equal plane with germs and bullets. These young physicians came back determined to learn more about the emotions and ill health. They subscribe to the notion that the term "psychosomatic" must be as unhyphenated as we can make it; that it must mean not less study of the soma, but more study of the psyche; that it must respect the scientific application of physiologic and psychologic techniques in the study of the human being in an effort to make a definitive diagnosis and in preparation for comprehensive medical care. I think that is as far as the term "psychosomatic" ought to go. There remains some question as to whether the term should be used to designate an ailment, although that is the interpretation placed upon it by many of its proponents who refer to certain diseases of the vegetative nervous system, such as migraine, asthma, et cetera, as psychosomatic disorders. If the term is used in this way, it means that the disorder is one that can be understood only when emotional factors are studied as well as physical factors. Beyond that, I think the term refers to a technique—an approach that applies equally to all aspects of medicine and surgery—a methodology; that is all. I am willing to concede that it is an interim term, good for the present time, to be abolished when good medicine becomes psychosomatic medicine. That day, I think, is fast approaching.

Psychosomatic Diagnosis

In the words of Halliday, when we study a sick person we must do so from three points of view. We must ask ourselves, first of all, what *kind* of person is this; what are his physical and psychologic characteristics, inherent and acquired? Second, what has he *met*; what noxious

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influence in his environment, whether it be germ, allergen, or emotionally disturbing event? Third, what has *happened* as a result of the meeting of this predisposed individual with this disturbing event in his environment? If we regard a sick person from that point of view, then we do away with the age-old tradition in medicine that illness must be either organic or functional. The day has passed for us to look upon a sick person as either organically diseased or functionally disturbed and, instead, we must ask ourselves: What are the physiologic disturbances? What are the psychologic disturbances? And, are they related? That is the science of psychosomatic medicine which makes an effort to work out the precise relationship between the emotions and bodily disturbances.

Let us draw an analogy between this approach and the organic tradition in medicine. In studying an individual with what we consider to be an allergic manifestation, we first of all try to establish a background and family history of allergic disturbances. Then, having learned that heredity may play a part, we see if there is a seasonal influence—in the distribution of pollen, for example. Then we try to see whether there is a skin reaction and, perhaps, evidence of antibody formation. Sometimes we expose such an individual to pollen or to the allergen in an effort to induce an attack. And, finally, by means of hyposensitization or avoidance of the provocative agent we try to bring about improvement.

In order to establish postulates in our diagnostic survey, exactly the same thing is true of psychologic medicine. Heretofore, in medical school we have been taught to place the psyche last. The patient is studied by means of the bare facts of medical history, a thorough physical examination, and the various laboratory studies, and if all are negative, then and then only, dare one make the diagnosis of functional or psychogenic disorder. There are grievous errors involved in this kind of thinking. First of all, there is the organically minded physician who never admits the possibility that he has excluded all of the various diseases that may make his patient sick; so, in dealing with chronic illness in particular, he can always think of another possibility in the realm of obscure infection, allergic disorder, endocrine disease, or metabolic disorder that remains to be investigated. So the patient accumulates a thick sheaf of documents, containing the results of hundreds of dollars worth of laboratory procedures; becomes fixed in his neurotic obsession with the disorder; and is often put through many medical and surgical procedures in an effort to achieve a cure. That is

one of the dangers of the either/or approach based upon diagnosis by exclusion.

The psychosomatic approach does not use a different history from that which we have been using in medical schools ever since the days of Osler, but the substance of that history form must differ considerably. In other words, we have all had the experience of going on the hospital wards or of studying a private patient who has been in a special clinic and seeing a history of four or five neatly written sheets, often underlined in red, stating the various symptoms and going through the various systems, and yet we look in vain in that large medical history for some picture of the human being who is sick. It is true that one finds hints here and there, but no place is there a concerted effort to give a real social background of the illness. The form of the history is the same, but the substance must differ.

We must make an effort to build up certain postulates from positive personality data in an effort to establish a diagnosis of neurotic or psychosomatic illness as well as establish negative data derived by exclusion or evaluation of organic disease. In other words, neuroses and psychosomatic illnesses have their own distinctive features to be discovered by personality study. What are they? To go back to the analogy of the allergic disorder, we must first of all establish a family-history background of psychopathology—events of neurotic, psychosomatic, or psychotic disturbances in the family history among blood relatives or siblings that disclose a hint in this individual of certain characteristics inherited and acquired that make him vulnerable to emotionally disturbing events.

Second, we must try to establish a diagnosis of disturbed behavior in childhood, because only rarely does neurotic or psychosomatic illness make its appearance for the first time in adult life. Usually disturbed behavior in childhood has marked the background for a neurotic ailment. It is the sort of thing about which the family doctor used to say, "Oh, he'll grow out of it." It is true that he grows out of it for a period of time, but the seeds of disorder remain within the personality, later to come out when some situation in adult life reawakens old associations.

Third, we try to establish a temporal relationship between the onset of the illness and some emotionally disturbing event that is specific for the individual. That means that we must do more than simply inquire of a patient "Are you worried about anything?" or "Has anything happened?" and be satisfied with a negative reply. I recall a middle-aged woman who came to see me several years ago, who seemed to be a

very sick person and who was apparently suffering from some obscure disorder that I did not understand. After many futile efforts to discover what was the matter, she drifted away. I saw her again many months later looking like a person transformed. She had on new clothes, a new hat, rouge and lipstick, walked differently, acted differently, and presented the picture of health. I was interested to learn that her husband had died. He was an alcoholic and she had suffered his beatings in silence. Martyr-like, she had absorbed this punishment and never trusted herself to talk about it to anyone. With his death she had relief instead of grief. I cite it as an example of the fact that the usually disturbing event—grief—did not apply in this particular case because it was not specific for the individual.

Fourth, in an effort to build up our diagnosis, we want evidence pointing to other neurotic symptoms or other evidence of a character disorder. We make a longitudinal instead of a cross-sectional study of the life history in an effort to show the genetic development and the specificity of certain events in this particular personality. Again, this does not differ from organic medicine where the typhoid bacillus is specific in causing typhoid fever; nevertheless, it depends upon a certain susceptibility of the individual. In the same way, the emotionally disturbing event must be specific and must be present in sufficient degree to disturb the individual.

Fifth, in taking a psychosomatic history, we can often reproduce in the patient, like an allergic attack, evidence of disturbed behavior if we touch upon significant material in talking to the patient or, rather, encouraging the patient to talk. Evidence of disturbed behavior—the racing pulse, the mounting flush, or other evidence that we have touched upon meaningful material—is very significant from the standpoint of diagnosis.

Lastly, and again comparing it to the allergic problem, hyposensitization by means of catharsis—talking about the problem again and again; or avoidance of provocative situations by means of environmental manipulation—changing the environment if we can't change the person—ought to lead to a significant degree of improvement and thus establish our six postulates in psychosomatic diagnosis.

If we add these to the physical and physiologic studies, we should have a definitive diagnosis. In other words, just as we teach in physical medicine that we must make an etiologic, anatomic, and a physiologic diagnosis, so in the psychosomatic concept we teach that we must have a

clinical, a dynamic, and a genetic diagnosis. The dynamic diagnosis refers to the emotionally disturbing event in the cross-sectional history that has precipitated the illness; the genetic diagnosis refers to the longitudinal section of the life history which establishes the background for this emotionally disturbing event to produce an illness. Having established a diagnosis, the question of treatment arises—it is a controversial one.

Psychotherapy

How far should the general practitioner go in dealing with these problems? How much of it lies within his province? Does any of it? Or should he ignore the psyche in dealing with his patients, referring them to psychiatrists as soon as he suspects that the emotions are playing a part? This is intimately bound up with the question, "What is psychotherapy?" Is psychotherapy the art of medicine as practiced by the old family doctor—reassurance in large doses—a kindly, sympathetic manner, perhaps slapping the patient on the back and telling him that he is all right, or sending him away on a vacation or serving food in pretty dishes? Is this psychotherapy? No, psychotherapy is something more. Psychotherapy is a medical discipline, perhaps not as precise as the biologic sciences, but nevertheless a system which can be taught, that has rules of order, and that can be learned if we start soon enough in our medical curriculum.

There is a minor psychotherapy as well as a major psychotherapy, just as there is a minor surgery and a major surgery. I think you will agree that most physicians are prepared to do minor surgery and feel themselves able to do it, but would not attempt major surgery for which they are not prepared. However, they recognize the indications for major surgery and send the patient on to a specialist for further help. I think our responsibility in regard to psychotherapy in general medicine is the same. The great majority of patients whom we see, particularly with chronic illness, have an emotional component to their illness that has entered into the problem of ill health, either wholly or in part.

From my own practice, including hospital and clinic experience, I divide patients with chronic illness into three groups: One-third have an illness that is not to be accounted for on the basis of physical disease, but in which emotional factors are chiefly responsible. Another third of patients have organic findings, but they do not explain the entire illness; in other words, the symptoms are out of proportion to the disease. In a final third the physical factors seem respon-

sible for the clinical picture that the patient presents. If these figures are true, and studies from many sources confirm them, then it stands to reason that we have an important job in medicine, so far as the psyche is concerned, that cannot be ignored, and the truth of the matter is that nobody ignores it. Everyone who deals with human beings who are sick has to deal with the psyche, no matter how clumsily or how unconsciously he does it, and my point is that he must do it with understanding, that it can be taught, that we must practice a minor psychotherapy in general medicine rather than continue to neglect this factor.

What can be said about minor psychotherapy? The following questions are usually raised: "How can I possibly take the time to do this?" "How can I afford to do it?" "How far shall I attempt to go?"

First of all, I think we cannot afford not to do it. In a study of "thick-chart patients," when you add up the expense of the various laboratory procedures, the time consumed by the dozens of visits in which perhaps only a single entry was made or a prescription written, but nevertheless time taken up and money spent; when you add that up and balance it against an hour or two spent in trying to understand the patient as a human being, I say the other form of medicine, psychosomatic medicine, is less costly to the patient and yourself in time and effort and harmful procedures. That does not mean, of course, that the man who practices general medicine has to sit down and spend an hour with every patient whom he sees. Obviously that is not so, because the great majority of patients suffer from minor ailments or acute ailments, easily understood without a prolonged discussion of emotional factors. But for chronic illnesses, the kind that accumulate thick charts and are subjected to all kinds of unnecessary medical and surgical treatments, for that kind of patient you have to take time, and it is economical in dollars and cents as well as in the salvage of human resources when you do so.

What are some of the problems that we deal with in minor psychotherapy? Think of the number of patients who present themselves to you daily in whom you find that the central core of psychosomatic disturbance is anxiety—anxiety which grows out of emotional conflict. That is why it doesn't do much good to say to a patient "Are you worried about anything?" because the things that disturb him are often not in his consciousness. They are expressing themselves as bodily disturbances for the very reason that they are repressed, pushed out of consciousness, and,

therefore, create tension or pressure from within. I use homely analogies in talking to patients. I say to them "You are like a tea kettle full of steam; if it does not come out of the spout, it tries to blow the lid off"; or perhaps a more elaborate explanation, "You are like an engine with the steam up—your wheels fail to go around in productive work; your whistle wants to blow (in talking about your problems) but can't and so the steam tries to part your seams." Think of this in relation to hypertension. I say to such patients, "If you have tension of emotional origin which you can't get rid of by word or deed, that tension is going to find some way of expressing itself. It's like steam under pressure."

Often such tension will be expressed in symbolic language, a kind of body or "organ language." The individual who cannot eat, who cannot tolerate food, who is nauseated or vomits, often cannot tolerate something in his environment. He cannot *swallow* this or that environmental situation. He cannot stomach this or that thing that has happened to him. Atypical neuralgia of the arm or face often represents the response to focal conflict rather than to focal infection. How many patients have you seen who have had their teeth pulled out and are getting injections of vitamin B₁? So often the pain represents the response to two opposing forces within the individual. He'd like to punch somebody and is prevented from doing so by the affection and respect that are mingled with his hostility, and he gets a pain—atypical neuralgia. And so you can go through the body and study various systems and find a homely explanation which either explains the complaints in whole or in part—the physical expressions of tension—and provide a ready avenue for the patient to talk about some of the problems which are disturbing him. How often we see patients with shortness of breath or sighing respirations which represent a load on the chest that they would like to get rid of by talking about some of their problems. As one woman said to me the other day, "Whenever I start to talk about my sex life, my doctor gives me another prescription for phenobarbital." Weakness in the legs, shakiness, and tremors represent the physical evidence of *insecurity* which we can usually ascertain by talking to the patient about his feelings of inadequacy. This is an approach that I find very useful in minor psychotherapy.

Anxiety is the nucleus of the disorder, and it often finds a physical expression. The patient rationalizes that expression in some phobia which unfortunately is often added to by his medical

adviser. Nearly every woman you see suffers from the fear of cancer. Many men do, too. They don't tell you that, but you're safe in the assumption that it is in the back of the mind. When you examine a patient who presents a vague complaint, an ache or discomfort, fatigue, or a lump, bump, or swelling which she thinks she sees, and you're sure she is quite free of any organic disease, it is well to reassure her as to the absence of cancer. Often the most significant material is expressed in the last few minutes as the patient is leaving your office, when in the least formal part of the interview she says "I am so glad to know that you find me all right, doctor. I was so afraid I was developing cancer." The cancer fear is added to by our cancer propaganda. I think that it is a price we have to pay, but it must be recognized for what it is.

And how about the fear of heart disease in which we so often see the iatrogenic influence? A patient develops an anxiety attack in a crowded room, suddenly feels faint, breaks into a sweat, the heart races, the pulse pounds, and a doctor is called. He feels the pulse, listens to the heart gravely or overlong, takes the blood pressure, then says to the patient "I don't *think* there is anything the matter with your heart, but you better take it easy," or "Your heart *seems* to be all right, but you better take these drops for awhile." Here we have the beginning of a cardiac neurosis because the heart, from days of antiquity, has been known as the seat of the emotions, just as the belly is the sounding board of the emotions. People fear heart disease and we have to be on the alert not to add to their apprehensions.

How often we see patients with organic heart disease in whom the disability is caused not by the heart but by the concern and the preoccupation with the heart. I am always delighted when I see a patient with hypertension who has a lot of symptoms, but not much organic disease as far as heart, renal function, or eyegrounds are concerned, because I know that patient can be helped a great deal. He can be re-educated in regard to his hypertension and the phobias he has picked up. One young man I saw only recently was afraid to go out in the sun because of some fancied relationship between the sun and heat and an addled brain; afraid to lift his arm because of the exertion; afraid to have a bowel movement because of the strain on his cardiovascular system; afraid to have sexual intercourse for the same reason. This, I grant you, is an extreme instance of cardiac phobia on the basis of hypertension. Look for it in every patient you see and take away the fear of blood pressure, the

phobia of hypertension. Cardiac neurosis is a very common disorder and generally recognized as emotional in origin; it is usually approachable only by psychotherapy. But did you ever stop to consider how many symptoms in organic heart disease are brought about by psychic stress, and that the disability might be indefinitely postponed if we could deal adequately with that psychic stress? I am sure that many cardiac patients come to grief long before their time because they have not been dealt with satisfactorily from an emotional standpoint. Make no mistake about it—the emotions add a real burden to the work of the heart, not only in stress and strain but in disturbed function. Even auricular fibrillation can be precipitated by an emotionally disturbing event.

Third on the list of major anxieties is the fear of patients that they are losing their minds. They don't tell you that. They complain that their memory is slipping, that they cannot concentrate, that they are so preoccupied they cannot read—they must read over and over to understand. What they don't say is, "I'm afraid I am losing my mind." With it often goes the thought of suicide, which is most damaging of all. Bring that anxiety out on the surface. They may be greatly helped by sharing their burdens of anxiety. Tell them that their problem is emotional, not mental. It will achieve marked relief.

I think that you can deal with these things in minor psychotherapy and often do a great deal of good. If the neurotic disposition is not too great, you can help your patient immensely by dealing with these physical manifestations of anxiety. But what can we do about the problem so far as the future is concerned? I think that medical education has to do a very different job than it has done in the past. More and more stress is being put on psychiatry, but we must have a real integration of psychiatry into the medical curriculum rather than just more and more hours of psychiatry. We must introduce it from the very beginning. We must study a person not only as a corpse on the dissecting table but as a human being constantly reacting to environmental stresses. We must teach our students that such reactions disturb the working of the body as well as the soul. Our medical faculties must pay respect to and be oriented in these concepts, and I submit that if we don't do it in the medical school, we will never do it successfully. It is too late at the postgraduate level. I don't think that it is impossible, but it is late. Even premedical education must be changed. College psychology has to be different; it must be a psychology which really teaches human be-

havior. Our medical students have to come well grounded in all of the social sciences, in addition to being taught a different kind of psychology. Then we must prepare our medical residents with rotation through a good department of psychiatry. In the interim, perhaps we can do something about postgraduate education for the men who are interested and who want to learn something about the psychosomatic approach. Maybe we can have some short courses in various insti-

tutions to do something to repair the deficiency in medical education. We have tried it on two occasions at Temple University and it was tried at the University of Minnesota through the facilities of the Commonwealth Fund. The experience was published in book form—*The Teaching of Psychotherapeutic Medicine*. It is a very interesting description of this effort to bring the general practitioner up to date in the application of psychiatry to general medicine.

HOW THINGS ARE DONE TO REACH YOUR HOUSE OF DELEGATES

Suppose you as a physician are critical of some action your county or state medical society has taken, or has not taken; suppose you have ideas of your own concerning medical policy or procedure which you think are very sound but to which no one seems to pay attention. Suppose finally you become convinced something should be done and suppose you have sufficient initiative and determination to try to make your ideas effective on both a county and state level. How then do you proceed?

Having arranged your ideas and your arguments in an orderly manner, you present them to the committee of your county society whose work encompasses the subject matter you have in mind. You can also discuss them with the officers of your society and the members of the comitia minora. After study and consideration of your proposals, the committee will report favorably or unfavorably to the comitia minora, which in turn will accept or reject the committee report, or may request further study and clarification. Whatever action is taken by the comitia minora will be reported to the members of your society for their consideration. Through all these proceedings it is your task to follow and support the progress of your proposal, and to do everything you can to insure its success. Rejection of your ideas will be due to lack of work and follow-through on your part or will be based on the conviction that they are not to the best interests of your society.

Let us assume, however, that your proposal has been approved by your fellow-members and is now part of the policy or procedure of your county society. What next has to be done to obtain adoption by your state society?

Prior to the annual meeting of your state society, a resolution has to be drawn up embodying the specific arguments for the proposal you wish approved and indicating the reasons for its presentation to the House of Delegates at the annual meeting. This resolution must be worded with extreme care. Beyond all else it must be factually correct, it must be complete yet concise and as brief as possible, it must not be verbose, it must never be redundant. The chairman of the delegates then decides which delegate is most familiar with the background of the resolution and is best prepared to present it to the House of Delegates. The afternoon and evening before the annual meeting the delegates review in

detail all resolutions and plan their procedure at the meeting. Each delegate is made responsible for the success of the resolution he presents.

After the House of Delegates has heard the reading of the resolution, the Speaker of the House refers it to a reference committee for consideration. The responsible delegate attends the meeting of the reference committee and makes every effort to obtain the committee's approval of his resolution. Following this study the reference committee chairman reports the conclusion back to the House. If the report is unfavorable, the delegates of your society then have opportunity to present their arguments before the assembled House in an attempt to over-rule the reference committee report. If the report is favorable and the House agrees, then your resolution finally becomes adopted by your state society and your proposal becomes accepted procedure. — *Westchester Medical Bulletin*.

WANT A FREE TRIP TO ENGLAND?

Naturally, there's a string tied to this, but if you need a gallbladder removed, or an appendix, save your money and buy tickets. The following paragraph from a letter appearing in the *British Medical Journal*, Sept. 25, 1948, shows how:

"Sir,—In the Supplement (Sept. 4, p. 104) appears the statement, 'Visitors staying in Britain for less than two months are entitled to treatment under the National Health Service as temporary residents.' Why entitled? Why should foreigners who come to Britain, say, on a sight-seeing tour be entitled to free medical attendance at the expense of the British tax-payer and of the medical profession? Why should the medical profession be singled out for this imposition? To carry the matter to its logical conclusion the hotel keepers ought to be directed to give free accommodation to these visitors and the motor companies be ordered to provide cars free of charge. . . . I suppose now the overseas offices of our travel organizations are advertising, among other inducements to foreigners to visit Britain, free medical treatment during their two months' stay here. Positively, it would pay many of them to come here to have their appendices removed or their chronic gastric ulcers treated—all for nothing."—*St. Louis County Medical Society Bulletin*.

The Clinical Management of Deafness

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THE object of this paper is to summarize the various ear conditions causing deafness. I shall comment on the efficacy and limitations of medical and surgical therapy for its relief, and give a more detailed discussion of some of the ear conditions which are commonly overlooked or improperly diagnosed. I shall discuss also the value and suitability of hearing aids.

Prophylaxis

The earlier in childhood that pathologic changes of the middle ear, the eustachian tubes, and the nasopharynx can be detected and corrected, the less will be the trouble encountered later in life. Uncorrected lesions affecting the hearing mechanism may result in permanent defects as the child grows older.

Ventilation of the middle ears in infancy is most important. Routine x-ray examinations show a large percentage of mastoids with imperfect pneumatization. The so-called sclerotic mastoids are usually non-pneumatized mastoids of compact bone resulting from lack of proper ventilation in infancy. A common sequela of a non-pneumatized mastoid is chronic suppurative otitis with cholesteatoma.

Improper feeding in infancy is a major cause of non-ventilated middle ears. An infant should never be fed from a bottle while lying in the supine position. In this position it is impossible to swallow without forcing fluid into the nasopharynx and often into the eustachian tubes. An infant's head should always be elevated during the course of feeding. This rule should be publicized throughout maternity and children's hospitals. I have seen many instances in the infant wards where a bottle was suspended in a rack placed over the child in its crib. Milk or regurgitated fluids which enter the eustachian tubes are generally eliminated without outside help. Repeated recurrences, however, can cause inflammatory reactions of increasing severity with changes in the lining membranes of the eusta-

chian tubes and middle ears which may lead to more serious trouble in the future.

Fluid or Secretory Middle Ears

This condition is frequently not recognized on routine examination. It is quite common in children and rather uncommon in adults.

Etiology. — Obstruction of the eustachian tubes due to:

1. Swelling of the mucosa from inflammatory reaction associated with respiratory infections.
2. Entrance of foreign material in swallowing, vomiting, or regurgitating.
3. Sudden changes in barometric pressure, e.g., aerotitis.
4. Narrowing of the lumen of the eustachian tube by lymphoid tissue.
5. Distortion of the eustachian tube mouth from adhesions along the lateral wall of the nasopharynx.

Symptoms.—The only complaint, if any, is usually diminished hearing with a sense of fullness or stuffiness. Tinnitus and autophony may be present. Many children with this condition are brought to the doctor's office because of inattention at school or the discovery of a hearing defect during a hearing survey.

There are two types of secretory middle ears to differentiate between: (1) serous otitis due to a transudate following blockage of the eustachian tubes without inflammatory reaction in the middle ear; (2) mucous otitis due to an exudate from inflammatory reaction of the mucosa of the middle ear.

Physical Findings:

Serous

- Drum retracted if recent closure.
- Drum in good position if of long duration.
- Drum may have a yellowish-gray cast.
- Fluid level may occasionally be seen.
- Drum appears fixed on compression with Siegel speculum.
- Slight hearing loss for low tones.

Read before the Section on Eye, Ear, Nose, and Throat Diseases at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 6, 1948.

Greater hearing loss for high tones.

Negative Rinne test for low tones.

Mucous

Drum not retracted.

Drum normal or thickened, occasionally distended.

Drum appears opaque.

No fluid level.

Drum fixed on compression.

Marked hearing loss throughout scale, especially high tones.

Negative Rinne test.

Local Treatment.—Simple inflation of the eustachian tubes is frequently effective in relieving the serous type of secretory ear. If much fluid is present and the condition is of long standing, a true paracentesis or puncture of the ear drum should be performed, followed by inflation and suction. No anesthesia is necessary, as a paracentesis of a non-inflamed drum produces little if any pain. Enough fluid may be released by this procedure to run out of the meatus and drip down onto the neck.

In the mucous type of secretory otitis, simple inflation is ineffective. A myringotomy rather than a paracentesis is often necessary. This should be followed by inflation and suction. Usually a small drop of thick, gelatinous mucus will exude through the opening in the drum and is removed with a suction tip. Two or three such treatments may be necessary before enough serum forms to dilute the mucus and enable the complete evacuation of the fluid in the middle ear.

General Treatment.—Allergic rhinitis is frequently present, as can be demonstrated by the finding of clumps of eosinophils on nasal smears. Any allergy should receive appropriate attention.

Simple adenoidectomy may be effective in preventing recurrences, although secretory otitis frequently follows an apparently clean adenoidectomy.

Regeneration of adenoid tissue and the presence of lymphoid tissue in the vicinity of the mouth of the eustachian tubes may require radiation therapy. It has been my practice to employ general anesthesia at the time of the first radiation in order to remove any adenoid remnants and to destroy any adhesions along the lateral pharyngeal walls resulting from former surgery. The presence of apparently minor adhesions may have a pulling effect upon the lateral pharyngeal bands and cause a slight distortion of the tube mouths. The simple release of these adhesions may be sufficient to correct the secretory ears.

This accounts for the successful results of certain osteopathic procedures which have been described as reconstructive surgery of the eustachian tubes. In my private practice the prompt improvement and recovery of many patients which I formerly thought due to radiation therapy I now believe were due to the finger surgery and clinical treatment. The radiation therapy had little effect on the results, since the amount of beta ray emanation was too small to be effective. The lack of demonstrable changes in the germinal centers of lymphoid tissue of adenoids removed following a series of radiations confirms this belief. The explanation for this lack of effect is now apparent since Crowe's recent report that there was a mistaken time element advised for the use of radium salt applicators. A twelve-minute application is now advised instead of six and one-half to eight minutes as formerly advocated.

Sequelae.—If not recognized and treated, secretory ears frequently become infected and lead to acute and chronic suppurative processes or to fibrosis and adhesions with permanent damage to the hearing.

Middle Ear Suppuration

The major problem is to eliminate the infection and heal the ear with as little damage as possible to surrounding structures. A detailed analysis of this problem is beyond the scope of this report. A few comments, however, are called for regarding radical mastoid surgery and its effect on hearing. There is a general belief that hearing loss increases following a radical mastoidectomy. As a result many patients refuse to submit to such an operation even though intracranial complications may be imminent. Without operation, the continued suppuration and destruction frequently cause a gradual deterioration of hearing and occasionally a labyrinthitis destroys the hearing completely. Judicious radical surgery is never contraindicated because of the state of a patient's hearing. The effect of such surgery upon the hearing can usually be foretold before operation:

1. If functioning mucosa lines the middle ear at the time of operation, the hearing will probably become worse. Fortunately, radical surgery is rarely indicated in such a situation except when an attic cholesteatoma occasionally ruptures into the middle ear with secondary destruction of the ear drum. However, radical mastoidectomies are sometimes mistakenly performed in cases of simple, chronic, tubal otitis with bad results both as to hearing and healing.

2. If granulations and polyps fill the middle ear, the hearing can be expected to improve following surgery.

3. If the middle ear is lined with skin at the time of operation, the hearing usually remains unchanged.

4. If the ear drum proper is intact and infection confined to the attic and mastoid, a modified type of radical mastoidectomy is indicated which will preserve the drum and middle ear cavity. Under such conditions, the hearing often improves.

If a complete radical mastoidectomy is performed, the meticulous removal of granulations in the region of the oval and round windows followed by a primary skin graft reduces fibrosis and creates less insulation against the reception of sound. Thus a higher postoperative hearing level may be attained.

Otitis Media Effectus

When the middle ears are scarred and fibrotic, because of former infection or radical surgery, little can be done to improve the hearing. There is also the added danger of recurrent infection.

An artificial prosthesis with contact in the area of the oval or round window will occasionally result in a marked hearing improvement. The diaphragm rod prosthesis devised by Pohlman is particularly effective.

Chronic Conductive Deafness

Gradually increasing conductive deafness of insidious onset is one of the most frequent ear conditions encountered by the otologist. This condition is usually classified as chronic, catarrhal otitis media, and is treated by repeated inflations of the eustachian tubes. Even if no improvement occurs, this treatment is often continued with the avowed purpose of preventing the deafness from becoming worse. In my experience chronic, catarrhal otitis media is a rare condition. A prompt improvement of hearing following one or two inflations should occur if treatment is to be effective. Otherwise inflations are usually contraindicated.

Most cases with a diagnosis of chronic, catarrhal otitis media really have otosclerosis and the conductive block is between the middle ear and internal ear. The reports of retracted and thickened ear drums are usually erroneous and the ear drums merely show variations of the normal. Examination and compression with a Siegel speculum reveal that the drums are freely movable, and that there is air in the middle ears. The otosclerotic process may be rapid or slow. It

may involve the area of the oval window and footplate of the stapes alone, or it may invade the cochlea with extensive nerve damage. Over a varying period of years secondary nerve degeneration usually occurs. The complete loss of usable hearing from otosclerosis is a great rarity, and I have observed but two such cases in over twenty years of practice. Yet some doctors have used this possibility as an argument to persuade patients to undergo a fenestration operation. At the present time there is no known form of treatment which has proved to have any effect on the otosclerotic process. A hearing aid or a fenestration operation offer the only real help to a case of otosclerosis. Extensive publicity about the fenestration operation has led the hard-of-hearing public to demand it. Careful study and repeated hearing tests, however, are needed to determine the suitability of any case for the operation, which is effective in at least 70 per cent of properly selected cases if the surgery itself is properly performed. Practical hearing for normal speech is the only honest index of a successful result from operation. It should also be remembered that the best case for operation will hear best with a hearing aid.

Nerve Types of Deafness

It is important to be able to differentiate the different types of nerve deafness if we expect to give the best service to our patients. Although the hearing can be improved in only a few, the progress of nerve degeneration can be checked or retarded in many. The different types of nerve deafness include traumatic, toxic, vascular, allergic, and the deafness of Ménière's disease.

Traumatic nerve deafness is due to exposure to explosions or to continued and repeated exposure to high intensity noises. It commonly occurs among workers in certain occupations, such as riveters, boiler makers, chippers, and machinists. The damage is at first limited to the hearing area for high frequencies, often with a dip in the area around 4000 cycles. Continued exposure widens the dip and eventually involves the entire upper scale. The hearing loss is reversible if the cause can be eliminated before severe damage has occurred. The longer the exposure, and the more severe the nerve damage, the less the recovery. The only effective treatment is to wear ear defenders or change to a different occupation.

Toxic nerve deafness occurs occasionally as a sequela of such infectious diseases as mumps, diphtheria, typhoid, influenza, and syphilis. It sometimes follows the administration of such drugs as quinine, salicylates, and streptomycin. There are many instances of apparently toxic

forms of deafness of unknown origin. The deafness may involve the entire scale or be limited to the higher frequencies. For treatment, evident foci of infection should be eliminated, though the hearing rarely improves. Vitamin deficiencies and endocrine disturbances require attention. Treatment as a rule is ineffective.

Nerve deafness due to vascular deficiency is common because of limited blood supply to the labyrinth. Arteriosclerosis of the anterior cerebellar artery and its branches accounts for most of the cases of senile deafness. Vascular insufficiency may accompany either marked hypertension or hypotension. Disturbances of equilibrium or true vertigo are not uncommonly associated with the deafness. The deafness usually begins with involvement of the upper scale and gradually extends downwards through the speech range. Peripheral dilators such as histamine or nicotinic acid may give some relief, especially for the vertigo, but do not restore any of the hearing loss.

A nerve type of deafness, frequently unilateral, may be allergic in origin or associated with true Ménière's disease. The deafness involves the entire scale, and it appears to be due to fluid changes in the labyrinth and not to actual damage of the nerve endings. It is characterized by a fluctuating degree of deafness, diplacusis, and low-pitched tinnitus. Dramatic hearing improvement sometimes follows the removal of offending allergens. Some improvement may follow histamine or nicotinic acid therapy. It seems worthy of comment that allergy may affect the internal ear as just mentioned, or the middle ear as noted in some of the cases of secretory otitis.

Hearing Aids

When there is sufficient hearing loss to prevent an individual from understanding a normal, conversational voice, and the hearing cannot be improved by medical or surgical therapy, a hearing aid must be considered. In children and young adults, instruction in lip reading should also be advocated. The modern electric hearing aids perform very satisfactorily for people with a conductive or mixed type of deafness. Uniform amplification throughout the speech range provides the best hearing for these people. Any of the standard hearing aids approved by the Council of Physical Medicine of the American Medical Association are acceptable, but it is wise to advise a patient to try out at least two different makes before purchasing one.

The use of a bone conduction receiver should be limited to cases with little or no evidence of

nerve damage unless there be an infective process present in the ear which would make the occlusion of the external meatus by an earpiece undesirable and hazardous. The bone conduction receiver does not provide as good hearing as the air conduction receiver for cases of mixed deafness, such as otosclerosis with sufficient secondary nerve changes to make a fenestration operation inadvisable.

For cases of perceptive or nerve deafness, it is much more difficult to provide a satisfactory hearing aid, especially if there is a disproportionate loss of hearing at different points of the scale. Much less amplification of sound is needed than would appear to be indicated by the audiogram because of the recruitment phenomenon. If the hearing loss involves the entire speech range, a hearing aid with moderate amplification performs fairly well, though its efficiency decreases with increased background noise.

An electric hearing aid is less efficient when there is little hearing loss for the lower speech range but an increasing nerve loss for the upper scale. People with this type of hearing loss can usually understand conversation fairly well without a hearing aid in quiet surroundings or when talking to only one other person. Their main difficulty is in differentiating between conflicting sounds. Amplification of conflicting sounds increases their interpretation but little. The upper scale provides the overtones which give quality to the basic tones. If there is much hearing loss for the upper scale, ordinary amplification fails to provide this quality. The result is that voices sound louder but are still blurred. This is especially true of people with a high-tone, senile type of deafness who usually hear better and understand more if they use a simple ear horn instead of an electric aid. Any individual who has good hearing through 1000 cycles and an abrupt drop in hearing above that level will rarely tolerate an electric hearing aid. When the hearing loss extends downwards in the scale below 500 cycles, a hearing aid is of value. Most hearing aids have an adjustment which can suppress the amplification of low tones. With this adjustment such an individual may hear fairly well.

It is the duty of the otologist to provide the hearing aid agency with the patient's audiogram together with information concerning the patient's type of deafness so that an intelligent fitting of a hearing aid may be made. Poor cooperation between otologists and hearing aid dealers is often responsible for misfits and for dissatisfied and disgruntled patients.

In conclusion, there is a regrettable tendency among otolaryngologists to spend too little time

in studying their cases of deafness. If no gross pathology is evident on cursory examination, a common procedure is to try a few inflations of the eustachian tubes. If this treatment is ineffective, radiation is frequently the next step regardless of whether the eustachian tubes are patent or not. Even pediatricians and general practitioners are now using radium applicators in the nasopharynx. Another favorite general remedy is the use of some new drug hypodermically. Some years ago thyroxine was popular, then prostigmine, and now the drug of choice seems to be benzyl cinnamate or Jacobson's solution. These drugs have been used indiscriminately for both conductive and nerve types of deafness of unknown origin. The remarkable feature of their use is the fact that frequently there results an apparent improvement in hearing. This is due to the curious psychology of the hard of hearing. They have a tendency to shut themselves off from the outer world, and, because they cannot readily follow a conversation, they make little or no attempt to listen. The idea of a hearing aid is repugnant, as it would advertise their infirmity and seem to be a stigma. These people do not want crutches; they want miracles. They will eagerly try any new form of treatment which is advocated for the restoration of their hearing. The usual result is that, when some new form of treatment is started, they begin to listen attentively and temporarily they seem to hear much better. Even their audiograms may show improvement because of the increased attention factor. However, when restoration of good hearing fails to occur, they soon lapse into their former apathetic state until they hear of some other new kind of treatment.

We will do our hard-of-hearing patients a much greater service if we are frank and honest with them. If we find that their hearing cannot be improved by recognized medical or surgical therapy, we should so tell them and take a little extra time to give them advice and information about artificial hearing aids.

ABSTRACT OF DISCUSSION

GEORGE M. COATES (Philadelphia): This is a very comprehensive paper of Dr. Day's. It contains many interesting clinical points which can be a guide to all of us.

I disagree with Dr. Day in only one thing, and that is his use of the term "senile deafness." Those of us who are over fifty-five or sixty-five, or possibly much older, have a form of deafness—the loss of the high tones. Almost all of us reach a stage where we find it difficult to hear clearly in a noisy room or where a lot of other people are talking. I prefer to call this lessened acuteness rather than senile deafness, because I do not think I am senile yet, but I know that I have lessened acuteness. After all, the most important thing

in the management of deafness is its prevention, and we can do a lot to prevent deafness if we have proper systems of school testing and inspection, and factory testing when it is possible.

For many years we have had surveys of the school children, and we have a pretty good idea about how many of these children are subject to incipient deafness. After we have located these children and segregated them, what has been done for them? Unfortunately, not too much. There are various committees at work, such as the Committee for the Prevention of Deafness of the American Medical Association and the Committee for the Prevention of Deafness of the American Academy of Ophthalmology and Otolaryngology, who have been trying for a long time to do something for these children when they are found in the schools in the screening tests, and when they are still in the stage where measures can be taken to stop the progress of their deafness, or even to restore them to normal hearing. But progress has been difficult due to a lack of funds, possibly politics, and perhaps the indifference of the otological profession or its lack of knowledge of what is going on and what is being attempted.

Therefore, I make a plea to all of you otologists to do what you can to help out in any of these programs. The Academy program in this state is under the chairmanship of Dr. James E. Landis, of Reading, who has done some very fine work, but the program takes a lot of time and requires the interest of everyone. The school authorities, the general practitioner, and the otologist must cooperate, but, so far, we have not had that cooperation generally.

What can we do for these children when we find them in the schools? We presume that the majority of cases of impaired hearing occur in early childhood and are due to the various things which Dr. Day has mentioned—the exanthemata, excessive lymphoid tissue in and around the eustachian tubes and pharynx, sinus disease, etc. These cases can usually be helped by giving proper attention to the nasopharynx—one of the neglected areas in rhinolaryngology or otology.

The removal of adenoid tissue, which every child has, when it is excessive or when it has given rise to ear symptoms, is the necessary procedure, but this part of the combined tonsil and adenoid operation is the most poorly done. It is important to do a clean operation on the adenoids. Dr. Day says that in removing secondary regrowths of adenoid tissue he uses radium at the same time, and that, I think, is a very good idea.

Adhesions in the posterior lip of the torus tubarius certainly do cause deafness, and it is remarkable to see how the hearing will return in cases in which the adhesions are removed, with the finger or otherwise. Unfortunately, adhesions do recur, just as lymphoid tissue will recur at times, and must be watched. The nasoscope is an absolute necessity for diagnosing trouble in the region of the lateral wall of the nasopharynx.

The use of radium is possibly being overdone. We do not know yet how much good it is going to do permanently, but there is lymphoid tissue in many instances in the lumen of the lower part of the eustachian tube itself. It is what was recognized many years ago as the tubal tonsil of the otologists. Of course, it is surgically inaccessible, so if we are to do anything about it at all, radium or x-ray seems to offer the only hope. The armed services have reported satisfactory results from the use of radium among fliers who were suffering from aeritis, which is due to inflammation or closure of the eustachian tube. So if they are correct—

and we have no reason to suppose otherwise—the use of radium need not necessarily be confined to children. I think it is well worth trying in these cases.

Inflation will not restore hearing in a great many of the old cases of progressive deafness. It certainly will not improve cases of otosclerosis; nothing will, as far as the disease itself is concerned; but judicious inflation will give these patients a certain amount of relief, even those who haven't the classical open tube and who suffer from the great discomfort of a full head, as they explain it.

As to the fenestration operation, I believe that it is here to stay. It is certainly useful in properly selected cases, and, of course, requires well-trained, competent surgeons.

The criteria for a successful fenestration operation, as Dr. Day has said, are sufficient cochlear function, with the losses in the low tones and not in the high tones, with good bone conduction remaining, and with the Gellé test showing fixation of the stapes. A history of otosclerosis or progressive deafness in the family is also useful.

There is one other thing which Dr. Day said that is true, namely, the cases which are suitable for a fenestration operation are also suitable for a hearing aid, but in a case of otosclerosis the hearing aid does nothing to prevent the progress of the disease itself if it is located in the oval window. The hearing gradually gets worse, and finally, if the patient is using a hearing aid, a stronger one or a different type must be used as the disease progresses, not to complete deafness but to more and more disability.

If the fenestration operation is successful, and if the fenestra remains open, there is reason to suppose that the progress of the disease, as far as the hearing is concerned, will be stopped. So if the hearing has been restored to a serviceable unaided hearing level, the case can be said to have reached a satisfactory level.

Dr. Day said that fenestration operation is considered successful if the patient has serviceable unaided hearing. That is entirely correct. In a patient with seventy decibels' loss, in the critical frequencies, a fenestration operation may be successful to the extent of raising the decibel loss maybe twenty or thirty decibels, but if it still does not bring it up to or above the thirty decibel loss, threshold of normal hearing, then it is an unsuccessful operation; although it has increased the hearing, the patient is no better off than he was before.

In regard to the fitting of hearing aids, the armed services have given us a wonderful demonstration of what can be done for the deafened in their rehabilitation clinics, both in the Army and the Navy. Teamwork is necessary. It is not satisfactory simply to take an audiogram and send the patient to any one of the A.M.A. Council-accepted hearing-aid services to put on a hearing aid. That will help some, but it will not give the maximum service to a great many people. They need a satisfactory ear mould, and they need to try out a number of different hearing aids, because they all vary to some extent and all ears certainly vary.

These patients also need to be trained in the use of the hearing aid—not simply turned loose and told to get a new battery when the old one runs out, but told how to use the aid most effectively. Many of these patients also need considerable morale building and psychiatric training or guidance. So it is evident that it is necessary to work as a team with deafened cases to get the best results out of their hearing aids. That is what the armed services did. Their teams had instructors in speech reading and in speech correction.

An otologist in private practice certainly cannot do all that work himself, so it has seemed to me for some time that the eventual solution will be the establishment of rehabilitation centers for the deaf in the larger communities, or wherever there is enough work in prospect to make such a plan suitable. It would have to be on a paying basis, but the patient who pays for that service would certainly get more than his money's worth if it were properly established. In the smaller communities such centers would not be feasible, but they could be established in the larger towns throughout the state and they still would be within easy reach with our modern transportation systems.

DR. DAY (in closing): On only one point do I question Dr. Coates. Does the fenestration operation really stop the progress of the otosclerosis? I know that is an unanswered question up to the present time, but in my own experience the cases I operated upon five, six, and seven years ago are beginning to show the same deterioration in the operated ear which they show in the unoperated ear, and I feel that we cannot use that as a reason for doing the operation. I am afraid that we are going to find more and more cases whose hearing is decreasing gradually, regardless of the operation. I haven't enough cases in my own series to prove it, but I am very suspicious.

1949 SCIENTIFIC EXHIBIT APPLICATIONS AVAILABLE

The forms for applying for space in the Scientific Exhibit of the 99th Annual Session which will be held at the Hotel William Penn, Pittsburgh, Sept. 26 to 29, 1949, may be secured from Elwyn L. Heller, M.D., Chairman, Committee on Scientific Exhibits, Presbyterian Hospital, Pittsburgh 13, Pa.

Completed application forms must be returned to the committee by May 1 to receive consideration.

The Use of Propyl Thiouracil and of Radioactive Iodine

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THE advent of the antithyroid drugs and more recently of radioactive iodine (I^{131}) has given the clinician new therapeutic measures for the management of the thyrotoxic patient as well as afforded the experimentalist an opportunity to study the pathologic physiology underlying this condition. Since the introduction of propyl thiouracil,¹ the experience of most investigators has established this drug as the most potent and comparatively least toxic of the antithyroid drugs currently available. It is five years since Astwood's² first report appeared regarding the employment of thiouracil as a means of treating hyperthyroidism. Since thiouracil has the same physiologic and pharmacologic effects as propyl thiouracil, save for the fact that it is more toxic and less potent, we are afforded ample opportunity to evaluate propyl thiouracil and to determine its place in the management of the thyrotoxic state. This evaluation must of necessity be considered both from the standpoint of its use in preparing patients for operation as well as a means of treating patients for a long period of time without recourse to surgery.

The Presurgical Use of Propyl Thiouracil

A discussion of the use of this product as a means toward preparing the patient for operation requires a brief review of our present-day knowledge of thyroid physiology. Several factors must be considered as they relate specifically to the use of propyl thiouracil. The antithyroid drugs are known to inhibit the synthesis of the thyroid hormone within the gland.^{3, 4} This inhibition is a factor in causing the thyroid stimulating hormone (T.S.H.) of the pituitary to cause hyperplasia and hypertrophy of the acinal epithelium of the thyroid. Associated with the epithelial hyperplasia there is either a paucity or absence of colloid material. This results in a hyperplastic, colloid-poor gland, which is highly friable and vascular. In view of this we must

prepare the patient in such a way that the gland is in a state of involution so that friability is reduced to a minimum. There are two ways in which this may be achieved, but before we consider them we must proceed with our consideration of the physiologic factors involved in the preparation of the patient for surgical treatment. It has long been known (H. S. Plummer, 1923) that iodine will cause involution of the thyroid gland. This is manifested by a lowering of the height of the acinal epithelium and by the collection of colloid within the follicles. This condition facilitates operation by reducing bleeding to a minimum. Rawson et al.⁵ have shown that iodine has a twofold action. One is an iodinating effect, in which iodine is synthesized to the thyroid hormone, and the other is an involuting effect. These two actions are separate and distinct. When the patient has been brought to a basal physiologic condition by the use of propyl thiouracil, the iodine can be administered to cause involution of the gland.

The most expeditious manner of preparing a patient for operation when propyl thiouracil is employed presupposes the use of iodine as a means of involuting the gland. This can be achieved in one of two ways. The patient is given a daily dose of 200 mg. of propyl thiouracil in four divided doses until basal conditions are approximated as indicated by both the laboratory data and the clinical response. When the basal metabolic rate is within the normal range, the administration of the propyl thiouracil is stopped. The patient is best treated for a period of two to three months. Following the stopping of the antithyroid drug, 15 drops of Lugol's solution are given three times daily for a period of fourteen to twenty-one days. The question of the exact time that involution has occurred has interested us. We felt that if a means could be found to indicate this condition it would be of help in determining the optimum time for operation.

We adapted the galactose thyroid function test, as suggested by Althausen⁶ and modified by MacLagan,⁷ to our patients. It was observed by us that when the antithyroid drugs were employed that, as the basal metabolic rate dropped,

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the galactose index dropped with it.⁸ In contrast to this, if iodine was used alone to prepare the patient for operation, no response was elicited from the galactose test. When a patient is treated with an antithyroid drug and is then given iodine, the galactose index begins to rise as the involuting effect of the iodine becomes established. This was considered as the operative index and has been extremely helpful. It has been found to be useful in 70 per cent of our cases, but when applicable it has been found to be sensitive to within twenty-four hours of the time that involution is initiated.

The second method of preparing patients for operation is by the simultaneous daily administration of 200 mg. of propyl thiouracil in four divided doses and of 5 drops of Lugol's solution twice daily. This is continued for two to three months or as long as it is necessary to bring the patient back to physiologic conditions. We found that these patients can then be operated upon and that the gland is sufficiently involuted. The galactose test need not be employed when this method of treatment is used.

The question may properly be raised at this point as to whether propyl thiouracil should replace the exclusive use of iodine in preparing a patient for operation. Many surgeons are still loath to discontinue the sole use of iodine for the combined use of the antithyroid drugs and iodine. This can be readily answered by several important considerations. Since the use of the antithyroid drugs has been adopted as a means of preparing patients for operation, there has been a tenfold drop in the operative mortality rate. The Lahey Clinic⁹ has reported a drop in the mortality rate of from 0.73 per cent to 0.17 per cent. In addition to this, the surgeon is given wider latitude as to the time best suitable for operation and is not restricted to the narrow limits imposed by the exclusive use of iodine. An important consideration also is the fact that the period of hospitalization and of indigence is greatly reduced. Two potent agents, namely, propyl thiouracil and iodine, are available, which by judicious use greatly assist in the presurgical treatment of the thyrotoxic patient.

Propyl Thiouracil in the Medical Management of Thyrotoxicosis

It is almost inevitable that the question of the exclusive use of a drug such as propyl thiouracil in the treatment of toxic goiter should arise. Although surgical treatment is not entirely the answer to the correction of this disturbance, it is by and large the most satisfactory one that we have today. We have treated a number of pa-

tients exclusively with either thiouracil or propyl thiouracil and wish to record our observations. In approaching the question of the medical treatment of these cases we were governed in our selection of patients by several considerations. We chose patients who were considered mild cases, that is, those in whom the basal metabolic rate was not over +30 per cent, in whom the thyroid gland was not unduly enlarged, and in whom the condition was of recent origin. The second group was from those who, because of advanced age and poor physical condition, were not considered acceptable risks by the surgeons. The third group was from among those who steadfastly refused operation. There were several in the latter group who had had one or more thyroidectomies with recurrence of the symptoms and the findings.

We observed early in our work that the incidence of recurrence of symptoms after treatment was directly proportional to the length of time that the patients were treated. The relatively low and mild toxic effect of propyl thiouracil therefore affords us an opportunity to treat these patients for a prolonged period of time. We treated 25 patients by means of the antithyroid drugs alone and experienced an incidence of 50 per cent recurrence of symptoms six to twenty months after stopping treatment. The plan that was followed was to administer 200 mg. of the drug daily in four divided doses. After the patient approached physiologic conditions in from two to three months, the dose was reduced to 50 mg. twice daily. This maintenance dose was continued for two years. We observed that the type of goiter bore no relationship to the period of remission or the incidence of recurrence of symptoms after treatment was stopped. It should be stated at this point that toxic nodular goiters should not be treated for a long time with the antithyroid drugs in the hope of securing a sustained medical remission. The experimental work of Bielschowsky¹⁰ and the confirming work of Cantarow et al.¹¹ indicated that the hyperplastic action of the antithyroid drug on the thyroid gland in the presence of a carcinogenic agent caused localization of the carcinogenic effect in the hyperplastic gland. It would therefore appear advisable to subject patients with toxic nodular goiters who have been treated with an antithyroid drug to subtotal thyroidectomy.

In evaluating the medical use of propyl thiouracil, we can observe that this antithyroid drug precipitates a remission chemically in the same manner that surgery does mechanically—not by correcting a fundamental etiologic factor but by producing a readjustment of the endocrine inter-

relationship. The choice of patients selected for this manner of treatment is at present small but has the distinct advantage that recourse to surgery can always be had.

Toxic Effects of Propyl Thiouracil

The extreme danger of the occurrence of agranulocytosis through the use of antithyroid drugs has cautioned us to be on the alert for any such disturbance in the patients treated with propyl thiouracil. We consequently have continued to do weekly blood counts on all of our patients under treatment. We did not experience a single instance of agranulocytosis in the patients treated with propyl thiouracil, though we did have one very severe case when thiouracil was employed. There were three cases of leukopenia (below 3500 white blood cells). Two of these occurred as long as five months after initiating treatment. The third case occurred after the patient, who was non-reactive to treatment, was given 600 mg. of propyl thiouracil daily for five weeks. Two of the patients had previously developed severe leukopenia when they were treated with thiouracil.

The other complications were extremely mild and of a transient nature. Three patients developed urticaria, one had myalgia and an erythema, and one had mild pyrexia. Our incidence of toxic effects was 8.1 per cent as compared to 14 per cent with thiouracil with the distinct advantage of having the specter of agranulocytosis almost removed. Where a patient developed urticaria, we found that the simultaneous administration of one of the antihistamine drugs controlled the complication quite satisfactorily and that treatment could be continued.

Radioactive Iodine in the Treatment of Thyrotoxicosis

The known avidity of the thyroid gland for iodine stimulated the hope that radioactive iodine would fill an important place in the treatment of diseases of the gland. The preparation being used today is I^{131} which has a half life of eight days. The dose employed requires individualization and Soley¹² reported that no laboratory means has been found that will indicate the proper dose of radio-iodine. This potent and potentially dangerous substance has been a means of furthering our knowledge of thyroid physiology. Its use in treating the thyrotoxic state is extremely limited and the long-range effect on the body is as yet unknown. Of 33 patients treated by Soley, 75 per cent had remissions in from one and a half to seven and a half months, while 25 per cent did not return to normal and were clas-

sified as unsatisfactory. These figures do not compare favorably with the less dramatic but more effective methods now available. The proper total dosages of I^{131} and the ideal treatment schedules are not yet known. In consequence of this, the development of toxicity such as thyroid crisis, leukopenia, and marked permanent myxedema is inevitable. The same end result may be achieved by less hazardous chemical means as with propyl thiouracil and iodine.

The Use of Radioactive Iodine in Carcinoma of the Thyroid

The early hope that in radioactive iodine we had a modality for treating cancer of the thyroid was to be short-lived. There appeared to be a correlation of the ability of carcinoma of the thyroid to pick up radioactive iodine with the degree of differentiation of the thyroid cell. Marinelli et al.¹³ found that only 15 per cent of thyroid carcinomas may be expected to pick up radioactive iodine in some degree. It was shown¹⁴ that none of the iodine is deposited in the cancerous tissue (radioautographic technique), and that the iodine collected by the normal tissue is deposited in the colloid. It appears that the type of tumor that takes up the iodine is the one that is best differentiated and hence produces colloid and presumably the thyroid hormone. It was observed that those factors which increase the production of T.S.H. of the pituitary (thyroidectomy, antithyroid drugs) will increase the uptake of radio-iodine. In line with this, Seidlin et al.¹⁵ do not think that the degree of differentiation is always the factor determining the uptake of the radioactive iodine. They observed that when a previous thyroidectomy had been performed the subsequent uptake of the iodine by the metastases was greater. This was presumably due to the increased available T.S.H. which was thought to stimulate the thyroid metastases to greater functional ability. In 14 selected cases of metastatic thyroid carcinoma the uptake was demonstrated in 57 per cent. This compares with 10 to 15 per cent in the previously reported experiences with carcinoma of the thyroid. This interesting preliminary report opens up possible new avenues for the treatment of non-reactive malignant disease by the use of radioactive isotopes in conjunction with other means.

In reviewing the status of radioactive iodine in the treatment of toxic goiter, very little can be said as to its practical value at present. We can only recognize the fact that a potent tool is available for treatment and investigation. The knowledge concerning its action is too meager and the span of its use too limited to warrant its sup-

planting less hazardous and simpler methods of treatment. Its use in the treatment of cancer of the thyroid shows so low an incidence of reactivity of the tumor that we can only hope that the suggestion of Seidlin will be borne out by the reports of other workers.

* ADDENDUM: Since the presentation of this report in October, 1948, George Crile, Jr., and his co-workers¹⁶ reported the results of their experience in treating 105 patients with radioactive iodine. They feel that this modality holds promise for successful treatment of hyperthyroidism. The dose of I¹³¹ was varied with the change in the basal metabolic rate. The amount of radioactive iodine varied with the type of hyperthyroidism and with its severity, thus in Graves' disease the initial dose was 4 small mc., while in toxic nodular goiter 8 to 15 mc. was employed. The incidence of hypothyroidism as a complication occurred with the same frequency as with operative procedures. Since the long-range effect of the radioactive isotope could not be surmised, this method of treatment was reserved for the aged, those with recurrent hyperthyroidism, and for poor surgical risks.

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* At the suggestion of the editor, Dr. Grauer in March added this paragraph to his paper.

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TAXED OUT OF EXISTENCE

Recently we saw some excerpts of correspondence received by a colleague from medical friends in England. After reading these briefs one can realize fully what Emerson meant concerning a grain of sand and he could conceive of the Sahara, or a drop of water and he could conceive of the Niagara.

In other words, our British cousins seem about twenty-five to fifty years ahead of us, in one respect at least. And this is in the degree to which they have gone down the road of grinding every citizen to a fine dust in their economic crucible of planned austerity. Will it be so long as twenty-five or fifty years for us seems the only imponderable in this human equation.

We would like to quote a few excerpts:

"I am kept busy here on my half-pay. The general practitioners are indignant, but they have not been so Bevan-blitzed as the specialists. The worst of it is that one feels so helpless about it all. People grumble and do nothing. A central body acting for a large number of widely dispersed persons is so slow to move and creaks only half-heartedly into action . . . When one looks back there seems to have been a general lessening of security in this country. I don't mean from external attack, but from inside. In my lifetime there was the attack on the big landowners. It was held reprehensible to own more land than one could till oneself . . . So these people were taxed out of existence. Next

it was held to be a shocking thing to own any house property. Not only were crushing taxes put on the owners but the tenants were made masters. A tenant can do anything he likes to one's house—burn it bit by bit for firewood—as long as he pays his rent, or a little of it now and then; you can't shift him . . . The latest sin is to receive any money from investment, hence the capital levy which we will have to pay this year. It is called a 'special contribution' or something like that, but still, it is a capital levy. It will go on and increase in severity year by year, I have no doubt. When one asks 'What shall I live on in my old age if you take my savings from me?' the answer is: 'You will get 35 shillings (seven bucks) per week from the state; what more do you want?' The politicians who say this will get pensions of 3000 pounds per annum as long as they live. A mad world, my master."

These excerpts should serve as grim warnings to all Americans that "it can happen here"; it is happening here! Senator Borah, during the debate on the first income-tax law, said "Who would ever levy taxes of fifty to one hundred per cent?" And look what the income taxes are today!

Patrick Henry many years ago expressed sane sentiments when he said "I have but one light to guide my steps and that is the lamp of experience."—*Jackson County (Mo.) Medical Society Weekly Bulletin*.

Management and Treatment of Pulmonary Tuberculosis with Streptomycin

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THIS paper is a report on the use of streptomycin, in addition to other therapy, in 311 cases of tuberculosis in the Pittsburgh Tuberculosis Hospital at Leech Farm, and covers a period of one year and five months from December, 1946 to April, 1948.

The hospital has an average census of 380 patients of all ages. An average of 80 per cent are the patients who have far-advanced disease with cavitation or acute pneumonic involvement. Minimal or moderately advanced cases comprise 20 per cent of admissions including the children. Because of the type of our patient population, a special appropriation of \$6,000 a month was granted by the Mayor and Council of Pittsburgh, so that we were able to treat all patients with streptomycin where indicated instead of just a few of any one type. In addition, we were able to use it in a group of patients considered unsuitable at that time for antibiotic treatment, and in whom some hopeful results were obtained.

In December, 1946, we gave a daily dose of 2 grams divided into eight doses for ninety days which caused a mild degree of vertigo in almost every patient. In February, 1947, we dropped the dose to 1½ grams daily, but continued the third hour intramuscular injection for ninety days. In June, 1947, the number of doses was reduced to six a day. The duration of treatment remained the same. In November, 1947, the dosage was reduced to one gram a day given in four doses, and the time reduced to sixty days. This was changed again in January, 1948, to one gram a day in two doses, and the time reduced to forty-five days. The total dose per day and the number of daily intramuscular injections have been progressively reduced until, at the present time, we are giving 0.6 gram in one daily dose for a maximum of thirty-five days, and in certain cases we are trying a maximum of twenty-eight days. In retrospect, we should have reduced the

amount of the drug and total time of treatment much sooner than we did, as it was early noted that tuberculous laryngitis would apparently be healed in twenty-one days. It is possible that streptomycin has its maximum effect on mucous membrane tuberculosis as found in the larynx, trachea, bronchi and bronchioles within twenty-eight days.

Our first case in which streptomycin was used was a postoperative two-stage thoracoplasty complicated by an acute spread to the lower lobes on the operated side, ulcerative laryngitis, and presumably tuberculous enteritis. On a 2 gram daily dose hematuria developed in this patient in nine days and marked vertigo on the tenth day, at which time the drug was stopped. This patient recovered her voice on the fourteenth day; hematuria and vertigo disappeared in forty days and the patient has been home for seven months. We were fortunate that our first case had such a marked reaction, as our respect for the toxic properties of this drug was increased.

The toxic reactions in the group occurred in the 1½ and 2 gram daily dosage. These reactions were noticed in the first twenty-five days of treatment, except for the stomatitis and lichen planus type of dermatitis which were noticed after seventy days of treatment. The following tabulation shows the types and number of reactions that necessitated the discontinuance of the drug:

	<i>No. of Reactions</i>	<i>Average Time of Appearance</i>
Vertigo	4	25 days
Albuminuria	2	14 days
Stomatitis	2	70 days
Lichen planus	1	70 days

All these patients recovered after discontinuance of the drug. Since using the smaller doses, only transient mild vertigo has been noted, and that only in the older age group.

In this group there have been eight patients sputum-negative for an average time of five months who became sputum-positive again. One

Read before the Section on Medicine at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 5, 1948.

From the Pittsburgh Tuberculosis Hospital, Department of Public Health, Pittsburgh, Pa.

TABLE I
EXTRAPULMONARY TUBERCULOSIS

	<i>No. of Cases</i>	<i>Apparently Healed</i>
Laryngitis	26	100%
Osteomyelitis	8	87%
Enteritis	8	Symptomatic relief
Rectal abscess	3	100%
Miliary abscess	6	17% (1 living)
Fistula	3	0%
Epididymitis	3	100%

NOTE: Osteomyelitis and epididymitis must be drained in conjunction with the use of streptomycin.

of these was a case of long-standing thoracoplasty; one hilus tension cavity reopened, and the remaining six had extension to the opposite lung. Four of this group in which collapse therapy was possible converted to negative again.

We have repeated the use of streptomycin in our streptomycin failures, that is, when the sputum remained positive or when there was evidence of reopened tension cavities or an exacerbation of the disease.

In the tension cavities there will usually be a decrease in size during the time of treatment, but we have had none close in the second course without the aid of some form of collapse therapy. The acute exacerbation will usually clear.

In the above, and in the three-week courses given during each stage of thoracoplasty, toxic reactions have not been noted.

We now give streptomycin for a period not exceeding thirty-five days to all acute cases having an elevation of temperature on admission. If the patient is suitable for artificial pneumothorax but has a fever, streptomycin is given for thirty-five days or a shorter period if the temperature returns to normal. If the sputum converts to negative, he is continued on rest and x-rayed every week to check on retrogression of the lesion. Many of these patients will not need artificial pneumothorax, and if they do, it seems that the incidence of fluid in the pleural cavity is reduced.

TABLE II
CHRONIC CASES WITH COLLAPSE
Pneumothorax

<i>With Streptomycin</i>	<i>Without Streptomycin</i>
23 cases	56 cases
15 or 65% negative in 1.7 months	23 or 41% negative in 6.7 months
<i>Thoracoplasties</i>	
47 cases	22 cases
31 or 63% negative in 2 months	14 or 63% negative in 7.5 months

Streptomycin is given to all patients receiving temporary collapse therapy who have tension cavities or evidence of impaired bronchial drainage. It is given for three weeks during each stage of thoracoplasty or any major lung surgery. It seems to aid the collapse and decrease the amount of sputum, so that the danger of aspirating secretion to the opposite lung during an operation is lessened. It is given in the bilateral chronic case, even with small cavities where there is evidence of tracheobronchial tuberculosis.

We believe that tracheobronchial tuberculosis, long recognized but untreated, plays a large role in pulmonary tuberculosis, especially in chronic cases or where there is evidence of a tension cavity. This is so important that a review of the diagnostic points of this complication may not be amiss. These findings are wheezing, which is more annoying in the recumbent position, irritative cough, dyspnea, intermittent fever, and a prominent bronchus on x-ray. These can be proved in about one-half the cases by bronchoscopic examination depending on the proximity of the lesion to the bifurcation of the trachea.

TABLE III
CHRONIC CASES WITHOUT COLLAPSE

<i>With Streptomycin</i>	<i>Without Streptomycin</i>
24 cases—positive 1.4 years	24 cases—positive 10 months
13 cases or 54% negative in 1.7 months	0 cases—negative

NOTE: So-called "good chronics" with bilateral lesions.

This complication with its accompanying edema and ulceration tends to prevent egress of air from the lungs and prevents free drainage of the infected area. Streptomycin is of value to the lung in healing this complication, thus permitting free drainage and aeration.

Streptomycin is not used in treating large apical cavities, except in preparation for major lung surgery; however, we gave it to some cases to prove that fact to ourselves and to the patient population.

This report is tabulated in three groups: (1) extrapulmonary, 57 cases; (2) chronic pulmonary tuberculosis with and without collapse therapy, 150 cases; and (3) acute pulmonary tuberculosis, that is, cases with a history of six months' duration or less, 104 cases.

The streptomycin-treated pulmonary cases are compared with a group comparable as to x-ray findings and duration of disease, but who received no streptomycin.

TABLE IV

CASES WITH CAVITATION

Large Cavities (4 Cm. or More)

<i>With Streptomycin</i>	<i>Without Streptomycin</i>
15 cases	15 cases
0 negative	0 negative
5 went to thoracoplasty	

Small Cavities (4 Cm. or Less)

15 cases—positive 1.3 years	30 cases—positive 1.4 years
7 or 46% negative in 2.3 months	0 negative in 1.3 years

The word "control" has not been used as it is impossible to evaluate individual immunity and resistance in selecting a comparison group.

In this report no effort has been made to report on clinical improvement or the amount of clearing of the lesion on x-ray, as this is often a matter of opinion.

All patients had a positive sputum for approximately equal lengths of time in the same group, and, except in the acute cases, results are based on the patient having a negative sputum on twenty-four hour concentration examination made weekly for at least twelve weeks.

The results in the acute cases are based on recovery from the acute phase of the disease.

TABLE V

Hilar Cavities

<i>With Streptomycin</i>	<i>Without Streptomycin</i>
9 cases—positive 11 months	7 cases—positive 17 months
6 cases or 66% negative in 1.7 months	0 negative

Lower Lobe Lesions

17 cases—positive 9 months	None
8 cases or 47% negative in 2 months	

We hoped to show in this paper that streptomycin has a place in our armamentarium in the fight against tuberculosis. It is of definite benefit in tuberculous laryngitis, and for that alone we are thankful. It is at least palliative in tuberculous enteritis, peritonitis, and other extrapulmonary complications. It is of temporary value in the chronic case with tracheobronchial complications.

TABLE VI

ACUTE CASES

<i>With Streptomycin</i>	<i>Without Streptomycin</i>
104 cases	134 cases
13 or 12.5% died on an average in 5 months	119 or 88% died on an average in 2.5 months
40 or 30% negative	0 negative

Streptomycin is in no way curative in itself, but as an adjunct to bed rest, nourishing food, and timely use of all indicated forms of collapse therapy, it is of great value for its suppressive actions on the growth of the tubercle bacillus. It thus decreases the toxemia and allows the patient's natural resistance to come to the rescue.

TABLE VII

SUMMARY OF PULMONARY CASES

<i>With Streptomycin</i>	<i>Without Streptomycin</i>
254 total cases	288 total cases
120 or 47% negative	37 or 13% negative

There is no doubt in our minds that many of the patients here reported as negative will break down some time in the future, as an injection of an antibiotic does not carry with it the will power and common sense needed to continue the cure while at home or at work; nor does it guarantee against overcrowding and underfeeding. Our problem in the management of tuberculosis is still to find and hospitalize the infectious patient for treatment and to provide, after his discharge as non-infectious, adequate follow-up and after-care, particularly of an economic nature, so that he can restrict his activities and still feel that he is a useful member of society.

For help in preparing this paper, I wish to thank the entire hospital staff, and especially K. I. Fetterhoff, M.D., Samuel J. Camarata, M.D., C. Howard Marcy, M.D., consultant in tuberculosis, and William W. Briant, Jr., M.D., consultant in pediatrics.

ABSTRACT OF DISCUSSION

IRVIN E. ROSENBERG (White Haven): Dr. Martin has demonstrated that streptomycin has a definite use in the fight against tuberculosis. He has shown that smaller and less frequent doses are therapeutically effective. However, he has warned us, and I wish to emphasize this point again, that streptomycin is not to be used indiscriminately in every case of tuberculosis. Preference should be given to individualization of cases for therapy rather than blanket administration to patients running a temperature, for instance. Many mild febrile cases clear on bed rest alone, leaving streptomycin available for later needs, and in old chronic cases it is better to withhold streptomycin, for several reasons: (1) The drug is usually ineffective except perhaps for a period of symptomatic relief. (2) In our experience at White Haven, once there is loss of pulmonary substance, collapse therapy is needed in addition to streptomycin to insure permanent improvement; and if surgery is needed, resistance to the drug may have occurred, leaving the patient helpless against a spread of the disease. (3) A highly resistant strain of bacilli may develop which, if passed on to contact cases, leaves these newly infected cases resistant to streptomycin therapy.

In acute pulmonary tuberculosis, in endobronchial tuberculosis, and in laryngeal tuberculosis, we have specific indications for the use of streptomycin. Cough and expectoration lessen quickly and temperature drops; there is a feeling of well-being and there is definite

objective evidence of improvement. The results are far superior and more prompt and consistent than in the untreated cases.

Routine bronchoscopy before collapse therapy is desirable. However, if this ideal cannot be obtained, it is a good thing to give streptomycin to any patient in whom there is x-ray and clinical evidence of impaired bronchial drainage. In this connection I may add that we have found its administration with aerosol helpful in some cases. As to dosage, following reports by the American Trudeau Society and the Veterans' Administration we adopted a dosage of $\frac{1}{2}$ gram twice daily over a period of thirty-five to forty-two days. We are still maintaining that dosage. Longer periods of treatment may be useless because it has been observed that bacterial resistance may occur within four weeks after the start of treatment. Of course, streptomycin should

be administered for a longer time in acute generalized hematogenous tuberculosis regardless of bacterial resistance or toxicity.

We agree with many observers that patients frequently continue to show improvement after the drug is stopped. Apparently streptomycin retards the progress of the disease, presumably by the arrest of bacterial activity, giving the forces of natural resistance a chance to step in and fight off a previously overwhelming infection.

Regarding toxic reactions with the smaller dosage and shorter period of therapy, we have not encountered any serious toxic effects.

I want to thank Dr. Martin and compliment him for his attempt to be objective. His last paragraph is especially good, revealing a deep understanding of the fundamental socio-economic factors in tuberculosis.

MSAP ERECTS NEW OFFICE BUILDING TO ACCOMMODATE GROWING BLUE SHIELD PLAN

Erection of its own building has been started by the Medical Service Association of Pennsylvania in order to provide adequate facilities for the rapidly growing Blue Shield operations and services in Pennsylvania.

The new building will be a one-story and basement brick and limestone structure, consisting entirely of offices. It will be occupied exclusively by MSAP and will accommodate both the home office and the Harrisburg district office, both of which presently occupy rented quarters at 222 Locust Street, Harrisburg.

The location of the building is on Front Street at Radnor Street in Harrisburg. During recent years a number of organizations with state headquarters in Harrisburg have acquired their own buildings and have chosen locations on Front Street beyond the congested high-value business district.

Designed by Milford H. Patterson, registered architect, MSAP's new home office building will contain 5000 square feet of floor space. Present construction will permit the addition of a second floor when necessary in the future to provide additional office space. The building site is also large enough for the erection of a 100-foot addition in the rear, and permits adequate off-street parking for MSAP personnel and visitors.

The decision to construct a building as an investment was made by MSAP's Board of Directors because of Blue Shield's substantial membership growth throughout the State, the scarcity of suitable office space in Harrisburg, and the high cost of preferred accommodations in rented facilities. MSAP's present quarters on the second and third floors of a converted dwelling have been cramped and inadequate for many months, and permitted no opportunity for immediate or future expansion. The use of essential office machines required for administrative operations has been limited, and personnel are working under crowded conditions which militate against efficiency and minimum operating costs.

The new building has been designed to provide modern office space, with proper lighting and ventilation, suitable rest rooms, ample filing accommodations, and room for electrical tabulating and accounting equipment,

as well as adequate offices and workrooms. Although the exterior of the building will be plain, the new structure is of a design which will make it a completely acceptable addition to the neighborhood in which it will be located.

Among the many advantages of owning its own building will be the saving in taxes which are presently reflected in rent paid to a landlord. As a non-profit organization, MSAP is eligible for exemption from real estate taxes.

Contracts for construction were let after competitive bids were received. The construction schedule calls for occupancy by September 1.

RESEARCH GRANTS FOR PHILADELPHIA INSTITUTIONS

On March 17 Oscar R. Ewing, Federal Security Administrator, announced the allocation of \$2,040,900 to finance medical and allied research projects at non-Federal institutions.

Of this amount, Philadelphia medical institutions were given a total of \$106,918. Listed below is the name of each institution, the subject of the research problem, and the amount of the individual grant:

Children's Hospital of Philadelphia—(1) host-virus interrelationships in the influenza virus-chick embryo system, \$16,740; (2) investigations on virus diseases of the skin, \$28,166; Jefferson Medical College—(1) nature of hepatic enzyme mechanisms involved in (a) conjugation of phenols, and (b) inactivation of estrogens, \$5,454; (2) source and nature of the anticephalin activity of the blood, \$9,396; Temple University School of Medicine—treatment of tuberculosis in infants and children, \$6,000; University of Pennsylvania—(1) clinical studies in syphilis, including clinical and serologic response to penicillin and other agents, \$27,500; (2) experimental studies of the sweat glands and clinical application thereof, \$5,142; (3) turnover of adenosine triphosphate in cell metabolism, \$7,020; Woman's Medical College—determination of ascorbic acid content of sputum, gastric juice, blood, and urine, \$1,500.

TREATMENT OF ARTHRITIS

RALPH PEMBERTON, M.D.

Philadelphia, Pa.

THE syndrome of arthritis is not so difficult of successful treatment as is usually believed. It is not a disease of joints but a systemic disease with joint manifestations. There is no single curative measure of therapy and he who seeks one lacks understanding of the physiologic basis of medicine. There are at least two great varieties known as atrophic or rheumatoid arthritis and hypertrophic or osteo-arthritis, which are usually regarded as separate entities. There is also an involvement of muscles and tendons often referred to as fibrositis. It is possible, however, that such differentiations are somewhat arbitrary and certainly some cases of each type seem to be precipitated by comparable factors and to respond to almost identical therapy. It has been said, although without final proof, that there is but one rheumatism.

The disease process per se probably originates in the collagenous or connective tissue system and the first alteration is in the ground substance which becomes increased and more visible. The collagen fibers become swollen, cease to exist as bundles, and break into fragments. A smudgy patch results. Around this area of fibrinoid degeneration, edema and swelling of the ground substance result and fibroblasts proliferate.

The areas of fibrinoid necrosis are eventually replaced by proliferating fibroblasts and thus reorganized. Dense collagenous connective tissue is finally formed and may be again subject to fibrinoid necrosis. The pathologic process in connective tissue may thus be destructive on the one hand and productive on the other.¹

The character and extent of inflammatory reaction to such primary connective tissue injury may vary greatly. Thus, in rheumatic fever fibrinoid necrosis is generally overshadowed by the proliferative and inflammatory responses. However, in this disease and elsewhere fibrinoid necrosis forms the center of Aschoff bodies and fibrous nodules.

It is important for the general practitioner to know that in atrophic or rheumatoid arthritis

proliferation of the synovial membrane and other tissues leads to ankylosis, whereas in hypertrophic or osteo-arthritis the so-called degeneration of cartilage which occurs never so results. Overgrowth of cartilage and bone may result, however.

The background productive of the above basic pathologic change is not clearly understood although heredity may be a factor. Certain it is, however, that in arthritis nervous strain, overactivity, anemia, and infection may serve as precipitating factors. In spite of the iconoclastic views which have been expressed upon the subject, minor infections may be of great significance as precipitating agents and are usually inadequately analyzed. The pendulum of medical opinion, having swung to an extreme of enthusiasm for the infectious origin of arthritis, is now at an opposite position of negativism where it is equally misleading.

The statement can be made that, in a certain limited proportion of cases of chronic arthritis, part of the syndrome stems from imbalance in the neuro-endocrine chain.

The influence of pregnancy in alleviating all symptoms, the incidence of hypertrophic or osteo-arthritis close upon the heels of the menopause, and the exacerbating influence of the menstrual cycle all bear testimony to the relationships mentioned.

It might be deduced as a corollary to the above that replacement therapy with estrogens and the like constitutes the way out. This is not the case, however, and the problem is by no means as simple as that. Control of the imbalance in the nervous, vascular, and fibromuscular systems is of basic importance and should underlie all therapeutic effort. This usually means rest in bed at the outset of treatment followed by a continued regulation of the output of energy. It is important to determine the basic metabolic rate and cholesterol level because many of these cases, especially in the older brackets, show low metabolic rates and/or high cholesterol values.

Further, part of the disturbance encountered in arthritis consists of vasoconstriction in some

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of the capillary beds and it is probable that the anemia encountered frequently is a component feature of the disease. A tissue edema is often present in the three types of rheumatic disease just mentioned which is not due to low plasma proteins, though these may aggravate the situation.

In the above several connections it must be recognized that conditioned rest is not mere negation of activity; as such it could be harmful in many ways. In rheumatoid or atrophic arthritis uncontrolled rest might lead to ankylosis and in most cases it should include some form of physical therapy or postural exercise, as will be discussed later. However, properly conditioned rest in bed promotes passage of tissue fluids into the vascular channels and affords relief from static strains incident to maintenance of erect posture and relaxation of the nervous system. Further, it allows ptosed organs to assume proper positions and functions, reduces the metabolic load, and permits settlement of metabolic deficiencies. It should be added that faulty posture

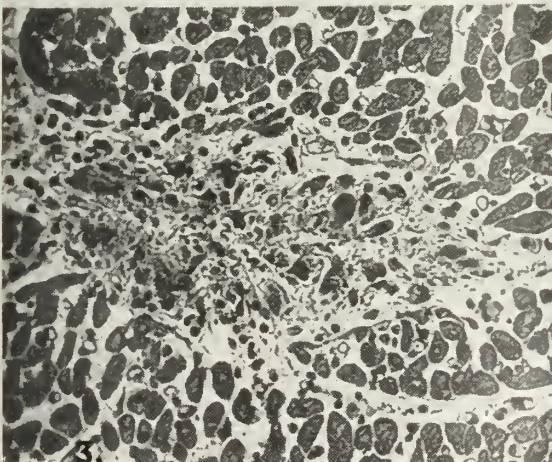
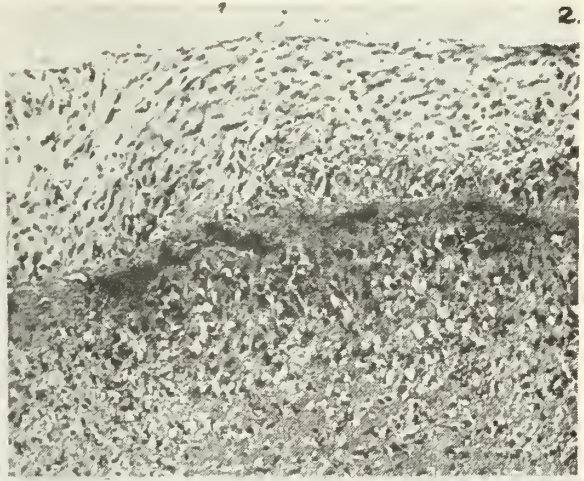
may operate disadvantageously, even in bed, and when present, needs attention and gentle measures of correction. Pillows under the knees induce deformity.

It is the conviction of the writer that if all arthritics at the outset were subjected to adequate analysis, "physiologic splinting," the corrective measures indicated in each case, and suitable gentle medication, chronic arthritis would cease to be a major problem.

Significance attaches to the order of examination and treatment, and failure to observe this fact may lead to aggravation of the disease process. The following tabulation is self-explanatory:

GENERAL ORDER OF TREATMENT²

1. Rest, systemic as well as local.
2. Psychic evaluation.
3. Sedation and/or stimulation; never opiates.
4. Optimal nutrition in a refined sense, including accessory vitamins if necessary.
5. Proper gastro-intestinal function.
6. Examination of the blood and body chemistry.
7. Time for establishment of a general equilibrium.
8. Psychic re-education.



Acute rheumatic fever (DUFF, G. LYMAN: The Diffuse Collagen Diseases, *Canad. M. A. J.*, 58:321, April, 1948).

9. Examination for foci of infection.
10. Medication, such as iron, arsenic, or nux vomica.
11. Replacement therapy when indicated.
12. Treatment of foci, conservatively.
13. Use of physical therapy, conservatively—chiefly heat, gentle massage, postural exercise.
14. Orthopedic help.
15. Last, if at all, gold, vaccines, or non-specific proteins.

Gentle sedation with the bromides or barbiturates, coupled with such mild stimulation as may be afforded by small doses of nux vomica, is usually of great value in helping the arthritic patient to adjust himself to his physiologic necessities. Anemia requires prompt management from the outset. Although the type of anemia usually present is microcytic and hypochromic, the administration of whole liver is often useful because of the accessory factors included in it. However, transfusion is often necessary.

Arsenic was well regarded by the older generation of physicians and still has a place. A further extension of this principle is to be seen in the administration of gold. It is not without significance perhaps that arsenic and gold both belong in the second group of elements. The influence of gold in early cases has been followed by success, but it has also been followed by failure and, what is worse, serious damage to the major tissues of the body, especially the liver. In view of the several kinds of imbalance known to exist in chronic arthritis, it is physiologically improper to expect this agent alone to correct them.

Physical therapy is often useful in the treatment of the arthritic, but can no more be ordered as a blanket prescription than can a patient be sent to a pharmacy with the request that he be given digitalis. There must be fuller knowledge on the part of the practitioner of the disturbances amenable to physical medicine and the measures adequate to control them. Great harm has often resulted from well-intentioned but undue enthusiasm unaccompanied by sound judgment. Perfection of technique is not alone adequate.

Nutrition is important in the sense that an adequate protein intake, including so-called red meat, is necessary for the purpose of regeneration of blood. The total caloric intake should be

adequate but so arranged as to supply vegetables, fruits, etc., which yield vitamins and mineral salts. Overingestion of concentrated carbohydrate foodstuffs may contribute to the tissue edema which most arthritics present.

Postural rehabilitation is of the utmost importance and a valuable lesson has been taught by the Boston school of orthopedists who have shown that many functions of the body may be handicapped by a narrow costal angle, shallow respiration, and improper methods of weight-bearing in the spine, pelvis, or legs.

The practice of medicine in the last analysis is not an artisanship in which tricks of various kinds can be expected to prevail. The general practitioner bears what is probably the heaviest burden in the medical field and he is fortunately coming to be more appreciated than has formerly been the case. However, nature accepts no excuses and it will be necessary for him, if he ventures to cope with the complicated problems of arthritis, to study the physiologic deviations concerned. When they are minor, they can be readily corrected, the rheumatic process being largely reversible. When, however, the deviations are major, they are far more difficult to treat. We must then take cold comfort from Ovid who wrote that, when we essay a difficult task, we must remember that there is no merit save in difficult tasks.

In conclusion, it should constantly be borne in mind that all cases of arthritis should be treated from the outset in the way that all systemic disease involving the whole body should be treated, i.e., by giving the body economy an optimal opportunity for normal physiologic equilibrium to be established. This is not a scrap basket recommendation but something to be interpreted literally and carried out with fidelity. There is no single remedy indicated for the treatment of arthritis. A coordinated approach is the only one which may be expected to achieve significant results in any large group of arthritics. Most refractory cases of arthritis are refractory because they have been inadequately cared for at the outset.

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The Significance of Symptoms and Roentgen Studies in Urinary Tract Disease

D. ALAN SAMPSON, M.D.
Philadelphia, Pa.

THE frequent failure of serious urinary tract abnormalities to make themselves known by readily recognizable symptoms deserves emphasis. Paucity of symptoms often causes such diseases to remain unremedied for such prolonged periods of time that irreparable damage results, whereas early recognition could prevent such damage. Failure by the patient or physician to recognize or heed definite urinary tract symptoms likewise is to blame in many instances in which ultimate investigation reveals advanced lesions. It is the purpose of this presentation to cite examples in which absence, apparent insignificance, or disregard of symptoms causes recognition of the abnormality to be unduly delayed. Other examples will be given in which attention to minimal symptoms resulted in prompt diagnosis and treatment.

Case Reports

CASE 1.—A white female, aged 64, had nocturia for two or three years, but this symptom was disregarded. She entered the hospital complaining of right lower quadrant pain of less than one week's duration, with swelling in the same region. On physical examination there was a firm, fixed tender mass in the right lower quadrant. Plain film roentgen examination showed a large homogeneous calcific density which was found at retrograde urography to be an extremely large calculus in a grossly hydronephrotic renal pelvis. It is quite obvious that the disease had been present for probably longer than the two or three years of nocturia. Loss of renal parenchyma had progressed to such a degree that it was necessary to remove the kidney.

CASE 2.—A white male, aged 53, had experienced pain in the left kidney region for several years and had passed many small stones. Roentgen studies showed extensive damage to both kidneys, gross hydronephrosis, enlargement of the kidneys, and obvious destruction of the mucosal linings of the collecting structures. This is the picture of pyonephrosis; it was more advanced in the right kidney. Operation on the right kidney showed it to be much enlarged and practically nothing but a large pyonephrotic sac. It was necessary to perform pyelostomy and nephrostomy, but the extent of damage was such that the patient survived only about nine months following operation.

CASE 3.—Symptoms of urinary tract infection can be misinterpreted and be attributed to other symptoms. A white female, aged 65, had a mass in the right side of the abdomen with pain. This was thought to be due to an abnormality of the gastro-intestinal tract, but x-rays of this system were negative except that the mass was shown to be in the right renal region. When an attempt was made to catheterize the right ureter, however, it was found that the meatus was pin-point in size. Dye injected showed an enormous sac occupying practically all the right side of the abdomen above the level of the lumbosacral junction (Fig. 1). Here, in spite of symptoms that were not recognized as indicating disease of the urinary tract, the damage was so great that essentially the right kidney had been totally destroyed.

CASE 4 illustrates the damage done by renal infection of many years' duration. A white female, aged 42, had suffered intermittent pain in the right flank and below the right costal margin for many years. When she presented herself, there was gross pus in the urine, tenderness in the right costovertebral angle, and a hard, slightly tender mass the size of a small grapefruit in the right upper quadrant. The roentgen examination showed a calcification of variable density to the right of the first lumbar interspace, a calcification about one-half as large as a vertebral body. The kidney itself extended from the tenth rib to near the iliac crest and it contained numerous smaller calcifications, all of them obviously renal calculi. A catheter inserted up the right ureter could not be passed into the kidney, but stopped just opposite the third lumbar interspace; the upper part of the right ureter could not be filled with the dye. These roentgen manifestations indicated what was found at operation—many hundreds of cc. of pus in the right kidney. The kidney itself had been almost completely destroyed and was replaced by fibrous tissue and granulations.

CASE 5 illustrates the severe damage that can be present with almost complete absence of symptoms. This white female, aged 58, had pain, not severe, in the right kidney region for only two weeks before seeking medical care. Roentgen studies before urography showed a dentritic type of calculus in the right renal region, but the retrograde examination showed marked destruction of the upper 60 per cent of the much enlarged kidney (Fig. 2). At operation 800 cc. of pus was found in this renal abscess.

CASE 6 is similar. This 18-year-old white male had pain and tenderness in the left kidney region for only one week, but excretory urography showed no function of the left kidney, plus the presence of a few calculi. Because of the extremely large size of the indefinitely outlined left kidney, with an elevated left dome of the

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Fig. 1 (Case 3). Gross pyonephrosis, cause undetermined.

diaphragm with restricted motion, a roentgen diagnosis of probable rupture of the kidney with abscess formation was made. This was confirmed by operation.

CASE 7 illustrates a fairly common urinary tract abnormality for which the patient often seeks relief to no avail. An aberrant vessel is often undiagnosed because the roentgen manifestations may not readily be recog-

nized as indicating abnormality. This white female, aged 37, complained bitterly of pain in the right renal region for seven years. Various roentgen studies were interpreted as negative, but because of persistence of the pain the patient was explored and a small right aberrant vessel was found. Following operation, at which this vessel was ligated and divided, this patient became asymptomatic. Here it should be noted that the urographic studies did show slight hydronephrosis on the right, so "borderline" as to be considered preoperatively as probably of no significance. Aberrant vessels should always be considered among the causes of hydronephrosis, particularly when the ureter remains normal in caliber.

CASE 8 (a white female, aged 36) is similar to Case 7, but shows permanent damage. This individual had pain in the right renal region referred to the groin for thirteen years. There had been recurrent attacks of pyelitis. The right kidney was tender and pus was obtained from the right ureter at cystoscopic examination. Preoperative roentgen studies (Fig. 3A) showed marked right hydronephrosis with a ureter normal in caliber throughout. Re-examination four months after operation for ligation and severing of an aberrant vessel showed considerable residual hydronephrosis, little less than the preoperative examination (Fig. 3B), although an erect film (Fig. 3C) showed excellent drainage.

CASE 9.—An aberrant vessel has in some cases produced an almost unbelievably severe hydronephrosis. This is illustrated in a male, aged 25 years, whose only complaint was "right-sided pain," occurring intermittently for two years, although becoming progressively more severe and frequent. A non-tender mass the size of a large grapefruit was found in the right kidney region. Excretory urography showed absence of right renal function. Retrograde examination showed the extreme hydronephrosis depicted in Fig. 4. At operation the renal parenchyma was found reduced to a very small

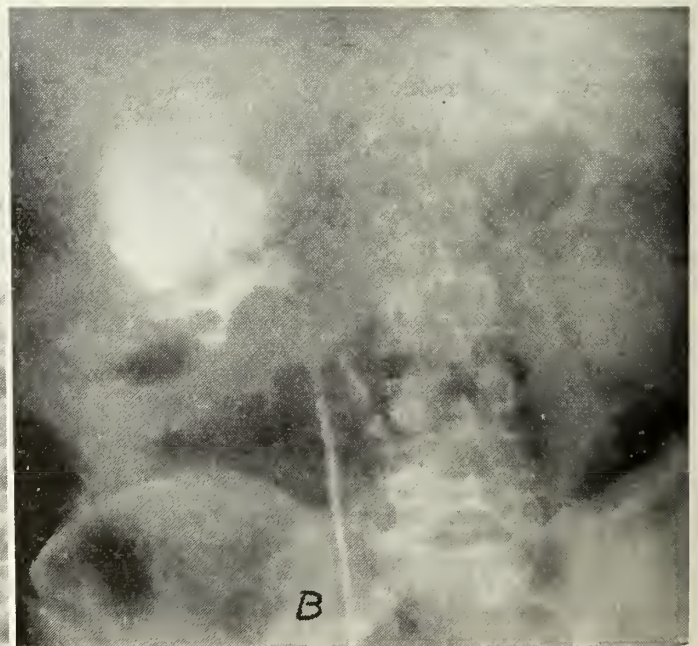


Fig. 2 (Case 5). (A) Dendritic calculus in enlarged right kidney. (B) Retrograde visualization showing large abscess in upper part of kidney.

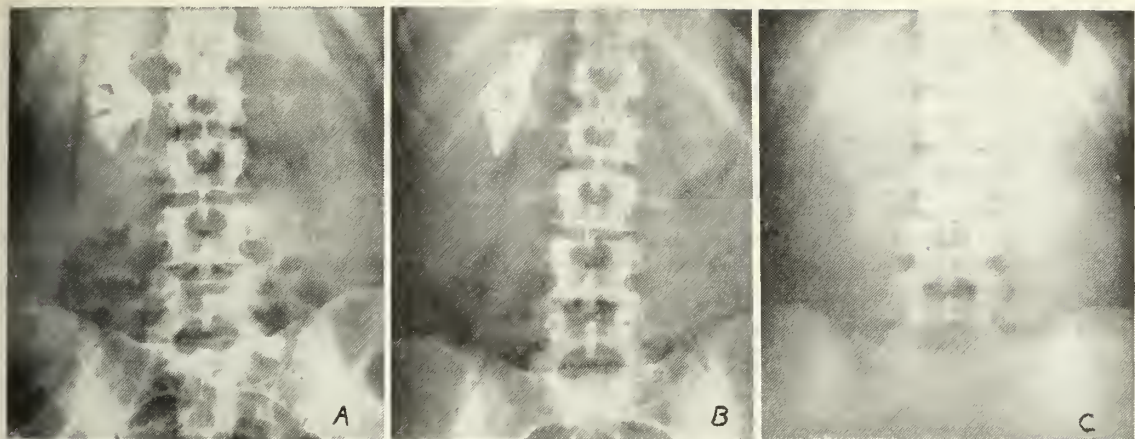


Fig. 3 (Case 8). (A) (Preoperative.) Hydronephrosis produced by aberrant vessel. Note normal caliber of ureter. (B) (Postoperative four months. Patient supine.) Considerable residual hydronephrosis. (C) (Postoperative four months. Patient erect.) Good drainage from pelvis into ureter.

quantity and an aberrant vessel was found as the cause of the virtual destruction of the right kidney. The importance of considering an aberrant vessel as a cause of urinary tract pain cannot be overemphasized. Obviously there must have been a time when ligation of the offending aberrant artery would have prevented the damage that eventually caused loss of function, although the apparent absence of symptoms until two years before operation can raise some doubts regarding the possibility of this in this case. In the hope of recognizing such cases early, even what appear to be the most trivial symptoms should be investigated promptly.

CASE 10.—Symptoms of short duration do not necessarily indicate such a short duration for renal disease. This white male, aged 61 years, had frequency, urgency, and dysuria for only three months, but cystoscopic examination showed ulcerative cystitis. Roentgen studies showed calcification in the substance of the left kidney, a form of calcification not typical of renal calculus. Excretory urography showed much enlargement of the calices with apparent ulceration of the mucosa. This combination of findings should be interpreted as indicating tuberculous infection. Here operation confirmed the diagnosis. The removed kidney was found involved by

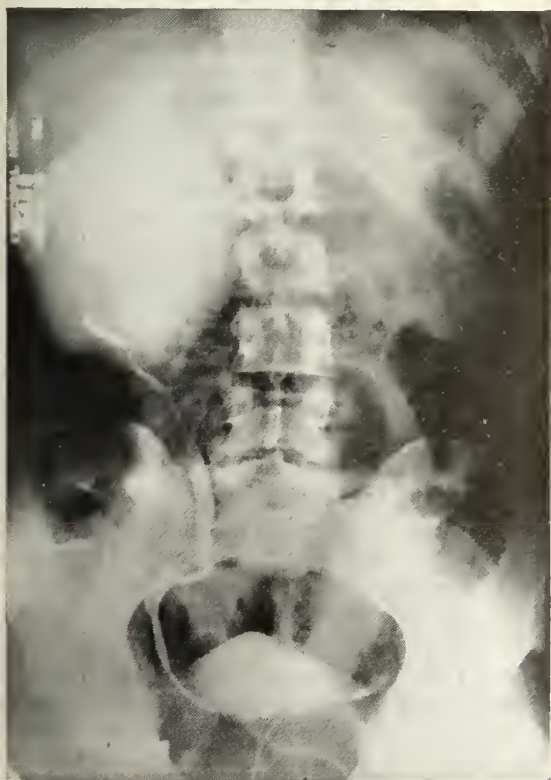


Fig. 4 (Case 9). Pyonephrotic sac replacing kidney. Cause—aberrant vessel.



Fig. 5 (Case 16). Enlargement of the right kidney and distortion of calices due to large hypernephroma.

tuberculous pyonephrosis with dilation of the minor calices and caseation.

CASE 11 presented a longer history. Plain film roentgen examination showed less obvious abnormality. Here there had been persistent pyuria for two years in a white male of 18 years with mild recurrent attacks of hematuria. The plain film showed only a faint but moderately large upper right renal calcification. Retrograde urography showed marked enlargement of the calices with destruction. After removal of this tuberculous right kidney and a low ureterostomy this patient became quite well.

CASE 12.—Even with symptoms of moderate duration, one may occasionally obtain reasonably satisfactory results by avoiding further delay after the patient seeks medical care. This woman, aged 36, had passed gravel twelve years previously. She reported with recurrent left flank pain of eight months' duration. The indigo carmine test showed no excretion from the left kidney. Retrograde examination showed a small calculus in the left ureter opposite the fourth lumbar transverse process, and above this there was definite hydro-ureter and hydronephrosis. Ureterostomy was promptly performed with removal of the stone. Re-examination a few weeks later showed the ureter and renal structures almost normal in size. Further delay in treatment undoubtedly would have resulted in severe damage as in Cases 3 and 4.

CASE 13.—Persistent obstruction low in the urinary tract is a common cause of permanent structural alteration. This white male of 60 years endured frequency, urgency, and nocturia for two years, but did not seek medical care until after he had difficulty in voiding for two weeks. A cystogram showed marked trabeculation of the bladder and several diverticula. The dye was regurgitated up the ureters which were somewhat increased in size. The roentgen examination also showed elevation of the lower part of the bladder outline, indicating prostatic enlargement. The prostate was found to be moderately large, soft, and boggy. The patient's symptoms were relieved by a transurethral resection, but of course the bladder changes were permanent.

CASE 14 (a white male, aged 62) is presented to illustrate marked abnormality that can be present without producing symptoms troublesome enough for the patient to seek care. A smooth dense calculus 6 cm. in diameter was present in the bladder, but the patient stated that it was only for about a week that he had urinary retention and overflow. Nevertheless, the urine was grossly bloody. Here the roentgen examination showed gross hydronephrosis and probable pyonephrosis of the right kidney.

CASE 15 (a white male, aged 57).—Hematuria usually is of much more serious significance than in Case 13. Bleeding had been present for one month. There had been constant dysuria for one week, apparently due to the presence of blood clots in the bladder. Cystoscopic examination showed a tumor of the bladder wall near the right ureteral orifice, shown on the cystogram by an irregularity of the upper part of the bladder outline. Biopsy confirmed the diagnosis of carcinoma.

CASE 16 (a white male, aged 50).—Hematuria must always be investigated promptly. This patient had blood

in the urine for only one day. It was associated with right abdominal pain radiating to the inguinal region, probably due to the clots. There were no other urinary tract symptoms. At cystoscopic examination a clot was found projecting from the right ureter. The retrograde examination immediately disclosed the presence of a large tumor occupying the upper two thirds of the right kidney area, depressing and distorting the calices (Fig. 5). Operation disclosed this to be a hypernephroma.

CASE 17 (a colored female, aged 65).—It is difficult to reconcile the duration of the abnormality in this case with the ultimate findings. In 1938, during an admission for pneumonia, a mass was found in the right side of the abdomen and roentgen examination done in April, 1939, showed marked right hydronephrosis with depression of the pelvis and calices, as if displaced by such a mass. The patient was seen again in 1943, at which time the mass was larger, but still there were no symptoms referable to it nor any hematuria or other suggestion of urinary tract abnormality. However, the roentgen examination showed an extremely large renal mass occupying the right upper part of the abdomen from below the level of the iliac crest. Some of the dye of the retrograde examination outlined some grossly enlarged calices which were now displaced to the left of the spine, while the rest of the dye trickled into an enormous sac replacing most of the right kidney. At operation a degenerated hypernephroma was found with a large pyonephrotic sac. Many calcifications were present in the tumor; the kidney was practically destroyed, but there were no peritoneal metastases.

CASE 18 (a white male, aged 59) again exemplifies how serious disease can be present in the urinary tract without symptoms indicating its true nature. For five months there had been upper abdominal discomfort radiating to the back, not related to meals. A gastrointestinal roentgen examination was negative, but showed what appeared to be a mass lesion of the lower pole of the right kidney in spite of the absence of hematuria or dysuria. No mass was palpable. Urography showed obliteration of the lower calices of the right kidney with a large mass of the lower pole. This was found to be a cystic tumor; the cyst was well encapsulated and contained thick cloudy fluid with necrosis. Because the renal pelvis was involved, the entire kidney was removed and pathologic examination showed this to be a renal carcinoma in a degenerated cyst.

Conclusion

Hematuria, pyuria, and the passage of calculi, even small ones, may indicate serious urinary tract disease and should never be ignored. However, even in the absence of symptoms that are definitely suggestive of urinary tract disease, we must always consider the possibility of such an abnormality. Roentgen examination by plain film (flat plate) is entirely inadequate; excretory or retrograde urography is necessary. Many cases require both methods of visualization. The patient with urinary tract abnormality should be promptly referred to a competent urologist to prevent irreparable damage. Do not temporize.

The Topical Treatment of Lung Abscess

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THE object of this paper is to present our experiences with direct or topical application of penicillin and other agents in treating suppurative pneumonitis and lung abscess, and to compare this method with previous ones. The method is so logical and the results so much better than previous ones that we think it is a distinct contribution to the treatment of these conditions.

Of 13 patients diagnosed as having lung abscess who were treated by this method, nine were cured rapidly and required no further treatment afterward. They were followed from five to forty-five months. The four others required subsequent surgery (Table II); the first was explored as a possible carcinoma of the lung because of persisting induration which proved to be a lipid type of chronic pneumonitis; the second was inadequately treated because of recurring pneumothorax so that treatment could not be completed and lobectomy was done for the chronic persisting abscess; the third was slow in responding and was submitted to surgery for excision of the abscess; and the fourth showed recurrence of cavitation with puriform material, for which lobectomy was done, revealing a pulmonary cyst rather than actual abscess.

Of the 9 patients who responded well to aspiration and reinstallation of antibacterial agents (Table I), seven who were tapped intermittently were relieved with an average of 2.7 taps. The other two had needles left in situ for ten and seven days respectively so that daily aspirations and instillations could be done. The period of treatment for eight, in which this can be determined from the record, averaged 4.06 days, although in one of these the two aspirations revealed sterile fluid on both occasions. These figures refer to the time from the institution of aspiratory and instillation type of treatment, although all of these patients had received antibiotics in large doses preceding the inception of topical application. The penicillin administered systemically had varied from 100,000 to

600,000 units per day and averaged for the 13 cases about 313,000 units daily. All had had bronchoscopic aspirations on several occasions. Six of them had had postural drainage, seven had been subjected to inhalations of aerosol penicillin or penicillin and streptomycin, and two had had sulfonamides administered systemically. These types of treatment preceded the topical application, and were usually continued during its use.

Of 5 patients treated in similar fashion but without either topical application or inhalations, two were cured, one was discharged with continued cavity and no follow-up can be obtained, and two required lobectomy for chronic abscess and associated bronchiectasis. The average time of treatment for four of these was 29.8 days. The average amount of penicillin administered was 300,000 units per day and three of them also received a sulfonamide.

In the same interval, 5 patients with chronic abscess were submitted to lobectomy. Two of them had had no previous drainage, one had been drained elsewhere, and two had been drained by us. All had sufficiently extensive lung destruction with residual bronchiectasis and chronic abscess cavity to warrant excision. One other patient with extensive bronchiectasis and pulmonary suppuration bilaterally was submitted to drainage and died thirteen days later. Of the 5 patients treated by conservative therapy, drainage and lobectomy, the average duration of the illness was 2.8 months or eighty-four days.

Thus it appears that this type of treatment can save considerable time, lung destruction, and lessen complications. One example is depicted (Figs. 1 to 5).

The logic which led us to try this treatment, and which has been justified by results, was that it is difficult to obtain extremely high concentrations of antibacterial agents by blood-borne distribution under ordinary circumstances. In the presence of actual sloughing or cavitation, very little of the blood-borne medicament is delivered into this dead tissue since its blood supply has been destroyed in the process of necrosis. Lastly, the presence of pus with para-aminobenzoic acid

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From the Department of Surgery, Temple University Medical School.

TABLE I
LUNG ABSCESS SERIES
Required No Surgery

	<i>Etiology</i>	<i>Postural Drainage</i>	<i>Systemic Daily Units Penicillin</i>	<i>Inhalations</i>	<i>Sulfons</i>	<i>Aspirations</i>	<i>Time Between Taps</i>	<i>Days Till No Pus or Odor</i>	<i>Amount of First Tap</i>
J. M. H.	?	0	100,000	0	+	5	Daily	5	20 cc.
J. L. P.	Pneumonia	0	200,000	0	0	Needle left in place	Daily	7	?
M. S.	?	0	240,000	0	+	3	3 days	?	0
J. J. M.	?	0	250,000	0	0	Needle left in—25,000 units penicillin daily	Daily	10	Several cc.
D. S.	?	0	200,000	0	0	Single tap			?
J. W.	?	+	300,000	0	0	2	3 days	Both taps sterile	0
R. H.	?	+	480,000	Penicillin	0	2	2 days	2	50 cc
C. W.	Post-ton-sillectomy	+	600,000	+	0	3	2 days	2	15 cc.
T. R. D.	Foreign body	+	300,000	Penicillin + streptomycin	0	3	3 days	7	Few cc.

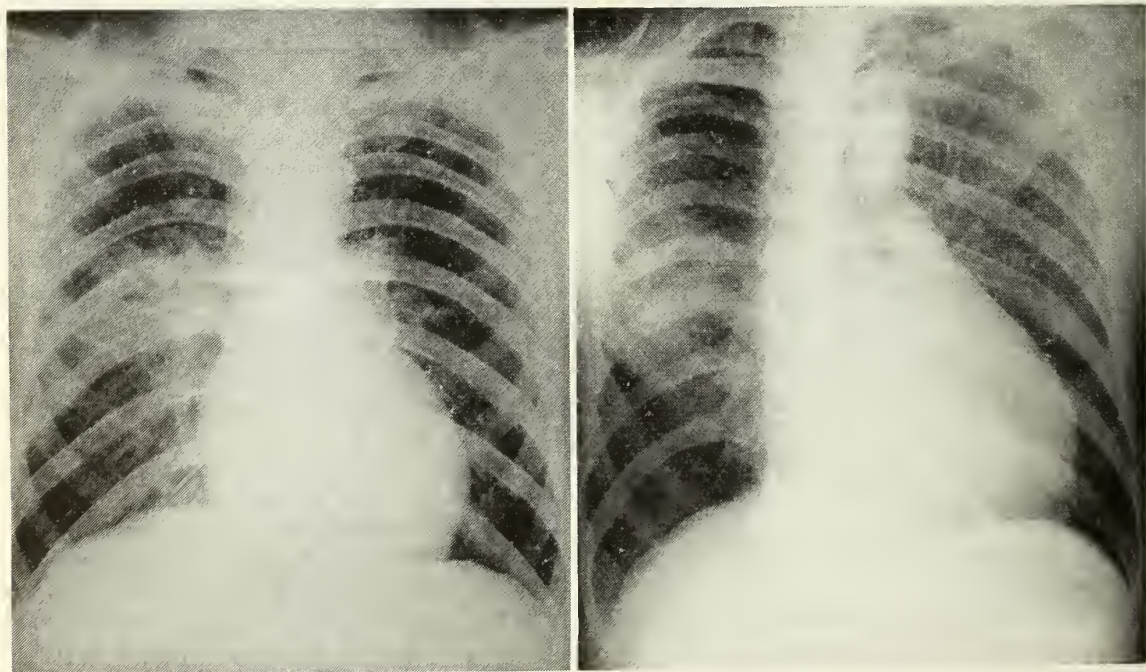


Fig. 1. R. H., May 9, 1947. A 31-year-old white male who was chilled in the rain ten days before admission. The following day, cough, fever, and malaise developed which persisted with some production, in the past few days, of dark and rather odorous material. A dull pain was noted in the chest. He received sulfons at home without improvement. X-ray appearance on admission.

TABLE II
LUNG ABSCESS SERIES
Required Lobectomy or Excision

Patient	Diagnosis
H. S.	Lipoid pneumonia
W. P. W.	Abscess
	Pneumothorax
S. K.	Pulmonary cyst
S. R.	Abscess
	Slow response

does not grossly affect the activity of penicillin and streptomycin, although it does prevent the antibacterial action of the sulfons. One should realize that suppurative pneumonitis is a fairly common disease frequently diagnosed as pneumonia, pleurisy, grippe or other lesion, and that, in its earlier stages, it is a cellulitis of the lung parenchyma in which there is exudate and increased blood supply. Under these circumstances, the natural antibodies and leukocytes of the patient may control the disease, particularly if assisted by adequate treatment with the antibiotics or sulfons given systemically, since the blood supply is adequate and distribution of the medicament in the involved area is often at effective levels. This accounts for the rapid response of such patients to early treatment.

However, if the infection is a very virulent one, if adequate treatment is tardy in application, or if the necrotizing toxins of these bacteria produce thrombosis and necrosis, then an area of destruction of lung tissue results which is inaccessible to any blood-borne medication. Such destruction and fibrosis frequently lead to a chronic thick-walled cavity or to residual bronchiectasis. In time, this tends to spread and involve additional areas. Thus prolonged treatment without cure results in irreversible lung damage, often requiring sacrifice of a lobe or even more lung for cure. This fact has been proven by us in

TABLE III
RESULTS IN 115 TREATED CASES
Reported by Jackson and Judd in 1940

Treatment	Total	Cured	Improved	Died
Surgical ...	37	14 (38%)	5 (13.5%)	18 (48.6%)
Non-surgical	78	33 (42%)	22 (28%)	23 (29.5%)
	115	47 (40%)	27 (23%)	41 (36%)

multiple studies of patients apparently cured of lung abscess after considerable therapy and even surgical drainage, in which lipiodol mapping will show residual cavitation which is often too thin-walled to be seen on routine x-ray study. One such patient returned with the symptoms of

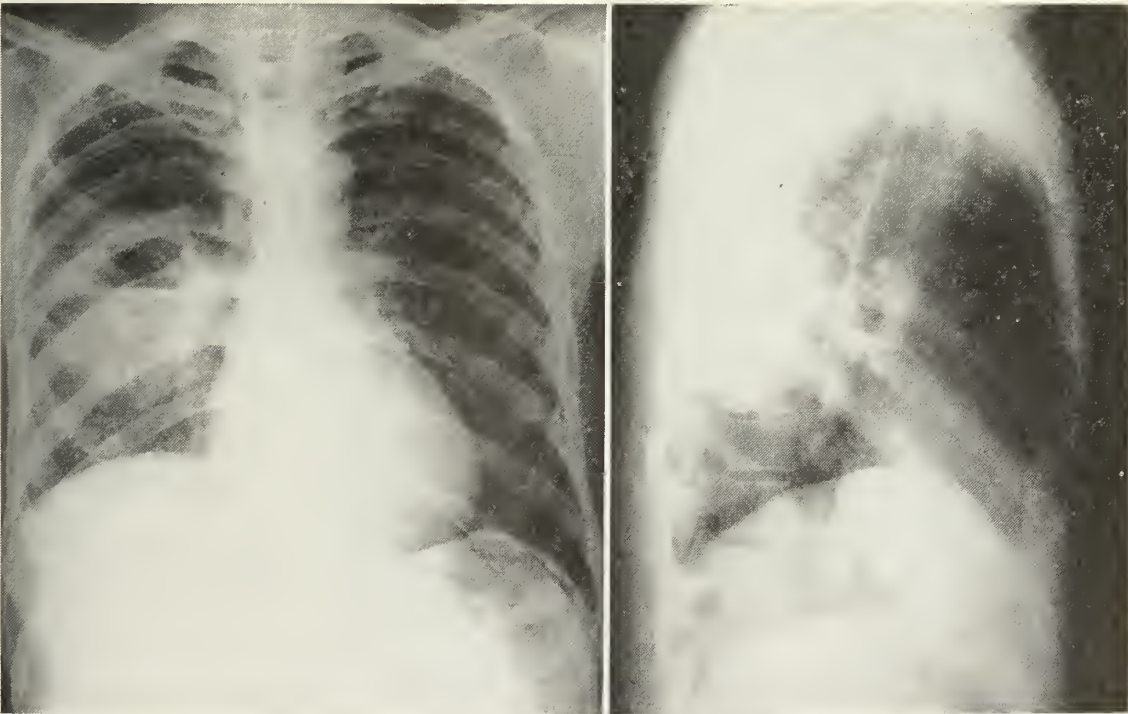


Fig. 2. R. H., June 2, 1947. There was progressive symptomatic and x-ray spread with 250 cc. of foul sputum per day in spite of penicillin systemically (240,000 units per day for nineteen days) and aerosol (80,000 units every four hours). Postural drainage for the past five days. He had his first intracavitary aspiration two days after these films.

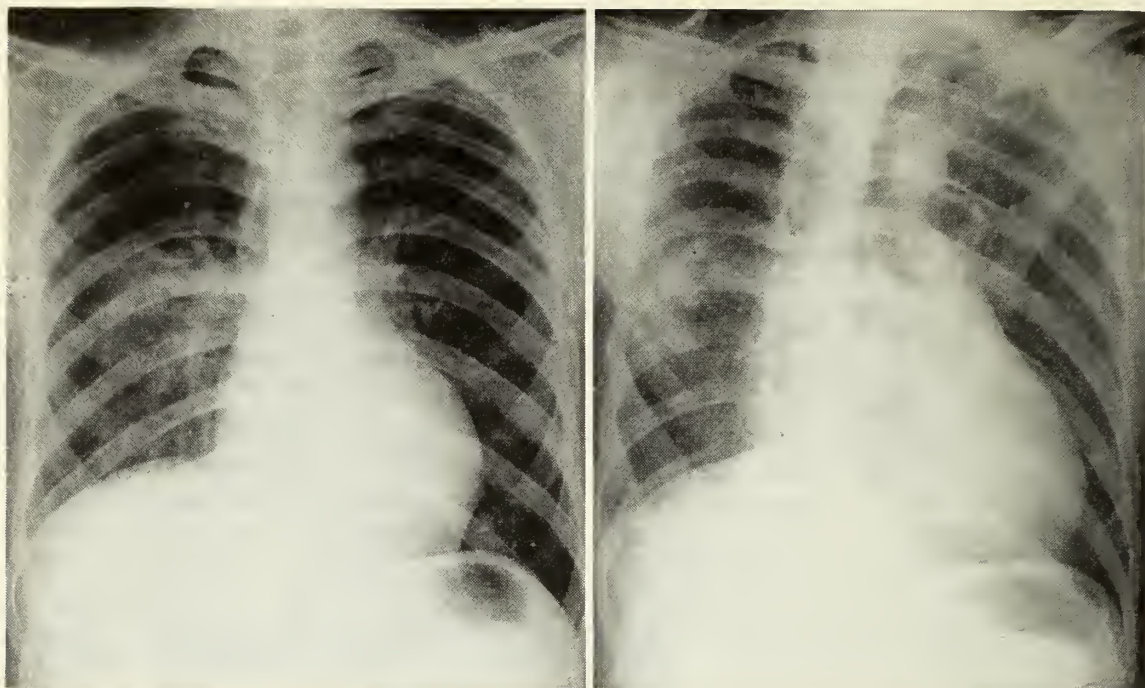


Fig. 3. R. H., June 16, 1947. Twelve days after first and ten days after second aspiration. The temperature dropped almost to normal after the first aspiration and remained normal after the second. Fifty cc. of foul, grayish-brown pus removed at first aspiration, none at second. One gram of streptomycin and 200,000 units of penicillin were instilled at each tap even though no pus was obtained on the second. No further taps were required. After the second aspiration, production was more profuse of thinner and non-odorous sputum which diminished from the peak of 250 cc. before aspiration to 40 cc. at the time of discharge nineteen days after first tap and seven days after these films.

bronchiectasis and lipiodol evidence of further extension of the bronchiectasis eight years after drainage and required lobectomy. Another disadvantage of continued ineffective treatment is the prospect of complications, such as empyema, spread of the necrotic process, embolism to the brain, or septicemia, as well as other less common occurrences.

It is worth while to compare the percentage of salvage by conservative and by surgical means before the days of antibiotics. Table III indicates that the percentage of salvage by conservative means alone in that era was approximately 40 per cent, using bed rest, support, postural drainage, bronchoscopy, and even the sulfons. About 30 per cent of the patients in this group were spontaneously cured by evacuation through fairly large openings into the bronchial tree and spontaneous drainage of sufficient degree to be curative. Of the group which failed to respond to such conservative treatment, the surgical salvage was only about 38 per cent or approximately 12 per cent of the original total. With routine early drainage of all acute cases, Neuhof and associates¹ reduced the mortality to less than 5 per cent.

The difficulties anticipated in attempting topical application were theoretically numerous but have proved to be very mild.

Pneumothorax, which is potential with any introduction of a needle into the lung structure, has apparently been prevented largely by the adherence of the pleural layers overlying the inflammatory zone, and has occurred only twice, both times in one patient. This patient improved with the first two aspirations, but thereafter only non-odorous air could be obtained, and x-ray revealed a pneumothorax so that treatment was discontinued until the pneumothorax disappeared. By then symptoms had again developed and new attempts at aspiration were successful on two occasions, after which pneumothorax was present and insufficient treatment had been delivered to produce cure. He is one of those patients in whom lobectomy was done at a later time.

Embolism has not occurred. Both empyema and phlegmonous infection of the thoracic wall at the site of aspiration on withdrawal of the needle had been noted on several occasions when a needle was inadvertently introduced into an abscess cavity before the days of the antibacterial agents here discussed. We feared this might occur in spite of penicillin and streptomycin, so in our earlier cases we made efforts to introduce the needle and hold it in situ for repeated aspiration. However, after it had fallen out on two or three occasions without producing these dreaded in-

fections, we began to withdraw it routinely after each aspiration, injecting a little penicillin along the withdrawal tract, and have seen no evidences of infection in this tract in any of these patients.

Because of the thick pus and slough usually seen in such abscesses at the time of surgical drainage, we feared that the needle would not remove sufficient material to make much difference, but believed that injection of our bactericidal agent might still produce a beneficial effect. Actually we have been able to remove pus from most of them, varying in amount from a few to 50 cc. at the first aspiration, and this has appeared thinner and in smaller amount with subsequent aspirations in those which were repeated. Frequently, after the first tap or two, the patients began to expectorate more freely of thinner material as though it had decreased in viscosity and as though the granulations which frequently block the bronchial communications had shrunk sufficiently to aid in endobronchial drainage. This is a very beneficial effect and may contribute to the success of the method.

The theoretical objection that the material might not remain in the cavity but would leak out through the bronchial communications has been verified in that patients have frequently coughed up some of the material injected, but this rarely happened until the process of healing was progressing and definite improvement had been noted, and does not seem to combat the eventual outcome.

Hemorrhage was another potentiality and has occurred minimally on three or four occasions, but has been a hindrance to treatment in only one instance—a patient recently seen and not included in this series. This woman had a severe myocardial disease with marked decompensation and a large thin-walled cavity in the left upper lobe which was almost empty and for which no etiology could be ascribed. She was not very toxic, but we attempted to aspirate and apply topical penicillin on two occasions, each of which led to a profuse endobronchial hemorrhage with some blood coming into the syringe. Therefore, the treatment was abandoned since the cavity seemed to be the least of her difficulties.

Treatment

The outline of treatment consists of the usual supportive measures, particularly in the early stages, of bed rest, a diet high in protein, large intake of vitamins A, B and C, transfusions for anemia, and penicillin systemically administered in the amount of at least 300,000 units daily, or other agents depending on sputum cultures and susceptibility tests. Aerosol inhalations of the appropriate agents in a detergent solution are given four times daily.

If there is not rapid response within a week, topical application should be employed, the essential moves for which are as follows: (1) guidance under biplane or multiplane fluoroscope for accurate insertion; (2) insertion, under local

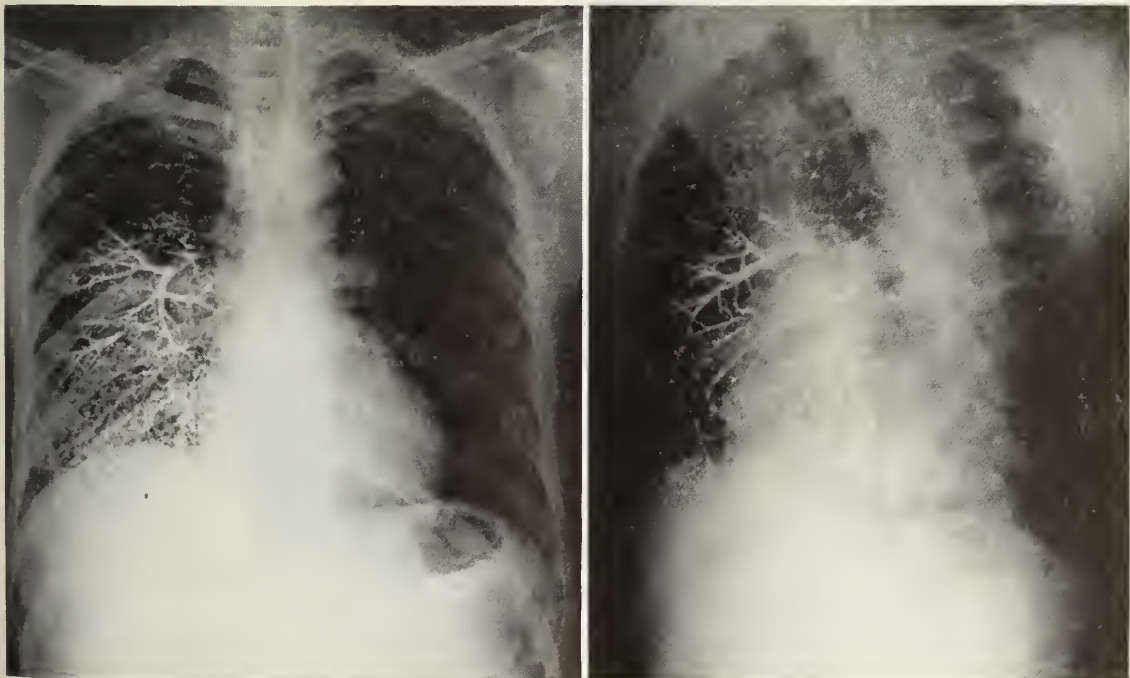


Fig. 4. R. H., June 20, 1947. Lipiodol mapping of affected lung three days before discharge shows no evidence of bronchiectasis and little of remaining cavity.

anesthesia, of an 18 gauge needle; (3) aspiration of as much fluid as possible for evacuation, for culture, and for susceptibility tests; (4) when all fluid possible has been obtained, the instillation of penicillin (100,000 units) and streptomycin (1 Gm.) suspended in from 1 to 5 cc. of a wetting agent such as zephiran (1:3000) or octimet (0.05 per cent), saving the last few drops for injection during withdrawal of the needle; (5) repetition of this procedure daily, using the same agents or modifying them according to the susceptibility tests, until a cavity can no longer be entered by needle or be demonstrated by x-ray.

The topical method can then be abandoned and systemic treatment continued until a check-up x-ray one week hence reveals that the process continues to disappear, when even general treatment may be abandoned except for routine convalescent care. Checkup x-rays should be made at two-week intervals on two occasions and again one month later to assure continued absorption of residual density in the lung. The successful case reveals rapid resolution of the x-ray opacity as well as amelioration of the clinical symptoms. Two warnings are extremely important. First, the failure to dissipate completely the x-ray evidence of pneumonitis or abscess in spite of clinical improvement may be due to the fact that the abscess is secondary to bronchial blockade by tumor, tuberculous stricture, or the granulations

of the pyogenic infection of bronchiectasis. Consequently, all abscess patients should be treated by thorough chest investigation including bronchoscopy, bronchial secretions or washings for cytologic study as well as tuberculin skin tests, smears, cultures, lipiodol mapping, etc. If the induration shown by x-ray does not rapidly abate and no other reason can be found for this, thoracic exploration should be done to avoid overlooking serious disease which may become incurable during a prolonged observation. Second, this method should be used only by those physicians trained in thoracic surgery, since such knowledge is necessary to avoid harm.

Discussion of the Literature

Although there are a few references to the use of penicillin in conjunction with external drainage,² we were able to find only a few articles in foreign magazines concerning intracavitary application of penicillin^{3, 4, 5, 6, 7} when we reviewed the literature for the purpose of writing this paper. The foreign literature also refers to intracavitary aspiration therapy alone^{8, 9, 10} and the use of penicillin by transparietal intracavitary injection in a few instances as well as similar methods of using sulfonamides¹¹ and even arsenamine.¹² Although some of these were reported in 1946 and 1947, we were not aware of them until this review was begun.

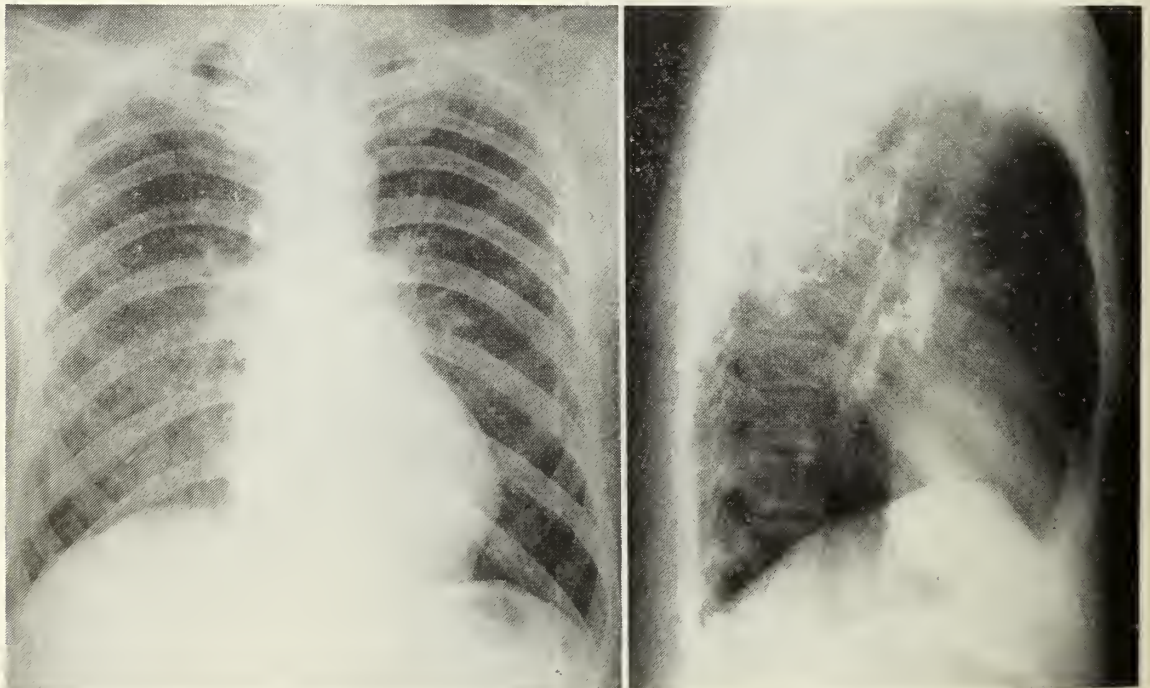


Fig. 5. R. H., Nov. 5, 1947. Multiple checkups showed continued improvement. These films, approximately five months later, reveal no evidence of abscess or scar, and patient has been free of symptoms since discharge. He has been followed for an additional year without evidence of recurrence.

Summary

1. Suppurative pneumonitis is fairly common and frequently misdiagnosed as pneumonia, bronchitis, pleurisy, or gripe. In its early stages, it responds in most instances to treatment by systemic administration of penicillin and inhalations by aerosol of the same. Occasionally, streptomycin or sulfonamides are required for organisms resistant to penicillin.

2. If treatment is delayed, and occasionally in spite of early treatment, suppuration, necrosis, and lung destruction of small or large areas usually occur, producing single or multiple abscesses.

3. Such resistant cases can be greatly benefited in most instances by the application of established principles, namely, the addition of topical penicillin or streptomycin or sulfons alone or in combination. This is accomplished by aspiration under fluoroscopic guidance, removing all accessible pus and instilling the materials mentioned suspended in a wetting agent.

4. Thirteen patients so treated are reported. Nine were rapidly restored to health, while failure occurred in two, requiring surgical extirpation, and two others were errors in diagnosis, a lung cyst and a lipoid pneumonia, which required lobectomy.

5. The percentage of salvage by other methods is discussed.

6. The method is outlined in detail.

7. This seems to be a very beneficial method of treatment and should be seriously considered by all who have to deal with such patients, but should be employed only by competent thoracic surgeons.

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ABSTRACT OF DISCUSSION

LEONARD F. BUSH (Danville): In the treatment of acute lung abscesses, it looks very much as though surgeons will not get to see many of them until they are out of the medical man's hands. Certainly acute lung abscesses can be cured today. Just the other day our medical service gave us a report on the last five cases that have come in the hospital in the past two or three months and they were cured by penicillin treatment alone. Therefore, there will be perhaps only two types that will get to the surgeon—the long-standing cases with tremendous abscessed cavities, and those which have large masses of necrotic material which can't possibly get through the bronchial opening.

JOHN H. GIBBON, JR. (Philadelphia): I congratulate Dr. Burnett on giving a very careful report of his trial of this method of treating pulmonary abscesses. I think for the present—and probably Dr. Burnett would agree—that this type of treatment should be carried on only in places where there is a good deal of thoracic surgery being done. He has had one pneumothorax and one hemorrhage. Although there were no empyemas, there is a possibility that one might occur. I don't think that Dr. Burnett would advise general application of this method at the moment.

As the chairman of the section said, we don't see many pulmonary abscesses these days, and very few are treated surgically. Many of them respond to conservative therapy with antibiotics. I can recall, I think, only two pulmonary abscesses which I have treated surgically in the last two years, that is, aside from pulmonary abscesses that are secondary to very obvious causes such as cancer.

I think his treatment is a logical one. The reason these abscesses fail to respond to conservative measures and parenteral antibiotics is that they are unable to drain pus through small bronchial openings. This is a method of putting a needle in, draining the pus through the needle, and injecting penicillin locally where it will come in direct contact with the organisms. It is a perfectly logical treatment, and analogous to the treatment of empyemas by repeated aspirations and injection of penicillin.

Dr. Burnett did not mention over what period of time these cases occurred and the length of his follow-up. I think it would be interesting in all these cases to have post-treatment bronchograms and more prolonged follow-up, because, as we all know, there are the late sequelae to pulmonary abscesses, such as bronchiectasis, as Dr. Burnett pointed out in his surgically drained case.

I think that the dangers of getting an empyema with a properly placed needle are relatively slight. It has been pointed out that you do not necessarily have to drain pulmonary abscesses in two stages if you make the proper approach and are directly over the abscess, and that can be done by good roentgenograms in several planes, or by fluoroscopic guidance, but, again, the needle must be inserted by someone very familiar with the anatomy of the chest, preferably a surgeon.

I hope that Dr. Burnett will continue with this work and let us know at a later time his further results. Until then, I think it should be used only in centers that are doing a large amount of thoracic work.

PROSTATISM

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PROSTATISM is a common state in the aging male. Its importance lies in the mechanical effect on the genito-urinary system by impairment of excretion, with secondary changes as a result, not only in the anatomical organs concerned but in other body functions. Discussion is pertinent since prostatism is seen primarily by the general practitioner, not by the genito-urinary surgeon. Likewise, it should be emphasized that surgical measures of themselves are only one facet of the problem. We must recognize that appropriate medical therapy not only enhances the safety of surgery but also contributes directly to the correction of biochemical abnormalities and the eradication of associated disease processes.

When we recall that urinary obstruction is probably the most common cause of kidney impairment, prostatic obstruction would be the most prevalent etiologic factor expected in the aging male. If one kidney functions well, metabolic balance can be maintained. The urethra and prostate assume importance since obstruction in this location affects both kidneys. Thus uremia is the most common chemical change produced. Obstruction from strictures, solid bodies such as stones or tumors, or inflammation may occur anywhere in the genito-urinary tract, but, unless bilateral obstructive effects are produced, they are less likely to produce profound chemical imbalance.

As a result of obstruction such as that which occurs in prostatism, certain physiologic changes occur which may be outlined briefly, as follows:¹

1. Loss of normal ureterovesical valve protection with back-pressure interference with the normal flow of urine.

2. Intrapelvic pressure increases. This results in increased pressure against the anatomical kidney elements such as glomeruli, tubules, and interstitial tissue. The urine becomes more concentrated and mineral salts and urea are less efficiently excreted. Glomerular filtration is reduced and nitrogen and other catabolites, especially acid radicles, accumulate in the blood.

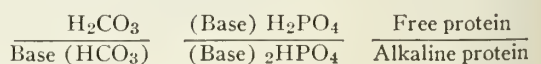
3. Next, we may expect that the inherent damage to the kidney substance from pressure alone will produce a hydronephrosis with atrophy of the functional elements.

4. Stasis of urine makes the kidney more liable to infection, especially with the colon group of bacteria. This may further interfere with the functional ability of the organ since in kidney infections all functional elements are likely to be involved in some degree.

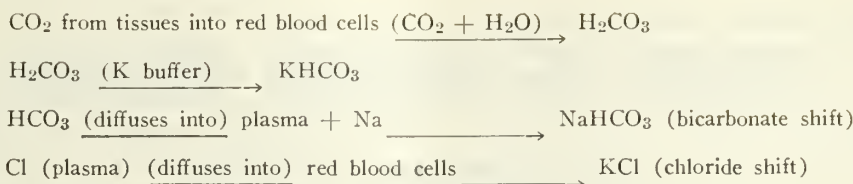
5. From this series of events we may then expect changes in the fluid and acid-base balance with retention of nitrogen and disturbance in chemical metabolism. There is interference with bone marrow function, nervous system balance, and gastro-intestinal tract efficiency. Bone marrow depression produces an aplastic blood picture; nervous system disturbance may produce irritability, convulsions, or even coma; the gastro-intestinal tract in uremia commonly reveals a non-specific inflammation with sometimes shallow ulcerations.

These above-mentioned changes occur when the acid-base balance is sufficiently disturbed to produce azotemia and acidosis. The maintenance of equilibrium depends upon several basic mechanisms:² (1) the buffer system of the blood, (2) the expiration of CO₂ by the lungs, and (3) kidney excretion.

Each of the two large components of blood—plasma and red blood cells—has a function in the buffer system. Plasma, or the extracellular fluid component, contains the carbonate, phosphate, and protein fractions in equilibrium commonly expressed, as follows:



The red blood cells contribute readily to the maintenance of equilibrium under normal conditions through their content of potassium. This is commonly expressed as follows:



Kidney function is the most important phase of the acid-base balance for purposes of this discussion. Kidneys excrete the acid products resulting from the metabolism of protein and fat such as sulfuric, phosphoric, and organic acids. Basic elements, principally sodium, are reabsorbed and conserved by the formation of ammonia which is excreted as acid or acid salts. In profound disturbances of kidney function, basic elements are excreted and ammonia products accumulate with the production of azotemia and acidosis.

Thus, we may readily understand that the treatment of prostatism revolves about two main principles: (1) the correction of the disturbed physiology, and (2) the correction of the mechanical factors responsible for this disturbance. In the approach to the problem, both temporary, and later, surgical corrective methods must be considered. To relieve the back pressure and stasis phenomena mentioned previously, a retention catheter must be installed. In addition, certain urinary antiseptics or bacteriostatics are employed to aid in control of infection. These include penicillin, streptomycin, mandelic acid derivatives, and others. Adequate fluids must be administered orally, and if necessary intravenously, to overcome the dehydration and acidosis, if present, as well as to provide adequate fluid for filtration and mechanical flushing. In the presence of a CO_2 combining power below 30 volumes per cent, it is desirable to employ intravenous solutions of M/6 lactate-Ringer's solution with glucose to repair the loss of base. Other general measures utilized should include adequate diet, establishment of normal bowel function, and restoration of blood levels, by transfusion if necessary. Only after sufficient preparation, with the re-establishment of metabolic, nutritional, and fluid balance, should surgical measures for the relief of the prostatic obstruction be undertaken.

Two case histories are presented in summary which illustrate many of the pertinent points to be emphasized.

CASE 1.—A 73-year-old male was admitted to the hospital with complaints of weakness, fatigue, insomnia, and anorexia for six months. He had suffered hemorrhages from peptic ulcer in 1917 and 1945 and for some months had noted a tendency to bruise easily. There

had been a retinal hemorrhage three months before admission. Treatment with iron, liver, and rutin had produced no improvement in his condition. There were no genito-urinary symptoms whatever, except for several drops of blood following urination on two occasions. He was suspected of having a blood dyscrasia when referred for study. Examination revealed numerous hemorrhages and exudates in the right eye, a 3 plus prostatic hypertrophy, and a large rounded mass in the suprapubic area which did not decrease in size following urination and of which the patient was not conscious.

Laboratory study revealed 2.44 million red blood cells with 7.5 Gm. (53 per cent) hemoglobin, 6700 white blood cells with 80 per cent polymorphonuclear cells. Prothrombin concentration was 43 per cent of normal. The CO_2 combining power was 39 volumes per cent. The nonprotein nitrogen was 120 mg. per cent. The phenolsulfonphthalein test returned 2 per cent in two hours. Urinalysis revealed only a faint trace of albumin. Other laboratory studies were considered within normal.

Catheterization revealed over 1200 cc. of residual urine. A régime of a retention catheter with decompression at the rate of 300 cc. per hour along with the principles of treatment outlined above was instituted. Two blood transfusions of 500 cc. each were given. In three weeks the nonprotein nitrogen had returned to normal and the phenolsulfonphthalein had improved to 20 per cent return in two hours. Transurethral resection was performed with uneventful recovery. The blood picture and eyegrounds returned to normal under observation and the patient has recovered his normal vigor of previous years.

CASE 2.—A 78-year-old male was admitted to the hospital for acute congestive heart failure. There was an additional history of nocturia, dribbling, small stream, and painful frequency for one year. Examination revealed the signs of congestive heart failure with 3 plus prostatic hypertrophy and 250 cc. of residual urine.

Laboratory study revealed 3.85 million red blood cells with 76 per cent hemoglobin, and 5800 white blood cells. The nonprotein nitrogen was 63. The urine revealed a 1 plus albumin with a few white blood cells. The phenolsulfonphthalein was normal on two occasions.

The nonprotein nitrogen returned to normal within two weeks under treatment for the congestive heart failure with a retention catheter to establish drainage and the use of urinary antiseptics. No intravenous fluids were given because of the complicating congestive failure. Transurethral resection was done sixteen days following admission with uneventful convalescence. The blood count at discharge from the hospital was normal.

The first case undoubtedly was one of long-standing obstruction but without symptoms referable to the urinary tract. The pertinent symptoms were those due to the prolonged back pres-

sure with kidney damage, acidosis, anemia, nervous system irritability, and gastro-intestinal tract dysfunction. He was suspected of having a blood dyscrasia, but became entirely well with appropriate treatment for prostatism. The second case was admitted to the hospital because of congestive heart failure, but, with symptoms of one year's duration, had produced no marked evidence of kidney damage. The complicating congestive heart failure did not prevent the completion of proper treatment after thorough preparation.

Prostatism is not a completely surgical problem. The diagnosis is not made by the surgeon.

It is made by the family doctor! We must remember that certain pathologic physiologic changes result over a long period of time and that these must be corrected as far as possible before mechanical correction with surgery is advisable. The physician and genito-urinary surgeon are therefore a closely cooperating team in the attack on this very important problem of the aging male patient.

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IN PENNSYLVANIA AS IN MICHIGAN

Facts vs. Propaganda

Publicity refers to the use of the common media of public expression—radios, newspapers, magazines, and public forums. It is recognized that the use of publicity can be an important part of any public relations program, but the reverse is not necessarily true.

It is possible for an organization to hire an individual or an agency to see that it receives frequent and favorable mention in the press, radio, and publications. In the sense that this job can be done by an agency entirely separated from the organization, and that the agency attempts to influence the public's attitude merely by uttered and published words—this might be considered *propaganda*.

Public relations, however, is not something apart from the general program of an organization. It cannot be wrapped up in a package and delivered. It is neither a cover for shortcomings nor a substitute for good works. It should not be turned over completely to a single agency or individual in the vain hope that, by the use of some magic formula, public relations can suddenly be transformed. Good public relations, in fact, depends on good works. It cannot exist in a vacuum. Therefore public relations must be built on the program and the accomplishments of the organization.

Public relations is not measured in column-inches in newspapers and magazines, nor in sponsored and sustaining radio time. It is measured in the hearts and minds of people. Although public attitude is influenced to some extent by the press and radio, a greater influence is made by individual personal contacts. Medical public relations begins and ends in the office of each individual physician, and no unified public relations effort can succeed which is not based on the organized participation of each individual doctor.

The Michigan State Medical Society and subsequently the A.M.A. have recognized these facts in their campaigns against compulsory health insurance. The main effort is to be made through the offices of the individual members—there will be no large bills for advertising and radio time. The A.M.A. will prepare educa-

tional material on the issue of compulsory health insurance which will be distributed, through state and county units, to its membership.

The material to be prepared by the A.M.A. will be based on plans and accomplishments—facts, not propaganda. It is regrettable that a few physicians have indicated their unwillingness to participate in this program, because it is a plan for positive action and not one for defensive propaganda. All forward-looking doctors of medicine should be willing to cooperate in this task.—Excerpted from *Detroit Medical News*.

A STRAIGHTFORWARD OBJECTIVE

The straightforward aim of the American Medical Association is to tell to the general public the story of progress made in American medicine by a free profession. To that purpose the fund raised by the assessment of \$25 on each member will be devoted this year. The people want and should have facts; they want and should have good medical care.

The source of these funds will be the doctor himself, and the accounting will be an open one, so that all may be aware of the spending program.

The important question at issue is national compulsory sickness insurance as projected by the Federal administration vs. voluntary health insurance plans as advocated by the A.M.A. in its twelve-point program. Publicity on both sides should adhere to the facts in order that the question may be fairly settled in the public interest on the basis of cold, hard facts.

“. . . And to contend that a government-imposed health insurance program is 'the logical development of private insurance' is tantamount to arguing that a totalitarian state completely dominating all lines of industry is the logical outgrowth of democracy and free enterprise.”—*The Hartford Courant*.

SUBDURAL HEMATOMA IN INFANTS

JEROME F. GRUNNAGLE, M.D.

Pittsburgh, Pa.

SUBDURAL hematoma occurring in the first year of life seriously impairs the growth and development of the infant's brain. Untreated infants who survive are usually mentally and physically retarded.

This report is based on our experiences with 16 cases treated from April, 1947 to July, 1948.

Etiology

Trauma to the head is probably the precipitating cause in all cases. This may occur at birth or in the postnatal period and need not be severe. There was a skull fracture in only one of our cases. There was a history of difficult labor in six of the cases, two of which were premature births. In four instances a history of postnatal trauma was obtained, and in one of these the symptoms attributable to the hematoma antedated the injury. Ingalls, Naffziger, Peet and Kahn, and Rosenberg are of the opinion that dietary deficiencies in the child or the mother during pregnancy predispose to subdural bleeding. Ingalls demonstrated evidences of scurvy in many of his cases. Most of these authors observed that the majority of the patients with this condition come from homes in which the economic status is poor. Ingraham and Matson, whose series is by far the largest, reported that 20 of their 98 cases showed some clinical evidence of vitamin C deficiency, but did not consider it a uniform or even very common finding. One case in the present series exhibited frank evidence of scurvy. Many of these children are undernourished when seen, but this is a result rather than a cause of subdural hematoma.

Infection is common in these children and may mask the true diagnosis, but it is not important from an etiologic standpoint. We have seen subdural hematoma develop following cauterization of the choroid plexus in the treatment of congenital hydrocephalus due to tearing of bridging veins when the brain collapses.

Trauma remains the important etiologic factor, but it is frequently a minor bump and hence is quickly forgotten; therefore, the absence of a history of trauma should not affect the diagnosis of subdural hematoma.

Pathology

Bleeding occurs into the subdural space from tearing of the pial veins connecting with the lacunar spaces of the longitudinal sinus. Fibroblasts and young capillaries invade the clot from the undersurface of the dura. Fibroblasts also advance from the edges of the clot, between the clot and the arachnoid, thus forming a complete membranous sac. The central portion breaks down and liquefies, resulting in a fluid of high protein content. Enlargement is believed to occur by osmosis from the adjacent cerebrospinal fluid in the subarachnoid space.

The outer membrane is relatively vascular, 1 to 4 mm. in thickness, and moderately adherent to the undersurface of the dura. The inner membrane is much less vascular, thin and transparent, but consists of fibrous tissue and hence is inelastic. There is always considerable fluid present in the sac, which varies from a light yellow to a deep bluish-green hue. Occasionally it is colorless and clear, but with an elevated protein content. Solid clots may be present.

The sac extends from the longitudinal sinus over the hemisphere to well under the temporal lobe. It extends from over the frontal pole to the parietal region in an anteroposterior direction, according to Ingraham and Matson. By filling the sac with air at the time of trephining and then obtaining x-ray films, we found that the sac covered the entire hemisphere from frontal to occipital poles.

Symptoms and Signs

There were 11 males and 5 females in this series. Ages on admission varied from eighteen days to one year, with the peak at eight months.

There is no clinical picture which is characteristic of subdural hematoma. Common groups of symptoms and signs occur which should suggest

Read before the Section on Pediatrics at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 6, 1948.

From the Children's Hospital, Pittsburgh, Pa.

the diagnosis and it can then be proved easily and accurately by tapping the subdural space.

Like other intracranial disease in early childhood, subdural hematoma is frequently manifested by general symptoms, such as failure to gain in weight or progress properly, temperature variations, vomiting, and irritability. Such cases at this stage may be treated as "feeding problems." Convulsions may occur and the child may lapse into coma.

Frequently, the first symptom is a convulsion, which may be focal or generalized, followed by fever, irritability, vomiting, and stupor. Disturbances of consciousness varying from listlessness to deep coma were observed in 14 cases. The degree of consciousness varied in individual cases. Some of these cases had a short history of a few days to a week or two, even though the presence of organized membranes indicated that the clots had been present for weeks or months. Apparently symptoms are not produced until the gradual expansion of the clot has been sufficient to reach a pressure necessary to cause a convulsion.

Convulsions occurred in 12 of our cases and the temperature was elevated in 10 cases. In several instances it was recorded at 105 and 106 F. Infection, usually of the respiratory tract, was present in many; meningitis was found in one. These patients appeared dangerously ill when admitted. The usual picture was that of a dehydrated, pale, listless child who became very irritable when disturbed, or could not be aroused at times, and who had frequent focal or generalized convulsive seizures.

Most cases in this series had enlarged heads. In contrast to hydrocephalus, the enlargement was biparietal. The fontanel was bulging and frequently tense. The sutures of the skull were usually separated. Hypertonicity and increased reflexes were common findings, while actual paralysis was not seen.

The optic fundi were abnormal in most cases. Retinal hemorrhages were frequent and often large. Optic atrophy was common and choked disks were seen. Inequality of the pupils was observed in two instances. In one the lesion was unilateral and the dilated pupil occurred on the side of the lesion. The hematoma was bilateral in the other case, but much larger on the side of the large pupil.

Auscultation of the skull may reveal a bruit, and when this is present the question of intracranial vascular anomaly arises. One patient exhibited this finding, which disappeared after the hematoma had been tapped several times. No vascular anomaly was seen at craniotomy.

Diagnosis

Once the lesion is suspected, subdural taps should be done at once, as this procedure not only establishes the diagnosis but is the first step in the treatment. This is a simple operation, and if done carefully, exercising strict aseptic precautions, is a safe one. Such taps have been done daily on each of these cases for several weeks by the residents at Children's Hospital, with no infection and no untoward symptoms.

The infant's head is shaved from the ears forward and the skin prepared with any good antiseptic solution. With the baby in a restraining sheet and the head held firmly by a nurse, a small novocain wheal is raised in the scalp at the lateral angle of the anterior fontanel or over the coronal suture line. The scalp and dura are pierced with an 18 or 19 gauge short beveled spinal needle, introduced at right angles to the scalp. It is controlled by grasping the shaft near the point, between the index finger and thumb of the left hand, with this hand held firmly against the head, while advancing the needle with the right hand. A definite click is felt when the tough dural membrane is pierced at a depth of about 5 mm. Upon withdrawing the stylet, fluid, which varies in color from a clear yellow to a dark bloody color, flows from the needle. If no hematoma is present and the subarachnoid space is entered, either no fluid or a few drops of clear colorless fluid is obtained. More than 1 cc. of fluid is considered pathologic. Cerebrospinal fluid normally contains less than 40 mg. per cent of protein, while the fluid from a subdural hematoma is considerably above this figure, 150 to 1200 mg. per cent in this group. Both sides are tapped and specimens collected and analyzed for protein content. About 15 cc. is removed from each side. A firm gauze dressing or cotton collodion dressing is applied to the puncture sites. A syringe is not attached to the needle.

No other tests are necessary for diagnosis. Pneumo-encephalograms are unnecessary and may be very disturbing to these patients.

Treatment

Mere washing out of the sac through trephine openings, which is so successful in adults, is inadequate in many cases in infants. During the first three months of life the brain volume approximately doubles, and doubles again in the following six months. The thin, inelastic, constricting, inner membrane must be removed to permit this rapid expansion and development of the brain. Repeated aspirations, or washing out of the contents of the sacs, without removal of membranes has resulted in a high percentage of

cases with mental retardation and blindness (Naffziger, Sherwood). On the other hand, Peet and Kahn, in an early report, cite 9 cases treated by immediate craniotomy and removal of membranes, with 5 postoperative deaths. They attributed this high mortality to the poor general condition of the patients and the sudden release of such massive intracranial pressure. Ingraham and Heyl, and Ingraham and Matson suggested early conservative, combined with ultimate radical, therapy in subdural hematoma in infancy and report a large series of cases with a case mortality of 7.9 per cent and operative mortality of 5.3 per cent.

We have followed their outline of treatment in the present series and, although insufficient time has elapsed for adequate evaluation, the results to date are gratifying.

Daily subdural taps are done on alternate sides with removal of 10 to 15 cc. of fluid. Vigorous supportive therapy in the form of parenteral fluids, vitamins, and repeated transfusions is continued throughout the treatment. When the patient's condition has improved sufficiently, usually in ten days to two weeks, the second step is undertaken.

This consists of bilateral burr holes in the temporal region. At this time the outer membrane is opened and the fluid evacuated and clots washed out. If desired, the sac may be filled with air and x-ray films made to determine its extent. The primary purpose of the burr holes, however, is to determine whether a constricting inner membrane is present. If it is, the third step is necessary.

A small bone flap is turned about a week after making the burr holes, and the exposed portion of the outer membrane is removed. As much of the inner membrane as possible is removed and it is torn well beyond the exposed area. If restricting membranes are found on both sides, a similar procedure is carried out on the opposite side in a week or ten days.

We have utilized local anesthesia combined with sodium nembutal preoperatively in all of our operative procedures on these infants. This combination has proved satisfactory.

An ankle vein is exposed and a large cannula tied in position before surgery for the administration of whole blood.

The subdural hematoma occurred on both sides in 14 of the 16 cases. In five of these, bilateral burr holes and irrigation were considered adequate. Bilateral bone flaps were done in two instances, while seven required craniotomy on one side. Both unilateral lesions required craniotomy.

Results

Sixteen cases of subdural hematoma of infancy have been treated by the above method at Children's Hospital in the fifteen-month period from April, 1947 to July, 1948. There have been no deaths in this series.

Follow-up studies are available in 14 cases, from three to fifteen months since operation. Convulsive seizures have not occurred in any of the fourteen since discharge from the hospital. Ten of these cases suffered convulsions before operation. All have shown a steady gain in weight. One infant vomits occasionally. There have been no feeding difficulties in the remaining thirteen. Some pallor of the optic disks is present in two cases, but vision is apparently good in all cases. Retinal hemorrhages have disappeared in all cases. Two infants, who were considered blind, appear to have no visual disturbances now. Most of the children are too young for accurate evaluation of mental ability, but twelve of the fourteen appear to be normal, active, healthy children. The other two show evidences of retardation, but are otherwise asymptomatic.

Summary and Conclusions

We have presented briefly the findings in 16 cases of subdural hematoma of infancy. To summarize, the common symptoms are irritability, listlessness, periods of stupor and coma, convulsions, feeding difficulties, and failure to progress normally. Most cases are hypertonic with enlarged heads, tense fontanels, evidences of malnutrition and fever. The picture is often confused by superimposed infection.

Diagnosis is made by tapping the subdural space through the anterior fontanel or coronal suture.

Radical treatment is indicated and can be accomplished with a very low mortality rate. The prognosis is good if this treatment is instituted early.

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ABSTRACT OF DISCUSSION

HARRY LEE (Philadelphia): Have you found any cases in which it was necessary to tap further bilaterally in order to discover the hematoma?

ISRAEL BINDER (Philadelphia): I would like to know the age of your oldest patients—the ones in whom you did not get the best results.

DR. GRUNNAGLE (in closing): In answer to Dr. Lee's question, we have not gone any further laterally than slightly beyond the angle of the anterior fontanel. However, we have found occasionally that, in order to get fluid without using a syringe for aspiration, it is necessary to do it with the patient's face down, to bring the fluid forward, but all the cases we studied to determine the extent of the hemorrhage by putting air in covered the entire hemisphere on that side.

In answer to Dr. Binder, the children ranged from eighteen days to one year of age, and the best results occurred in the ones who had symptoms the shortest time. However, in some of the cases with symptoms for several months we obtained good results, but obviously, the younger they can be treated, the better the results should be.

The oldest patient was eleven months at the time of operation, and that child shows some retardation.

A.M.A. HAS NO OFFICIAL SPOKESMAN

The American Medical Association has not now and never has had an official spokesman, points out an editorial appearing in the March 19 issue of *The Journal of the American Medical Association*. Quoted below is the editorial in part.

"No committee, council, board, officer, or employee of the association is charged with establishing policies for the American Medical Association. The association has not now and never has had an official spokesman.

"In February, the Board of Trustees announced the 12 point program, which is an expansion of other programs which the House of Delegates accepted and announced over a number of years. In making this announcement the chairman of the Board of Trustees is not establishing any new policies. The announcement is made for information of the medical profession and the public concerning the activities of the Board of Trustees.

"The employees of the American Medical Association now number about 800. Many councils, committees, and bureaus are charged with specific duties by the constitution and by-laws. The president of the association is elected annually as president-elect and succeeds to office one year following his election. His duties are specifically defined by the by-laws, as are also the duties of each of the councils, committees, and officers.

"All officials of the association, including the president, the president-elect, the secretary, and the chairman of the Board of Trustees, make public appearances and are interviewed. When they speak, they endeavor to interpret the policies of the House of Delegates. The employees of the association, including the general manager, the editor, the secretaries of the various councils and committees, and the directors of the bureaus, also make many public appearances; when they speak or when they are interviewed, they also present the policies adopted by the House of Delegates.

"Recently the association has established a division of public relations and has employed special public relations counsel in connection with a program of education of the American people regarding the present status of medical care and the proposals that have been made for extension of medical care. These agencies represent the American Medical Association. When they issue releases to the press or make public pronouncements, as they frequently do in delivering addresses, they also present the point of view of the House of Delegates.

"The statements here made are intended to correct unwarranted misrepresentations as to the association. The House of Delegates at the St. Louis session reaffirmed the point of view of the American Medical Association

in its determined opposition to compulsory sickness insurance. The House of Delegates also recommended the widest possible extension of voluntary hospitalization and sickness insurance, but did not consent to the formation of a national insurance company under the sponsorship of the American Medical Association. These are the two most prominent issues now discussed in editorial opinion throughout the United States.

"Until the House of Delegates acts to change a decision, every council, bureau, officer, and employee is bound by the prevailing actions of the House of Delegates."

SMEAR TEST AIDS DIAGNOSIS OF LUNG CANCER

The smear test is an extremely valuable aid in diagnosis of lung cancer, according to two physicians from the Section on Surgical Pathology of the Mayo Clinic, Rochester, Minn.

Writing in the February 19 issue of *The Journal of the American Medical Association*, Lewis B. Woolner, M.D., and John R. McDonald, M.D., say:

"Our experience with cytologic examination of sputum and bronchial secretions has served to convince us of its tremendous practical value in the diagnosis of indeterminate pulmonary lesions.

"To date we have examined the sputum or bronchial secretions of 2188 patients. All material was reported positive or negative for cancer cells. A diagnosis of cancer on the basis of smears was given in 200 cases. In 194 of these cases, a final diagnosis of cancer was made."

Examination of sputum for cancer cells by the smear test is especially valuable for patients suspected of having bronchial cancer in whom examination by the bronchoscope is not advisable, the physicians indicate, adding:

"The accuracy of diagnosis with this technique varies directly with the experience of the cytologist. Erroneous diagnoses may occur, especially in the early period of investigation before sufficient experience has been acquired. After a large volume of work has been done, however, a remarkable degree of accuracy may be expected.

"When this degree of accuracy has been attained, the findings on sputum examination in the majority of cases of cancer are as convincing to the cytologist as are the findings on tissue section."

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EDITORIALS

BEWARE! "A DOCTOR DRAFT"

The pages of the JOURNAL have been used before to bring to attention the current and urgent needs of the armed forces of the USA for doctors of medicine to voluntarily seek commissions in Army, Navy, and Air Force Medical Corps. Such messages, regardless of the form in which they appeared, were highlighted by the significant statement that "doctors must volunteer or be drafted." Copy of a covering resolution, unanimously adopted by the 1948 House of Delegates of The Medical Society of the State of Pennsylvania, in addition to appearing in the JOURNAL, was forwarded to officers of our component societies. Under date of Dec. 20, 1948, President Sensenich of the A.M.A. addressed a letter to all doctors under the age of 26, urging them to volunteer.

As of February 8, a total of 991 cards had been returned, of which 508 requested applications for commission. Not a few of those returned came from physicians already on active duty. The response while encouraging is not nearly sufficient. Twenty-one hundred doctors now on active duty are to be released this spring.

It is believed that the time has come for direct conversation with the young doctors who did not reply, since it is known that sufficient doctors could be recruited from this group to prevent a special "doctor draft" by Congress. These names with current addresses are being prepared for distribution to representative officers of compo-

nent societies in Pennsylvania, requesting personal contact and interviewing.

As late as February 25, Secretary of Defense James Forrestal publicly stated: "Voluntary commissionings in Army and Navy Medical and Dental Corps must rise sharply, and quickly, or it will become necessary to ask Congress for a doctor draft." The most equitable solution, according to Secretary Forrestal, rests with the 15,000 young doctors who were draft-deferred to complete their education and subsequently saw no military duty. Mr. Forrestal is "requesting medical organizations, especially county medical societies, to appeal to former young ASTP's and V-12's who are non-veterans."

It is believed that the last thing the organized medical profession will want under these trying circumstances is compulsion, and that each county medical society will, without awaiting the further risk of military draft of doctors, speak to:

1. The doctors in their vicinity under age 26, most of whom undoubtedly will be currently serving an internship or a residency in hospitals in 20 Pennsylvania towns which have a population of 50,000, or smaller towns with general hospitals of minimum bed capacity of 200.
2. Young doctors who graduated in medicine in 1945, 1946, and 1947, who may now be in private practice or serving a residency.

It will not be convenient or practical to address each member of The Medical Society of the State of Pennsylvania on this topic, but all who read this editorial should constitute themselves as ambassadors of good-will by interviewing young doctors, with the hope of helping to meet the profession's responsibility to furnish military doctors in adequate number, and above all to avoid the necessity for a "doctor draft."

MINOR PSYCHOTHERAPY

Having found it advisable to consult the dictionary, the editor herewith quotes briefly the surprising definition of the word *iatrogenic*, which means "generated by the physician."

If you never before thought of yourself as an *iatrogenic* etiologic factor in the development of a syndrome in one of your own patients, read the treatise on minor psychotherapy on page 692 of this issue under the title "The Psychosomatic Concept in General Medical Practice." In spite of its valiant title it should be read and reread by every general practitioner. This fine paper deals understandingly with "the long-recognized relationship between *feelings and sickness*."

NO PANELS OR DESIGNATED PHYSICIANS

Area Medical Offices of the United Mine Workers of America Welfare and Retirement Fund medical, health, and hospital service are being established in western Pennsylvania, one in Pittsburgh, and one in Johnstown. A third office in Morgantown, W. Va., covers some territory in southwestern Pennsylvania.

Members of the medical profession of Pennsylvania will always be welcome at our area offices in Johnstown, Morgantown, W. Va., and Pittsburgh. Drs. Sterling B. Brinkley, Lorin E. Kerr, and Leslie A. Falk look forward with pleasure to the prospect of meeting and talking with members of the profession in the respective areas they serve. Any questions of mutual concern will be gladly discussed at any time.

The medical program of the Fund is in line with the recommendations of its Medical Advisory Committee, consisting of representative members of the medical profession. It has been reviewed favorably by the Council on Industrial Health of the American Medical Association,

whose report was accepted by the House of Delegates at its most recent meeting (*J. A. M. A.*, 138:1239, Dec. 25, 1948).

General statements concerning the nature and program of the Fund have appeared elsewhere.* Some additional comments concerning detailed operation of the program may be in order. It should be understood that, with developing activities, changes may need to be made from time to time.

As now operating, the Fund constitutes primarily a payment and arrangement mechanism. It has no hospital facilities and no clinical personnel of its own, relying entirely on existing resources to meet its needs. All qualified physicians wishing to participate are eligible to do so. No panels or "designated physicians" are maintained. No operating "check-off" or other prepayment plans for miners' medical care have to date been replaced by the Fund. Such replacement, however, will eventually be made.

At present, payment for medical care is being provided primarily for members and dependents who are receiving benefits from the United Mine Workers of America Welfare and Retirement Fund. These are:

1. Miners and their families who are receiving disability benefit awards from the Welfare and Retirement Fund (for non-work-connected disabilities of thirty days or longer).
2. Miners and their families who are receiving miners' pensions from the Fund (age 62 or over with twenty years in the mines and at work as of May 29, 1946).
3. Widows and their families who are receiving widow's assistance from the Fund.

In addition, three additional groups are provided medical care as follows:

4. Miners and their families who would be receiving disability benefits if they did not have some income from workmen's compensation, veterans' benefits, or the like.
5. Miners and their families who are unable to secure medical care they need because of the absence of specialists in the area in which they live.
6. An occasional extreme hardship case among employed miners, which must be considered on its own merits.

The Fund is unable to provide payment for services to which its eligibles are entitled under workmen's compensation, tax-supported, volun-

* *J. A. M. A.*, 138:1249, Dec. 25, 1948; *ibid.*, 138:134, Dec. 25, 1948; *Pennsylvania M. J.*, 52:613, March, 1949.

tary prepayment, or other similar legal or contractual entitlements.

Payment is authorized only through a document issued by the Area Medical Offices of the Fund to the physician and hospital. The Fund is unable to pay back medical bills, the program at this stage being a "prior authorization" program. In other words, an eligible miner must apply on a suitable form to his District Office for payment of medical care to be or being received. This is supported by a Physician's Statement Form filled out by the family or attending physician. This form restricts itself to such simple data as the patient's diagnosis, treatment planned, and an *estimate* of the probable fee, and is for administrative use only. On certification of the miner's eligibility by the union, the Fund is then able to issue an authorization to the physician or hospital for the care to be received. The exception to this procedure is telephonic authorization for emergency medical care. Accordingly, no physician should accept the word of a miner (or the dependent of a miner) as final authority that his medical care will be paid for by the Fund.

After an authorization has been issued to a physician or hospital and the medical service has been provided, a copy of the authorization is then used as an invoice by the participating physician. The billing may be monthly or at any prompt time interval suitable to the physician. Itemization, with the dates that services were rendered, is requested. By and large, this simple mechanism is working well.

At present the program is primarily for major medical care such as hospitalization including surgery and specialized services. It is not intended to cover, at this stage, day-to-day minor illness, home and office care except for certain chronic cases for which special arrangement is made, health examinations, and preventive services. The Fund hopes, of course, to shift its emphasis to prevention, early diagnosis, and early treatment as soon as possible. This means, in essence, that the Fund does not alter immediately any of the existing "check-off" or other prepayment agreements for physicians and hospital service as now exist widely in the mining areas.

The Fund is expected ultimately to bear the full expense of medical and hospital services for the members, but this is a development which will come only with time and as the replacement of existing mechanisms becomes feasible and desirable. It is possible that "experience may demonstrate the necessity of providing additional and more special facilities for meeting the needs, but this will come from knowledge gained through

present procedure and through the availability of funds." *

Physicians will wish to know some of the details of the administrative lines of the Fund. The Area Office in Pittsburgh is now serving the following counties: Allegheny, Washington, Westmoreland, Mercer, Butler, and Beaver. The Johnstown office is serving the following counties: Cambria, Indiana, Clearfield, Armstrong, Somerset, Jefferson, Clarion, Bedford, Blair, Centre, Clinton, Elk, Juniata, and Tioga. Fayette and Greene counties are handled through the Morgantown, W. Va., office of the Fund. These administrative lines follow those of the United Mine Workers of America and the coal industry.

It is the aim of our offices to assist in the provision of high-quality medical care. The full advice, assistance, and participation of the medical profession of Pennsylvania are needed in order to make this program the success it must become. It has already made an auspicious beginning, and is setting a pattern for the future. It has vast potentialities for good, some of which are already being realized.

LESLIE A. FALK, M.D.,

Pittsburgh Area Medical Administrator.

PHYSICAL STIGMATA OF SYPHILIS

(EDITOR'S NOTE: This is the second of a series of guest editorials prepared by members of the Pittsburgh Syphilis and Venereal Disease Control Program and the Department of Dermatology and Syphilology, University of Pittsburgh School of Medicine. They should refresh the minds of practicing physicians on the procedures necessary to establish a diagnosis of syphilis, the modern therapy, the follow-up of treated cases, and certain public health aspects.)

Early Syphilis

The secondary manifestations of syphilis may appear while the chancre is still present and as late as four years after infection. The blood test at this stage is always positive, and the organs most commonly involved are the skin and mucous membranes. The early secondary cutaneous syphilids are characterized by their tendency to be generalized, uniformity in size of the individual elements, rarity of itching, and absence of vesicles or bullae. The lesions are either macular, maculopapular, papular, or rarely pustular and ulcerative, with the macular or maculopapular, known as roseola, being the most common and often being so mild as to be overlooked. The sites of predilection are the lateral aspects of the chest and abdomen, and the flexor surfaces of the arms. Purely papular involvement may involve

* *Pennsylvania M. J.*, op. cit.

other areas, such as the face; and pustular and ulcerative types occur predominantly in the Negro.

Late or recurrent secondary cutaneous syphilids occur some months after initial infection. Such lesions are less numerous, larger, and lack the uniformity in size of the early types, with an inclination toward grouping and less tendency to generalization. The sites of predilection are the palms, soles, genitals, perianal region, and oral mucosa. In the latter location they form the so-called mucous patches, while on the genitalia and perianal region large, flat, moist papules are produced, known as condylomata latum, which may coalesce into large cauliflower masses. When such lesions are found, the disease is probably at least several months old.

Symptoms resulting from central nervous system involvement occur in about 10 per cent of cases of early syphilis, but are rarely severe. Persistent headache resulting from meningeal irritation may be the only symptom. However, there may be associated nerve palsies, and occasional nausea and vomiting.

Syphilitic alopecia may occur in one of two forms: the rarely encountered diffuse type, which is similar to that seen in other systemic infections; and the circumscribed type, which is characteristic of syphilis. The latter consist of numerous, small, incompletely bald patches, producing a moth-eaten appearance. It rarely occurs before the sixth month of infection.

The laryngitis of early syphilis appears as a late secondary manifestation, is low pitched, and rarely produces complete aphonia. Ocular involvement is likewise relatively late in appearing, and is manifest as iritis, choroiditis, uveitis, or neuroretinitis. Visceral involvement seldom produces symptoms.

Tertiary Lesions

Late manifestations of syphilis may occur any time after the fourth year of infection, usually somewhat later. The cutaneous lesions are allergic and destructive in type, but are not contagious. They are either gummatous, nodular, or nodulo-ulcerative, with the latter being the most common. Their characteristics include asymmetry, indolence, indurated borders, arciform configuration, sharply punched-out ulceration, central healing and peripheral extension, atrophic non-contractile scarring (never any recurrence in scars), and peripheral hyperpigmentation. Involvement of the mucous membranes is uncommon, but may occur as gummas of the tongue or soft palate. Ocular involvement is likewise rare,

except for primary optic atrophy, which is almost always associated with central nervous system involvement.

Late syphilitic disease of bone is fairly common, and is characterized by formation of new bone. Gummatous periostitis is most frequently seen, with syphilitic osteomyelitis and osteitis being considerably rarer. Pain, frequently nocturnal, is the outstanding symptom. The tibia, frontal bone, clavicles, humerus, nose, and palate are the sites of predilection.

Syphilis of the cardiovascular system constitutes 10 to 15 per cent of all cardiovascular disease, and is responsible for more than one-third of all deaths occurring from syphilis. The earliest type of involvement and the most difficult to recognize is uncomplicated aortitis, which is usually detected only by fluoroscopic examination. Suspicion should, however, be aroused by the history of dyspnea and palpitation, the finding of a tambour aortic second sound, or an aortic systolic murmur. If and when sacular aneurysm develops, its recognition is considerably easier. The signs and symptoms of such involvement include pain of a continuous, grinding and neuritic character; enlarging dullness; asynchronism of pulses; difference in blood pressure in the two arms; diastolic shock; visible pulsation or thrill; hoarseness; cord paralysis; pupillary inequality; tracheal tug; and x-ray and fluoroscopic signs of a pulsating tumor. Involvement of the aortic valve, with development of aortic regurgitation, is likewise easily recognizable. Its signs and symptoms include diastolic murmur at the aortic area; cardiac enlargement and hypertrophy, increasing finally to cor bovinum size with definite heave to the heart beat; high systolic and low diastolic blood pressure; Austin Flint presystolic murmur at apex; water-hammer pulse; femoral pistol shot sound; accentuation of dyspnea; heart failure, and death.

Late recognizable syphilis of the liver is less common than is generally supposed, occurring primarily in three forms—diffuse hepatitis, gummatous hepatitis, and syphilitic cirrhosis. Gummas may be single, or more commonly multiple, the former often being associated with clinically undetectable multiple lesions. Symptoms and signs include jaundice, pain, nausea and vomiting, a palpable mass, and even ascites, the latter almost exclusively in the diffuse type of involvement. Cirrhosis is manifested by jaundice, esophageal hemorrhages, loss of weight, ascites, etc. The presence of ascites offers the poorest prognosis. Therapy in such cases is rarely of value.

HARRY W. WOOLHANDLER, M.D.

FALSE IN FACT AND IMPLICATION

Doubtless the more than seven thousand doctors of medicine in Pennsylvania who are registered as participating physicians in the voluntary non-profit insured medical service plan—Medical Service Association of Pennsylvania (Blue Shield)—will be joined by most of the other physicians in Pennsylvania in harmonious support of the appended statement made by the A.M.A. in reply to charges publicly released, April 15, by the Committee for the Nation's Health.

Needless to state, the several hundred thousand satisfied subscribers in Pennsylvania to Blue Shield voluntary insurance service will have also recognized the untruths contained in the publicized statement of the above-mentioned committee to the effect that The Medical Society of the State of Pennsylvania, which has sponsored MSAP Blue Shield from the date of its inception, in so doing is using "monopolistic control" to sabotage voluntary health insurance programs.

Reply by A.M.A.

The American Medical Association, on April 16, in a blistering reply to charges by the Committee for the Nation's Health that state and county medical societies are using "monopolistic control" to sabotage voluntary health insurance programs, declared today:

"This is an irresponsible statement by an irresponsible organization. The charges are false in fact and false in implication. If there are any saboteurs at work seeking to destroy voluntary health insurance, they undoubtedly will be found in the membership of the Committee for the Nation's Health, which has repeatedly sought to discredit and decry the voluntary health insurance movement."

The American Medical Association statement was issued by Dr. Elmer L. Henderson, chairman of the A.M.A. Board of Trustees, and continued:

"The people have a right to question the source of these charges—and the sincerity of the people making the charges.

"The Committee for the Nation's Health has done nothing to advance the Nation's health since it has been in business. It was organized solely as a propaganda agency for the socialization of medicine and now apparently has embarked on a campaign to discredit the voluntary systems.

"The state and county medical societies throughout the United States, and the American Medical Association, are proud of the part they have played in the phenomenal growth of the voluntary health insurance systems, which now provide prepaid health protection for more than 52,000,000 people.

"The cry of monopoly is as absurd as it is false. There are hundreds of competitive voluntary health insurance systems functioning in the country, some under medical sponsorship, some under hospital auspices, and many operated by outstanding private insurance companies.

"The doctors of America are supporting all sound voluntary systems which offer the people adequate protection, and we are now engaged in a great nationwide campaign to make America health insurance-conscious and to increase voluntary coverage. The charges that the medical profession is sponsoring restrictive legislation to achieve 'monopolistic control' of the health insurance field are utterly without foundation."

WHO TREATS HIM FIRST?

The editor contributes the above caption and clips the two appended paragraphs from a paper appearing on page 712 of this issue of the JOURNAL.

The writer of the article referred to, as do others with articles frequently appearing in this and other issues of this and other medical journals, indicates that the general practitioner, *bearer of the heaviest burden*, usually sees first the patient who eventually has a lingering illness.

The practice of medicine in the last analysis is not an artisanship in which tricks of various kinds can be expected to prevail. The general practitioner bears what is probably the heaviest burden in the medical field and he is fortunately coming to be more appreciated than has formerly been the case. However, nature accepts no excuses and it will be necessary for him, if he ventures to cope with the complicated problems of arthritis, to study the physiologic deviations concerned. When they are minor, they can be readily corrected, the rheumatic process being largely reversible. When, however, the deviations are major, they are far more difficult to treat. We must then take cold comfort from Ovid who wrote that, when we essay a difficult task, we must remember that there is no merit save in difficult tasks.

In conclusion, it should constantly be borne in mind that all cases of arthritis should be treated from the outset in the way that all systemic disease involving the whole body should be treated, i.e., by giving the body economy an optimal opportunity for normal physiologic equilibrium to be established. This is not a scrap basket recommendation but something to be interpreted literally and carried out with fidelity. There is no single remedy indicated for the treatment of arthritis. A coordinated approach is the only one which may be expected to achieve significant results in any large group of arthritics. Most refractory cases of arthritis are refractory because they have been inadequately cared for at the outset.

MATERNAL MORTALITY

On page 772, this issue, will be found a listing of "Deaths from Selected Causes in Pennsylvania, November, 1948." The column "Maternal Deaths" totals 14, divided by counties as follows: Philadelphia, 5; Lancaster, 2; Bucks, Centre, Clinton, Dauphin, Erie, Fayette, and York, 1 each. It is hoped that the causes for these deaths were determined and discussed by members of the medical societies in the counties where such deaths occurred.

ORGANIZATION OF THE SPEAKERS' BUREAU

The best public relations representative is the family doctor—if he will realize the important part he might play in providing his patients with dependable information on medical economic problems. Yet, only a few utilize this opportunity. When it comes to "meeting the public" in response to a request to talk before a local lodge, parent-teacher association, Legion post, or service club, the average physician is unwilling and unprepared to assume such a responsibility. As a result, a few members of each county medical society must carry the load—and risk charges of "publicity seeking."

The Speakers' Bureau of the Lackawanna County Medical Society was first organized in 1942 to provide a coordinated program of health talks for lay organizations. After a period of instruction in public speaking and preparation of talks, the group postponed their local efforts to enlist in the armed forces. Since the end of World War II, they have taken an active part in Red Cross, cancer, polio, tuberculosis, and other campaigns.

Reorganization was effected late in 1948, because of the demand for speakers on socialized medicine, as well as medical topics. These speakers and their program answered a long-felt need for taking the public into our confidence and to counteract undue publicity given minor sins of omission and commission. Likewise, there was provided an ethical means of acquainting the public with the daily benefactions of the medical profession in our free clinics and the wards of our voluntary hospitals.

A form letter was sent out, with return postcard, asking those interested to sign the card and attend an organization luncheon. Forty-two members responded. At the luncheon, plans for future meetings were outlined to provide:

1. Individual study as well as thorough briefing of the group in all phases of socialized medicine.
2. Instruction of other members of the society through a series of symposia on socialized medicine.
3. Finally, after briefing in socialized medicine and a short course in public speaking, the group would be ready to provide authentic information to lay audiences wherever and whenever they could be reached.

At the first meeting, each was given a folder containing mimeographed abstracts of the Brookings Institution report, with discussion. Violent arguments arising, each dissenter was asked to look up and report upon his topic at the next meeting. A wide variety of pamphlets and source books was made available to all, including:

- The Brookings Institution Report (individual copies).
- Analysis of the Ewing Report.
- Report of the Hoover Commission.
- "Uncle Sam, M.D."
- "The Case Against Socialized Medicine" by Sullivan.
- "Compulsory Health Insurance" by Crain, *Hospital Management*, January, 1949.
- World Medical Association Report—Medical Practice in 23 Countries.
- The Blue Cross-Blue Shield plans and rates.
- The 12 point program of the American Medical Association.

The assigned subjects were presented by the speakers and thoroughly discussed at each meeting. After four meetings these subjects were grouped and presented as symposia on compulsory health insurance before the well-attended weekly meetings of the Lackawanna County Medical Society. Such programs are of value only insofar as they provoke general discussion. Therefore, the talks should be short and not too inclusive. The speaker should be able to talk on all phases of his subject.

Instruction in public speaking should include:

- Planning the talk—prepare an outline.
 - keep the language simple.
 - never "read a paper."

The approach—varies with the type of audience.

Presentation of the subject (from memory).

Controlled discussion.

Use of visual aids (see MSSP public relations guide).

Radio presentations—preferably interview type.

Provision for adequate press coverage is essential:

Insist on adequate pre-meeting publicity.

Provide each speaker with a short, interesting abstract of his talk, cleared through public relations, emphasizing newsworthy points.

Listings of available medical and medical economics topics and the names of the speakers are mimeographed and sent out, at intervals, to service clubs, lodges, churches, Legion posts, PTA groups, women's clubs, and others. The members of the Woman's Auxiliary will be of help here.

The county medical society office should be the central agency for booking speaking engagements:

- Provides an accessible, daily service.
- Secretary reports requests to committee.
- Committee makes assignments.
- Secretary reminds speakers the day prior to presentation.
- Requirements for booking: Reputable organization.
 - Two weeks' notice.
 - Adequate publicity.
 - Audience of at least fifty.

Where a medical topic has been requested, the speaker has asked permission to speak a few minutes, at the close of his talk, on compulsory health insurance. The members of the Speakers' Bureau have addressed dozens of organizations, the discussion has been general, and the resulting comments the same: "Why were we not told about this before? Should we sign a petition . . . ? Should we write to our Congressman?"

Perhaps we are a bit late. But, let's "meet the public!"—FREDERIC B. DAVIES, M.D.

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*

8104 Jenkins Arcade

Pittsburgh 22, Pa.

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State From What It Is to What It Ought to Be.

AMENDMENTS TO CONSTITUTION AND BY-LAWS

In the interim between annual sessions, proposals for amendments or alterations to the Constitution and By-laws of our Society must be sent to the secretary-treasurer of the Society at least four months before the next annual session, and must be published in the JOURNAL at least three months in advance.

The Official Call for the 1949 Session will be published in the June JOURNAL. It should include all proposals for amendments or alterations, and they should be received by the secretary-treasurer not later than May 25.

A BRIGHT NEW SCIENTIFIC PROGRAM FOR A BRIGHT NEW CENTURY

Apparently anticipating a change in the year 1949—the first year of the second century of the life of The Medical Society of the State of Pennsylvania—the 1948 House of Delegates approved of a significant change in the organization of the Committee on Scientific Work. The delegates must have believed that the division of the annual scientific program into eleven to thirteen scientific sections involved too many specialty groups which, generally speaking, neglected the place of the general practitioner of medicine in their individual programs. The formation of a Section on General Practice of Medicine had not seemed to answer the problem presented by the existence of too many finely drawn specialty groups. It served only to intensify a lapse in the educational activities of the Society. Hence the change from eleven scientific sections (with two additional applied for in 1948) to two—*medicine* and *surgery*, each with its allied specialties to be considered in the development of a program.

The Medical Society of the State of Pennsylvania was formed in 1848 primarily for the edu-

cation and training of the general practitioner, and its scientific activities were originally concerned only with medicine and surgery. It is considered significant that we may be returning in 1949 to the ideals of our founders.

The 1949 scientific program will be inaugurated in Pittsburgh on Monday afternoon, September 26. The time (1 to 5 p.m.) will be divided into two periods, with a program involving both medicine and surgery to be presented in one room.

During the first period, 1 to 3 o'clock, there will be a panel discussion on anthrasicosis with Dr. Burgess Gordon, of Philadelphia, as moderator. Because of the importance of this disease in Pennsylvania industry and the confusion existing in the interpretation of our occupational disease laws pertaining to silicosis, it was decided to give this subject a prominent place on the program and to have the best informed speakers, both medical and legal, available to take part in the symposium. Invitations are to be extended to all of Pennsylvania's referees in compensation cases to attend the panel.

The second Monday afternoon group presentation, 3 to 5 o'clock, will be concerned with modern phases of cardiovascular disease and will consider such subjects as the dietary treatment of hypertension, surgery of mitral stenosis, diagnosis and surgery of congenital heart disease, and the use of anticoagulants in heart disease.

Throughout the entire four-day program adequate time will be allowed to visit the exhibits.

The great advantage in this form of scientific program is that physicians interested especially in medical topics will be able to hear all the medical papers throughout Tuesday, Wednesday, and Thursday in the same room. The same will be true of surgery and its allied specialties.

At the first meeting of the 1949 Scientific Work Committee the members were very skeptical that the type of program authorized by the House of Delegates could be satisfactorily developed. As the committeemen became more famil-

iar with the program mechanics, all were elated over what had been accomplished and are now confident that this will be the best annual scientific program presented to date and that it will set a pattern for those that follow.

Each successive issue of the PENNSYLVANIA MEDICAL JOURNAL will carry program information in detail, and JOURNAL readers have the committee's assurance that those in attendance will enjoy up-to-date instruction giving due recognition to all the specialties in skillfully integrated program arrangements provided comfortably in two rooms rather than in five or six rooms simultaneously, as has prevailed in recent years.

WILLIAM A. BRADSHAW, M.D., Pittsburgh, *Chairman*, 1949 Committee on Scientific Work, Medical Society of the State of Pennsylvania.

PRESIDENT ENGEL'S TEN-POINT PLAN BEARS FRUIT

The plan proposed by Dr. Gilson Colby Engel, president of The Medical Society of the State of Pennsylvania, has been discussed in the two preceding issues of the PENNSYLVANIA MEDICAL JOURNAL. By reference the reader may learn that his plan was freely submitted to four current officers of the American Medical Association and freely criticized by them with suggestions, which were generously accepted by Dr. Engel, "to be supplied to one or more senators as a basis for a counter-bill of their own with the blessing of the doctors of America—no mention to be made of any medical society or organization."

The American Medical Association officers referred to were Drs. Sensenich, Henderson, Lull, and Borzell.

As previously reported, the plan was enthusiastically accepted for study and consideration as a basis for Federal legislation by United States Senator Lister Hill of Alabama. Dr. Engel has conferred with the Senator in Washington on several occasions.

Finally, on March 30, 1949, Senator Hill (D. Ala.) on behalf of himself and Senators O'Connor (D. Md.), Withers (D. Ky.), Morse (R. Ore.), and Aiken (R. Vt.) introduced a "bill (S. 1456) to authorize grants to enable the states to survey, coordinate, supplement, and strengthen their existing health resources so that hospital and medical care may be obtained for all persons."

Its purpose is "to make high-quality hospital and medical care available to all by

"1. Providing protection to persons financially unable to pay all or part of subscription charges for prepayment of hospital and medical care.

"2. Stimulating voluntary enrollment in prepayment plans for hospital and medical care, emphasizing (a) employer participation in transmission of subscription charges and (b) enrollment in rural areas.

"3. Strengthening and coordinating existing health resources."

On March 31 Whitaker and Baxter of the A.M.A. Educational Campaign distributed to "Fellow Campaigners" a copy of S. 1456—the Voluntary Health Insurance Bill, also an analysis of it by its sponsors, and a statement concerning it by Senator Hill, one of the authors, with the warning that "this material is sent you solely for your information, as there has not been time as yet for detailed study of the proposal."

It is not possible at this writing to provide an analysis of this bill (S. 1456), but we may all rest assured that it will promptly be studied by A.M.A. representatives as well as those of state medical associations, including Pennsylvania's. Such analysts will wish to be assured that the bill will, if enacted, not only provide for good medical service and satisfactory hospital care on a voluntary basis but will carefully scrutinize other provisions so that they recognize the different plans under which insured hospitalization care and insured medical service are now administered in the several states.

Pennsylvania doctors of medicine, if and when satisfied that S. 1456 is entirely worthy of support, will solicit its favorable consideration by Pennsylvania's U. S. Senators Martin and Myers.

DOCTORS AND BUSINESSMEN HAND IN HAND AGAINST STATE SOCIALISM

DEAR DOCTOR:

The National Federation of Small Business, Inc., has just completed tabulation of a vote for or against compulsory sickness insurance among its 136,000 members.

The vote or mandate, as the federation calls it, is as follows:

For socialized medicine	9%
Against socialized medicine	89%
No opinion	2%

The federation mailed a questionnaire to every member. The marked ballot was sent to a teller appointed in each congressional district. The teller in turn notified the congressman in each respective district of the vote and then each teller sent his total to the federation's

headquarters where all the votes were tallied. The headquarters office notified all of the congressmen of the vote result.

Hard Fight Ahead

Minnesota Poll Shows People Favor National Health Plan. Two out of three adults in Minnesota favor Mr. Truman's proposal for government tax-supported national health insurance, according to a carefully worked out poll of the *Minneapolis Tribune*.

The poll results showed, however, strong support for another plan under which the government would provide funds for use of the various states in providing medical and hospital care for needy persons. On this question, 36 per cent voted yes, 39 per cent no, and 26 per cent no opinion.

The Minnesota poll is a public service sponsored by the *Minneapolis Tribune*. Every poll question, it is claimed, is checked for impartiality and approved by an advisory board of 20 outstanding Minnesotans, including a prominent Duluth physician, and each question is pre-tested to determine clarity. Ballots are then printed and sent throughout the state to 65 interviewers who personally interview specific numbers and types of individuals, as a cross-section sampling. The cross-section includes a certain proportion of the entire population including a proper representation of men and women, young and old, residents of big cities and small towns.

Among people of the lower economic group, 70 per cent feel that a national health insurance program is needed, compared with half of the people in the upper economic group.

More than seven in every ten Democratic-farmer-labor voters interviewed say that the program is needed compared with 63 per cent of the independent voters and 52 per cent of the Republicans.

One question asked was:

"Are you personally for or against such a national health insurance program?"

The replies:

For, 56 per cent; against, 23 per cent; qualified, 4 per cent; and undecided, 17 per cent.

The poll revealed that many of those interviewed believed that "people as a whole would be healthier" under a national health insurance program.

The above proves again that we have a hard fight ahead.

Mayo Doctors Support Assessment. Dr. Haddon Carryer, secretary-treasurer of the Olmsted-Houston-Fillmore-Dodge County (Minnesota) Medical Society, reported that virtually 100 per cent of the Mayo Clinic physicians have supported the A.M.A. assessment campaign. He said that 97.7 per cent of the members of the Mayo Clinic and 99.7 per cent of the Fellows of the Mayo Foundation have "reaffirmed their support of the American Medical Association."

Sign Up New Medical-Surgical-Hospital Plan. Approximately 90 per cent of the more than 800 A.M.A. employees signed up recently for coverage in a new medical-surgical-hospital plan.

The plan is more comprehensive than the plan which was in effect during 1948. It includes *home and office benefits and in-hospital medical benefits*, as well as the usual surgical and hospitalization coverage.

The A.M.A. pays part of the premium, so that the cost (for all benefits) to the employee is only \$1.50 a month, excluding dependents. The complete program is also available to dependents of employees at an additional rate.

The A.M.A. Board of Trustees selected the Illinois State Medical Society Plan for the medical-surgical coverage and the Blue Cross Plan for hospital care and for hospitalization.

Doctor Poll Shows Opposition to Government Medicine. A poll taken by the Worcester (Massachusetts) District Medical Society shows that 96.6 per cent of its members are opposed to government medicine and 3.4 per cent are in favor of it.

(Continued on next page.)

NOTICE OF AMA MEMBERSHIP ASSESSMENT

(Clip this form and mail with your check today if you have not already done so.)

The American Medical Association has requested your state medical society to collect this year a \$25 assessment. Please make check in favor of *American Medical Association—Assessment* and mail to The Medical Society of the State of Pennsylvania, 8104 Jenkins Arcade, Pittsburgh 22, Pa.

If your county medical society has combined this AMA assessment with its own dues for 1949, the bookkeeping of your county, state, and national medical societies will be greatly simplified if these two obligations are paid by separate checks.

AMA assessment check sent via
state medical society ☐

AMA assessment paid through
county medical society ☐

_____, M.D.
Name

County (Pa.)

To The American Medical Association, Debtor
Special Assessment \$25.00

"When the minority groups make a statement that many doctors favor government medicine," writes Dr. N. S. Scarcello, chairman of the public relations committee, "then they should be shown that when transposed into percentages, 3.4 per cent looks a lot less than the word 'many.'"

The Dan Gilbert Letter

New York Times Comments on Doctor Squabble. A few weeks ago the New York County Medical Society, with a total membership of nearly 6000, voted disapproval of the \$25 A.M.A. assessment. The vote was 333 for and 432 against. The action reversed a vote taken by the same group in January. At that time the vote was announced as four to one in favor of the assessment.

In reporting the meeting, the *New York Times* said:

"Resentment was felt against the A.M.A. by some members of the New York County Medical Society because of a letter circulated to the medical profession recently by the National Physicians Committee, the lobbying organization of the A.M.A. The letter opened with the greeting 'Dear Christian American.' There was said to be no doubt that this letter, by raising the issue of discrimination, had alienated some Jewish as well as non-Jewish physicians.

"At least one group in the county society felt that the vote was auspicious because it was said to indicate the existence of a large group of independently thinking physicians who could neither go along with the 'right,' as represented by the A.M.A., nor completely with the 'left.' This group thought the vote moved the society somewhat more nearly to the center."

The "Dear Christian" letter to which *The Times* referred was written by Dan Gilbert. Again we must reiterate that the A.M.A. had nothing to do with the preparation or distribution of the Dan Gilbert letter. The February 26 *A.M.A. Journal* said "the Gilbert letter was sent without the knowledge of any official of the A.M.A., that every official of the A.M.A. joins in condemning the letter as an expression of medical opinion in this country, and that the A.M.A. does not require allies of doubtful repute in its campaign for the maintenance of a high quality of medical care and for freedom in medicine in this country."

Sincerely yours,

GEORGE F. LULL, M.D.,
Secretary and General Manager.

March 14, 1949

EDITOR'S NOTE: The headlines inserted are ours.

A STIMULATING CONFERENCE

The thirty-seventh annual conference of component county society secretaries and editors, to which other county society representatives were also invited, was attended by 121 county society officers and committee chairmen. Twenty-two state medical society officers and miscellaneous representatives were also in attendance (see catalogued roster of attendance below).

The officers who sponsor these annual two-

day meetings, while disappointed that 14 county societies were without representation, were highly pleased with the program and the deep interest and faithful attendance displayed by all. That increased "every member" attendance and participation at and in society activities at the county level may be one result of this conference is the hope of our state society officers and the committee who planned the program.

The writer is greatly indebted to *Philadelphia Medicine* (March 12 issue) for the faithful and very readable story of the program which follows the attendance record.

Attendance Record

The societies having no representation were Bedford, Berks, Carbon, Centre, Clinton, Crawford, Franklin, Indiana, Monroe, Potter, Somerset, Susquehanna, Wayne-Pike, and Wyoming. Of our 60 component county medical societies, 46 were represented by their president, secretary, editor, and/or committee chairmen or members, who registered as follows:

ADAMS—John J. Knox,¹ Raymond M. Hale, Jr.,² Raymond F. Sheely,³ Roy W. Gifford,⁵ Eugene Elgin.
ALLEGHENY—Thomas McC. Mabon,¹ William F. Brennan,² Theodore R. Helmbold,⁵ Frederic W. Fagler.⁷

ARMSTRONG—F. O'Neil Robertson,¹ Cyrus B. Slease.²

BEAVER—James G. Weyand.^{4, 5, 6}

BEDFORD—No representation.

BERKS—No representation.

BLAIR—R. Marvel Keagy,¹ George R. Good,² James B. English,³ John O. Prosser,⁴ Elwood W. Stitzel.⁸

BRADFORD—George E. Boyer, Jr.,¹ Stanley D. Conklin,² J. K. Williams Wood,⁴ Dominic S. Motsay.⁵

BUCKS—Allen H. Moore,³ John F. McFadden.^{5, 6}

BUTLER—Charles B. Turnblacer,¹ J. Van S. Donaldson.²

CAMBRIA—Francis T. Carney,¹ Warren F. White,² George Hay,³ Arthur Miltenberger,⁵ Thomas J. Cush.⁸

CARBON—No representation.

CENTRE—No representation.

CHESTER—Alfred L. Chicote,¹ William Limberger,^{4, 5} Julius Margolis,⁸ George W. Truitt.

CLARION—I. Dana Kahle.

CLEARFIELD—Maximo J. Tornatore,¹ George C. Covalla,² Ward O. Wilson,⁴ Francis D. Taylor.⁸

CLINTON—No representation.

COLUMBIA—G. Paul Moser,¹ Otis M. Eves,³ Jacques H. Mitrani,⁴ Joseph V. M. Ross.⁸

CRAWFORD—No representation.

CUMBERLAND—E. Blaine Hays,¹ Richard R. Spahr,² Creedin S. Fickel.^{4, 5}

DAUPHIN—A Harvey Simmons,¹ Hamblen C. Eaton,² George L. Laverty,⁴ John A. Daugherty,⁶ Joseph C. Bolton, A. S. Cobb.⁷

1. President.

2. Secretary.

3. Editor.

4. Chairman, Committee on Public Health Legislation.

5. Chairman, Committee on Public Relations or Medical Service and Public Relations.

6. Chairman, Committee on Medical Economics.

7. Executive secretary.

8. President-elect.

Personalities at the Conference



1



2



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6

1) Former Congressman Forest A. Harness addresses the conference at the dinner. (2) Three members of the program committee, *left to right*, George R. Good, Altoona; James Z. Appel, Lancaster; and Wilbur R. Flannery, New Castle. (3) Archibald Laird, Wellsboro, points out publicity releases to William F. Brennan, Pittsburgh. (4) Two of the speakers—Mr. George Grey, editor of the Uniontown *Evening Standard*, and Mrs. Paul C. Craig, Reading, president of the Auxiliary. (5) President-elect Samuel and President Engel discuss the program with former Congressman Harness, *center*. (6) Delaware County editor, Irvin Stiteler, *left*, and Butler County secretary, J. Van S. Donaldson, *right*, confer with Vice-president Louise Gloeckner, Conshohocken.

DELAWARE—Walter E. Wentz, Jr.,¹ Walter E. Egbert,² C. Irvin Stiteler,³ John J. Sweeney,^{4, 5, 6}
 ELK—Robert J. Dickinson.²
 ERIE—Russell B. Roth,² Carl B. Lechner.³
 FAYETTE—Harold L. Wilt,¹ Alfred E. Wright, Jr.,³ Howard F. Conn.⁵
 FRANKLIN—No representation.
 GREENE—C. Leonard O'Connell,² Bruce R. Austin.⁶
 HUNTINGDON—John M. Keichline.⁶
 INDIANA—No representation.
 JEFFERSON—S. Meigs Beyer.⁴
 JUNIATA—Robert P. Banks.²
 LACKAWANNA — Victor J. Margotta,² Martin T. O'Malley,⁵ Frederic B. Davies.
 LANCASTER—Edgar W. Meiser,³ James Z. Appel,^{5, 6} William F. Hartman.
 LAWRENCE—Charles H. Whalen,¹ Wilbur E. Flannery,^{2, 3} Mary Baker Davis.⁸
 LEBANON—Herbert C. McClelland,¹ J. DeWitt Kerr.²
 LEHIGH—Robert L. Schaeffer,⁵ Joseph D. Rutherford.
 LUZERNE—M. Clark Johnson,¹ Joseph W. Ehrhart.²
 LYCOMING—James H. Burrows,¹ Edward Lyon, Jr.²
 McKEAN—John L. Neill.⁵
 MERCER—James W. Emery,¹ James A. Biggins.^{4, 5}
 MIFFLIN—Edward E. Reiss, Jr.,¹ John R. W. Hunter, Jr.²
 MONROE—No representation.
 MONTGOMERY — Joseph L. Hunsberger,¹ Alice E. Sheppard,² Charles E. Price,³ Edwin F. Tait.⁵
 MONTGOMERY—J. Reed Babcock,¹ Howard T. Fiedler,² James A. Collins,⁴ Walter I. Buchert.⁶
 NORTHAMPTON—Paul E. Schwarz,¹ James B. Butchart,⁸ Dudley P. Walker.
 NORTHUMBERLAND—Mark K. Gass.^{2, 3}
 PERRY—Amos G. Kunkle.²
 PHILADELPHIA—William F. Irwin,⁷ Joseph W. Post.
 POTTER—No representation.
 SCHUYLKILL—Charles V. Hogan,² James J. Monahan.⁵
 SOMERSET—No representation.
 SUSQUEHANNA—No representation.
 TIOGA—David E. Lewis,¹ Archibald Laird.³
 VENANGO—Gale H. Walker.⁸
 WARREN—John C. Urbaitis,² LeRoy E. Chapman.^{5, 6}
 WASHINGTON—Clarence A. Crumrine,¹ Robert W. Dunlap,³ Guy H. McKinstry.^{5, 6}
 WAYNE-PIKE—No representation.
 WESTMORELAND — John F. Maurer,¹ William E. Marsh,^{2, 3} D. Ray Murdock,⁵ Russell A. Garman.⁸
 WYOMING—No representation.
 YORK—James E. Throne,¹ Oscar A. Delle,⁴ Hedley E. Rutland.⁶

State Society representatives present (not in catalogued roster of attendance) were President Engel, President-elect Samuel, first and fourth Vice-Presidents Gardner and Gloeckner, former Presidents Borzell and Petry, Secretary-Treasurer Donaldson, Assistant Secretary-Treasurer Berkheimer; nine members of the Board of Trustees—Drs. Sweeney, Conahan, Hogan, Appel, Brown, Klump, Whitehill, Altemus, and Gagon; Chairman Jones, Committee on Medical Economics, Vice-Chairman Deckard, Committee on Public Health Legislation. Also pres-

ent were Dr. Bengs, representing the State Health Department; Messrs. Diller, Donley, Gale, Jenkins, Lawry, and Wray of the MSAP; Mr. Cobaugh, Executive Secretary, Pennsylvania State Dental Society; Mr. Worman, representing the Hospital Association of Pennsylvania. Others present were Messrs. Perry, Stewart, Jansen, Brown, Richards, and Hutchison of the State Society's headquarters staff.

The Philadelphia Story

The thirty-seventh annual Conference of Secretaries and Editors of Component County Societies of the State Medical Society was held in Harrisburg on March 3 and 4, 1949. The program was a diversified one and the interest and enthusiasm shown by those in attendance was outstanding. The following subjects were presented:

THURSDAY AFTERNOON, MARCH 3

*What Does the Woman's Auxiliary Expect from the County Medical Society? **

Mrs. Paul C. Craig, president of the State Auxiliary, called attention to the efforts being made within the Auxiliary to have its members understand the present problems of medical care and to work wholeheartedly together along the principles enunciated by the A.M.A. and its state and county component societies.

Public Relations.

Dr. Howard K. Petry, chairman of the State Society's Committee on Public Relations, made the following constructive suggestions relative to the public relations program of county societies:

1. Assign a job to every physician.
2. Appoint active committees.
3. See that members are informed.
4. Provide space in monthly meeting programs for medical economic problems as well as scientific matters.
5. Furnish information to physicians which they can impart to their patients.
6. Have active speaker's bureau.
7. Give full support to voluntary insurance plans.
8. Secure support of other local professional and lay groups.
9. Cooperate with Woman's Auxiliary.
10. Use waiting rooms as showrooms to educate the public.
11. Urge every physician to conduct himself so as to please the patient.

Dr. Petry called attention to the relatively few members of the A.M.A. who could be depended on for active help in behalf of the activities of organized medicine and pleaded for the interest of more physicians. He then called upon Dr. Frederic B. Davies of Lackawanna County and Dr. James Z. Appel of Lancaster County to describe the excellent public relations activities in their respective areas.

*Responsibility of Local Society in Disciplining Members.**

Dr. Charles V. Hogan, trustee and councilor of the Fourth District, called attention to the necessity for

* This paper will be published in a subsequent issue of the JOURNAL.

physicians and medical organizations to uphold the Principles of Medical Ethics and investigate any infractions.

Medical Publicity and Radio-Press Relations.

Mr. George Grey, editor of the *Uniontown Evening Standard*, stressed the necessity for medicine to improve its public relations and to make practical use of the press for this purpose. He felt that we cannot permit a too strict interpretation of medical ethics in regard to the use of physicians' names in newspaper releases. He urged the profession to develop a closer working relationship with the press. He said that we should inform the public that medicine is not maintaining a status quo position and endeavor to offset the vicious propaganda which is emanating from the Federal bureaucracy.

Mr. David Bennett, manager of Radio Station WKBO, Harrisburg, called attention to the greater potential audience over the air as compared to the reading public and to the present interest of radio stations in using local news items which previously were sent only to the press. He suggested that the county society find out who is handling news items at the local radio stations and work in close cooperation with these persons. He also recommended that the advice of the station personnel be sought in planning a radio program. The following types of radio programs are available to the profession:

1. Current news items.
2. Short talks on scientific subjects to fill in broadcast periods of from five to fifteen minutes.
3. Panel or round table discussions.
4. Forums.
5. Transcriptions.
6. Dramatic—this is generally on an amateur level and is not too practical.

He called attention to the problem of "mike fright" and suggested that the important thing to remember is to keep talking so as not to lose your audience. He said that radio stations themselves cannot express official opinions on controversial subjects because of the risk of losing their license.

Mr. Leo E. Brown, executive assistant of the Committee on Public Relations of the State Society, described the A.M.A. national education campaign with particular reference to the organization and activity at the local level. He referred to the variety of material which will soon be available to physicians and the laity to arouse public opinion concerning the dangers of socialized medicine, and the accomplishments of medicine in the field of private enterprise. He particularly emphasized the important immediate job which must be assumed by every county society and every individual physician, as well as the important use of lay groups.

EVENING SESSION

The guest speaker in the evening was former Congressman Forest A. Harness, chairman of House of Representatives Committee on Publicity and Propaganda, 80th Congress. Mr. Harness spoke of the terrific pressure from Washington in favor of a greater government bureaucracy which is particularly exemplified by its present attempt to socialize medicine. He called attention especially to the important job which medicine faces in the field of public relations and the necessity for physicians to get into politics and to carry the message of medicine to the "street corners" of the nation. An abstract of his excellent and timely talk will be published shortly in *Philadelphia Medicine*.

FRIDAY MORNING, MARCH 4

Hospital and the Private Physician.

Dr. Elmer Hess, member of the Council on Medical Service of the A.M.A., strongly urged physicians to take an active interest in all phases of hospital operation and to take a united stand in matters affecting the professional side of the institutions. Physicians were also urged to serve on boards of trustees of hospitals or, at least, to insist on professional liaison with them. Furthermore, the medical profession must take a greater interest in hospital deficits and the financial operations of hospitals. He felt sure that any hospital problems affecting the physician, superintendent, and board of trustees can be worked out if the correct approach is made.

*Orientation of New Members.**

Dr. George S. Klump, trustee and councilor of the Seventh District, gave an excellent talk on the influence which older physicians must bring to bear on the young physicians in the interest of their future medical career.

Rheumatic Fever.

Dr. Andrew B. Fuller, chairman of the State Society Commission to Study Control of Rheumatic Fever, explained the present plan of the commission to survey the incidence of rheumatic fever in Pennsylvania in persons under 21 years of age. He asked for the assistance of the county societies in securing the cooperation of individual physicians in furnishing the postal card data requested by the commission. These cards will be sent to physicians on request.

Medical Society Influence in MSAP Enrollment.

Dr. Bruce R. Austin, past president of Greene County Medical Society, described the activities of his organization in stimulating local interest in voluntary insurance plans and the excellent results obtained. The natural conclusion to be reached from this is that every county society can do likewise both with respect to increasing public interest in voluntary plans as well as the need for all physicians becoming participating physicians in Blue Shield.

A vote of appreciation was given to the program committee (Drs. George R. Good, Blair County; Wilbur E. Flannery, Lawrence; Joseph C. Bolton, Dauphin; and James Z. Appel, Lancaster), also Dr. Walter F. Donaldson, for their efforts on behalf of the meeting, which was considered very worthwhile by everyone present.

EXCERPTS FROM A.M.A. SECRETARY'S LETTER OF MARCH 7

Blood Banks. The American Medical Association's Committee on Liaison with the American Red Cross National Blood Program has one immediate objective: to find out where private blood banks in the country are located.

The A.M.A. committee, headed by Dr. L. W. Larson, of Bismarck, N. D., met jointly in Washington, February 13, with the Executive Committee and the Committee on Blood and Blood Derivatives of the Advisory Board on Health Services of the American Red Cross.

It was disclosed that there would be 34 Red Cross blood centers in operation by July 1, 1949.

At the Washington meeting, officials of the Red Cross reaffirmed their determination to abide by the policies established by the A.M.A. House of Delegates.

Pursuant to a directive from the House of Delegates at St. Louis, the committee developed a plan to survey the private blood bank situation throughout the country.

Cooperating with the A.M.A. in the survey will be the American, Protestant, and Catholic Hospital Associations, American College of Surgeons, College of American Pathologists, American Society of Clinical Pathologists, American Association of Blood Banks, the Red Cross, and the National Research Council.

To learn where the blood banks are located, letters with a return post card enclosed will be sent to every registered hospital. The attention of the county medical societies and the pathologists will be directed to this preliminary part of the survey in order that a complete return may be obtained.

"Plans for the second phase of the survey will be developed shortly," Dr. Larson said after the session. "This will involve a detailed questionnaire concerning the organization and direction of the private blood banks, number of blood units processed annually, charges, etc."

This is an important project. At present, the total blood bank resources of the nation are unknown. When this project is completed, information will be available indicating what further expansion is necessary and how mobilization of these resources can be achieved rapidly in case of emergency.

Dr. Sensenich Addresses 1500 at Clinical Conference. Dr. Roscoe L. Sensenich, South Bend, president of the A.M.A., told the fifth clinical conference of the Chicago Medical Society, March 1, that advocates of compulsory sickness insurance are trying to confuse the public into believing that this form of governmental health regulation does not represent the socialization of medicine.

"No matter by what name we describe this government compulsory insurance plan," he said, "it is not a desirable physician-patient relationship, but represents a government-physician and a government-patient control."

"We are dealing with governmental control of medical services by political agents of government, regardless of what name may be applied to the system by those who seek to advance the political control of individual lives."

Labor Official Hits Socialized Medicine. Addressing 700 officials of teamster locals in Chicago recently, David Beck, executive vice-president of the AFL International Brotherhood of Teamsters, said that he was "unalterably opposed to socialized medicine because I believe it will rob men of their incentive to do the best job that is in them."

Illinois Expands Machinery for Campaign. The Illinois State Medical Society held an enthusiastic meeting in Chicago, February 27, to set up the expanded machinery needed to bring its educational work into more precise alignment with the national A.M.A. program. Their committee called together in Chicago more than 150 speaker representatives of the 91 component county societies and woman's auxiliaries to (1) enlarge the speakers' bureau and (2) to instruct the local committees in each society's jurisdiction.

Each registered speaker was supplied with a set of "speaker's notes," mimeographed on pocket-size cards, which will eventually cover the entire subject of compulsory sickness insurance. The cards, heavy enough to stand handling, will afford each speaker a wide selection of material, statistics, arguments, quotations, and other data in condensed form, from which he may choose what best fits his own views, his audience, and his time. It is a novel and interesting idea to reduce speakers' research time and insure uniformity and accuracy of presentation. The system will be operated like a loose-leaf encyclopedia, through which each possessor, registered in a special file, will be supplied within forty-eight hours with numbered cards bearing new material as available or required by the situation.

Gross Errors in Washington Report. Referring to the recent A.M.A. campaign meeting in Chicago, the February 14 issue of *Washington Report on the Medical Sciences* said that "one may be certain that the \$25 assessment was characterized as a blundering tactic by more than one state society delegate . . . that the assessment will be rescinded, in view not only of opposition by A.M.A. members but antipathy which it has engendered on the part of members of Congress who otherwise lack sympathy for compulsory health insurance, would be less than an extravagant prediction."

In a letter to Gerald G. Gross, editor of the publication, I called attention to the "very bad pieces of reporting." To the first statement referring to delegate criticism, I said that "to my knowledge, and I was present during the entire proceedings, not one voice was raised in protest." Then I added: "The second statement that the assessment will be rescinded certainly is founded on conjecture, which is far from true."

Sincerely yours,

GEORGE F. LULL, M.D.,
Secretary and General Manager of A.M.A.,
535 N. Dearborn St.,
Chicago 10, Ill.

CHANGES IN MEMBERSHIP OF COUNTY SOCIETIES

New (92) and Reinstated (8) Members

ALLEGHENY COUNTY: Charles F. Baltimore, Homestead; John E. Baltzer, James J. Brungo, Vincent P. Burby, Philip A. Coletta, Aaron N. Finegold, John C. Henthorne, and William H. Miller, Pittsburgh; Robert E. Haughey, McKeesport.

BLAIR COUNTY: John A. Ayres, Tyrone.

BUTLER COUNTY: Frank Edwards and John Vesley, Butler.

CHESTER COUNTY: Moses I. Francis, Coatesville.

COLUMBIA COUNTY: Robert Klein, Bloomsburg.

CRAWFORD COUNTY: Robert Hendricks, Meadville.
(R) Walter C. Ferer, Meadville.

DELAWARE COUNTY: Percy O. Batipps, Jr., Media; John A. Calhoun, Jr., Swarthmore; Max Harris, Havertown.

FRANKLIN COUNTY: Donald G. Egolf, Dry Run; Charles J. Shapiro, Chambersburg.

JEFFERSON COUNTY: Jean Audrey Cooper, Punxsutawney.

LEHIGH COUNTY: Robert F. Brennan, Henry H. Fetterman, Gustave Gorisse, William H. Henninger, Harry Hoffman, Jean Salines, and John M. Siegel, Allentown.

LUZERNE COUNTY: Frederick C. Bachman, Hazleton; Marian Agnew Campbell, Richard E. Crompton, and John D. Groblewski, Kingston; Morton W. Groves, Ashley; Alfred F. Slivinski, Luzerne.

LYCOMING COUNTY: Charles J. Bishop and Joseph Francis Campana, Williamsport.

McKEAN COUNTY: Jacob William Holler, Bradford.

MERCER COUNTY: S. Victor King, Jr., Sharon; Katharine A. Kline and Robert W. Monroe, Greenville; Francis L. Lally, Sharpsville.

MONROE COUNTY: (R) George Zehner, Tannersville.

MONTGOMERY COUNTY: William M. Faber, Pottstown; Ray Herbert Flory, Philadelphia; Ernest H. Heydt, Jenkintown. (R) John C. Burns, Wyncote.

MONTOUR COUNTY: Drake Pritchett, Danville.

NORTHUMBERLAND COUNTY: Richard G. Smigelsky, Mt. Carmel.

PERRY COUNTY: Frank A. Belmont and O. K. Stephenson, New Bloomfield; Paul Karlik, Jr., Duncannon; Robert N. Reiner, Loysville.

PHILADELPHIA COUNTY: Anthony J. Alosi, Joseph A. Balin, Solomon L. Balin, Robert S. Boyer, Robert M. Bucher, Nicholas A. Canuso, Ray Cramer, Stewart M. Finch, John H. Freed, Zachary B. Friedenberg, Samuel D. Gaev, Walter S. Gan, Arthur Packer Hitchens, John K. Knorr, III, Charles F. Kutteroff, E. G. McGruder, Sara A. Mercer, Harold H. Morris, Mildred R. Mitchell, Henry Rothkoff, William T. Shannon, Brandt F. Steele, William H. Sullivan, Wilbur C. Thomas, Arno E. Town, C. Robert Wells, Alfonso A. Willard, and Paul C. Wittman, Philadelphia; Gilbert M. Baynes, Lansdowne; Maurice L. Brown, Bala-Cynwyd; Charles M. Gruber, Jr., Drexel Hill; J. Vernon Knight, Guadalajara, Mex.; Cornelia E. Motley, Wynnewood. (R) Daniel E. Boyle, New Jersey; E. J. Moore, Jr., Merion Station.

SCHUYLKILL COUNTY: Kurt Hortner, Pine Grove; Glenn P. Schwalm, Valley View. (R) Sigmund M. Jaczack, Tamaqua.

SUSQUEHANNA COUNTY: Vincent G. Hammond, Susquehanna.

TIoga COUNTY: Patrick M. Berzito and Benjamin Sarota, Blossburg; Lamar E. Haupt, Lawrenceville.

VENANGO COUNTY: M. C. Dinberg, Oil City.

WARREN COUNTY: Jack A. Wolford, Warren.

WASHINGTON COUNTY: James B. Byrne, Marianna; Wallace G. McCune, Washington. (R) Arthur A. Paluso, Charleroi.

WESTMORELAND COUNTY: Earl B. Gilbert, Jr., Scottsdale. (R) Gertrude W. Baldwin, Greensburg.

Resignations (25), Transfers (17), Deaths (10)

ADAMS: *Transfer*—John P. Rhoads, Tioga, to Tioga County Society.

ALLEGHENY: *Transfers*—John P. Goff, Lebanon, to Lebanon County Society; James C. McElree, Sharon,

to Mercer County Society; John J. McParland, Jamestown, to Mercer County Society; Edw. L. Ringer, Monessen, to Westmoreland County Society. *Resignations*—William J. Fedack, Copperhill, Tenn.; Albert H. Christman, Long Beach, Calif.; Ermo P. Ingel, Washington, D. C.; Frank E. Hollstein, Thomas E. Allen, Richard D. Shelby, and Robert A. Rupp, Pittsburgh; Leon H. Hetherington, Baltimore, Md.; Joseph P. Tomsula, Baton Rouge, La., and Robert G. Heath, New Orleans, La. *Deaths*—Eugene J. Schachter, Brad-dock (Univ. Indiana '26), February 3, aged 47; Herbert E. Woelfel, Bellevue (Univ. Pa. '08), February 13, aged 66.

BERKS: *Transfer*—Roletta Jolly-Fritz, Allentown, to Lehigh County Society.

BLAIR: *Death*—Clair E. Robison, Altoona (Jeff. Med. Coll. '03), January 27, aged 69.

BUCKS: *Resignations*—Roscoe C. Magill, New Hope; Joseph J. McHugh, Putnam County, Ohio.

COLUMBIA: *Transfer*—Jesse W. Gordner, Jr., Danville, to Montour County Society. *Death*—George F. Drum, Mifflinville (Balt. Univ. '00), February 1, aged 76.

DAUPHIN: *Transfer*—John A. Bealor, Danville, to Montour County Society.

ERIE: *Resignations*—James J. Dusckas and Norman B. Tannehill, Erie. *Deaths*—Oscar W. Renz, Erie (Coll. Phys. & Surg. '15), February 3, aged 56; Arthur G. Davis, Erie (Univ. Buffalo '13), February 20, aged 62.

FAYETTE: *Transfer*—Earl W. Hemminger, Kittanning, to Armstrong County Society.

LACKAWANNA: *Transfer*—George C. Glinsky, Butler, to Butler County Society.

LANCASTER: *Resignations*—John S. Gates, Mt. Joy; William M. Simons, Columbus, Miss.

LAWRENCE: *Resignation*—Charles F. Kissinger, E. Palestine, O.

LUZERNE: *Transfer*—George A. Truckenmiller, Sayre, to Bradford County Society. *Death*—Edmund F. Hanlon, Hazleton (Jeff. Med. Coll. '27), February 16, aged 45.

LYCOMING: *Transfers*—Daniel E. Witt, Bloomsburg, to Columbia County Society; Joseph P. Robinson, Bethlehem, to Northampton County Society. *Resignation*—John W. Matthews, Edinburg, Texas.

MONTGOMERY: *Transfer*—James N. Edmunds, Scranton, to Lackawanna County Society.

NORTHAMPTON: *Transfer*—Henry A. Rothrock, Jr., West Chester, to Chester County Society.

PHILADELPHIA: *Transfers*—H. Craig Bell, Abington, and Martin Alex. Myers, Philadelphia, to Montgomery County Society; David D. Dunn, Erie, to Erie County Society. *Resignations*—Francis J. Audin, Newton Highlands, Mass.; C. Van Deusen, Lewistown, N. Y.; Curtiss B. Hickox, Hartford, Conn.; Ethel C. Russell, New Paltz, N. Y.; Thomas A. Schroth, Philadelphia; Charles O. Tyler, Haddonfield, N. J. *Deaths*—Eugene Rush, Philadelphia (Jeff. Med. Coll. '14), February 19, aged 61; Thomas S. Stewart, Philadelphia (Univ. Pa. '01), February 19, aged 73.

SCHUYLKILL: *Death*—Cyril A. Whalen, Mahanoy City (Univ. Pa. '34), January 25, aged 40.

CONTRIBUTIONS TO MEDICAL BENEVOLENCE FUND

The Committee on Medical Benevolence makes grateful acknowledgment of the following contributions to the fund. These have also been previously acknowledged individually.

Woman's Auxiliary, Lehigh County, in memory of Mrs. F. A. Fetherolf	\$10.00
Woman's Auxiliary, Northumberland County	55.00
Woman's Auxiliary, Hazleton Branch of Luzerne County	100.00
Woman's Auxiliary, Erie County	200.00
Woman's Auxiliary, Crawford County	75.00
Woman's Auxiliary, Lycoming County	300.00
Internatl. Ladies Garment Workers Union (Luzerne County), in memory of Mrs. Mildred Reese	5.00
Woman's Auxiliary, Delaware Medical Club ..	25.00
Woman's Auxiliary, Clearfield County	50.00
Woman's Auxiliary, Montgomery County	100.00
Woman's Auxiliary, Mifflin County	40.00
Woman's Auxiliary, Potter County	10.00
Woman's Auxiliary, Elk County	30.00
Previously reported	792.68

Total contributions since 1948 report\$1,792.68

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since Jan. 31, 1949. Figures in first column indicate county society numbers; second column, State Society numbers.

Feb. 1	Clarion	21-22	3237-3238	\$30.00
	Erie	190-191	10519-10520	30.00
	Erie	1-156	3239-3394	2,340.00
	Carbon	1-21	3395-3415	315.00
	Lackawanna	279	10521	15.00
	Lackawanna	144-151	3416-3423	120.00
	Westmoreland	109-121	3424-3436	195.00
	York	135-142	3437-3444	120.00
	Lancaster	4-146	3445-3587	2,145.00
	Bradford	15-23	3588-3596	135.00
	Northumberl'd	27-54,		
		56-58	3597-3627	465.00
	McKean	8-17	3628-3637	150.00
	Berks	180-192	3638-3650	195.00
	Delaware	191-200	3651-3660	150.00
2	Mifflin	1-10	3661-3670	150.00
	Cumberland	29-31	3671-3673	45.00
	Northampton	155-165	3674-3684	165.00
	Franklin	56-62	3685-3691	105.00
4	York	143-144	3692-3693	30.00
	Blair	1-91	3694-3784	1,365.00
	Lycoming	1-118	3785-3902	1,755.00
5	Mercer	1-50	3903-3952	750.00
	Lebanon	13-45	3953-3985	495.00
7	Armstrong	23-36	3986-3999	210.00
	Centre	1-17	4000-4016	255.00
	Dauphin	103-110,		
		112-122	4017-4035	285.00
	Berks	193-202	4036-4045	150.00
	Lawrence	47, 50-61	4046-4058	195.00
	Somerset	15-20	4059-4064	90.00

Feb. 7	Chester	1-86	4065-4150	\$1,290.00
	Chester	1948	10522	7.50
8	Westmoreland	122-143	4151-4172	330.00
9	Columbia	39-41,		
		44-46	4173-4178	90.00
	McKean	18-25	4179-4186	120.00
10	Schuylkill	1-82	4187-4268	1,230.00
	Warren	27-28	4269-4270	30.00
	Butler	42-58, 60	4271-4288	270.00
	Indiana	27-31	4289-4293	75.00
11	Bucks	70-74	4294-4298	75.00
12	Lackawanna	152-174	4299-4321	345.00
	Cumberland	32-35	4322-4325	60.00
14	Delaware	201-217	4326-4342	255.00
	Butler	61-63	4343-4345	45.00
	Warren	29-30	4346-4347	30.00
	Berks	203-214	4348-4359	180.00
	Indiana	32-33	4360-4361	30.00
	Fayette	48-85	4362-4399	570.00
15	Montgomery	75,		
		197-220,		
		272-291	4400-4444	675.00
	Bradford	24-28	4445-4449	75.00
16	Westmoreland	144-145,		
		147-164	4450-4469	300.00
	Westmoreland	209	10523	15.00
	Somerset	21-22	4470-4471	30.00
	McKean	26-35	4472-4481	150.00
	Washington	4-105	4482-4583	1,530.00
17	Jefferson	1-40	4584-4623	600.00
	Dauphin	123-146	4624-4647	360.00
	Schuylkill	83-114	4648-4679	480.00
	Franklin	63-71	4680-4688	135.00
	Columbia	47	4689	15.00
18	Clearfield	29-41	4690-4702	195.00
	Monroe	1-37	4703-4739	555.00
	Northampton	166-185	4740-4759	300.00
	Lebanon	49-55	4760-4766	105.00
	Centre	18-25	4767-4774	120.00
	Tioga	1-25	4775-4799	375.00
	Allegheny	1287-1425	4800-4938	2,085.00
	Lehigh	1-186	4939-5124	2,790.00
	Northampton	186	5125	15.00
	York	145-152	5126-5133	120.00
	Elk	1-18	5134-5151	270.00
21	Mercer	51-81	5152-5182	465.00
	Butler	64-65	5183-5184	30.00
	Bedford	1-5	5185-5189	75.00
	Lycoming	119-127	5190-5198	135.00
	Bradford	29-33	5199-5203	75.00
	Delaware	218-222	5204-5208	75.00
	Blair	92-108	5209-5225	255.00
	Berks	215-222	5226-5233	120.00
	Warren	31-40	5234-5243	150.00
	Lancaster	147-190	5244-5287	660.00
	Fayette	86-89	5288-5291	60.00
	Indiana	34	5292	15.00
	Northumberl'd	59-66	5293-5300	120.00
	Clearfield	42-44	5301-5303	45.00
	Mifflin	11-23	5304-5316	195.00
	McKean	36-41	5317-5322	90.00
	Luzerne	1-170	5323-5492	2,550.00
22	Carbon	22-26	5493-5497	75.00
	Cumberland	36	5498	15.00
	Bucks	75-76	5499-5500	30.00
23	Susquehanna	1-14	5501-5514	210.00
	Venango	1-5, 50-75	5515-5545	465.00
	Westmoreland	146,		
		165-171	5546-5553	120.00

Feb. 24	Somerset	23-25	5554-5556	\$45.00
	Cambria	5-37, 39-122	5557-5673	1,755.00
	Warren	41-42	5674-5675	30.00
	Fayette	90-91	5676-5677	30.00
	Lackawanna	175-205	5678-5708	465.00
	Philadelphia	50-1618	5709-7327	24,285.00
25	Montour	28-33	7328-7333	90.00
	Bedford	6-10	7334-7338	75.00
	Washington	106-117	7339-7350	180.00
	Clarion	23-24	7351-7352	30.00
	Susquehanna	15-17	7353-7355	45.00
28	Washington	118-130	7356-7368	195.00
	Fayette	92-98	7369-7375	105.00
	Delaware	223-254	7376-7407	480.00
	Lycoming	128-132	7408-7412	75.00
	Westmoreland	172-179, 181-184	7413-7424	180.00
	Lebanon	46-48, 56	7425-7428	60.00
	Berks	1, 224-233	7429-7439	165.00
	Cumberland	37-38	7440-7441	30.00
	Centre	26-30	7442-7446	75.00
	Butler	66-67	7447-7448	30.00
	Carbon	27-28	7449-7450	30.00
	Adams	1-26	7451-7476	390.00
	Susquehanna	18	7477	15.00
	Beaver	1-118	7478-7595	1,770.00
	Crawford	1-40	7596-7635	600.00
	York	153-158	7636-7641	90.00
	Columbia	48-49	7642-7643	30.00

Cushing's syndrome
Neoplasms of the cecum
Sex education (2)
Public health
Social hygiene
Child welfare
Heminephrectomy
Rice diet (5)
Renal insufficiency
Headache
Use of spleen extracts
Prostigmine
Hysterectomy
Pruritus vulvae
Facial paralysis
Mesenteric thrombosis
Mesenteric embolism
Raynaud's disease
Socialized medicine (9)
Insulin in the treatment of alcoholism
Complications of appendicitis
Treatment of chronic brucellosis
Arthritis and undulant fever
Solution G in urinary calculi
Treatment of subacute bacterial endocarditis
Complications following cholecystectomy
Intestinal tuberculosis
Guillain-Barré syndrome
Periodic health examinations
Medical service in schools
Therapeutic uses of vitamin K
Diagnosis and pathology of gastric cancer
Medical management of hypertension
Use of potassium in diabetes
Carcinoma of the breast
Vitamin E in heart disease
Perforation of the gallbladder
Treatment of mental diseases
Subtotal gastrectomies for duodenal ulcer
Saddle block anesthesia in obstetrics
Post-spinal headache (2)
Quinidine therapy in cardiovascular disease
Removal of superfluous hair
Treatment of senile cataracts
Technique of cesarean section
Laryngeal and tracheobronchial diphtheria
Use of implants following enucleation
Dissecting aneurysm of the aorta
External diseases of the eye
Diseases of the kidneys
Hospital administration
Von Recklinghausen's disease
Sexual sterilization
Iridocyclitis
Surgical techniques
Industrial nursing
Syphilis
Tuberculosis (2)
Nutrition
Cancer (2)
Cellulose
Muscle chemistry
Biography of Dr. Bortz
Blood deficiencies
Psychiatry (2)
Contract practice
Medical economics
Diabetes
The Gold-headed Cane

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Prior to 1944 the average yearly number of requests was approximately 350. However, from 1944 to 1948 inclusive, there has been a continuous increase in borrowers. A total of 1192 requests were received during 1948, an increase of 293 over the total for 1947.

One hundred and twenty-four requests were filled from February 1 to February 28 covering the following subjects:

American Indians	Tay-Sachs disease
Treatment of delirium	Ocular bacteriology
Visceroptosis	Prothrombin activity
Antihistamine drugs	Artificial breast
Hospitals	Silicosis
Recruitment phenomenon	Uremia
Ragweed control	Nephrosis
Lead poisoning	Anuria
Obstetrical paralysis	Liver diseases
Rh factor	Old age
Genital tuberculosis	Nurses
Sight conservation	Medical care program
Pregnancy diagnosis	Alcoholism (2)
Heart disease	Bronchiectasis

RETURN AMERICAN MEDICAL ASSOCIATION ORDER CARD PROMPTLY

Each member of the American Medical Association will receive a prepaid postage card upon which to request a colored poster of the beloved and dramatic painting by Sir Luke Fildes, entitled "The Doctor." This poster (20" x 19") labeled "Keep politics out of this picture" is intended for display in each doctor's reception room.

Complete your request card on receipt and mail it at once.

PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division, American Cancer Society, in cooperation with the Pennsylvania Department of Health, Philadelphia Division, American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

Health Department Activity

Postgraduate Refresher Courses.—The Division of Cancer Control of the Pennsylvania Department of Health is financially sponsoring postgraduate courses in the diagnosis and treatment of cancer as part of its professional educational program.

During the present fiscal year two courses for physicians have been given at the University of Pennsylvania and a third is scheduled to begin April 25. This course is of two weeks' duration. Tuition fees amounting to \$150 for each student and a stipend of \$200 is paid by the State. Applications for attendance at these courses may be secured from Robert C. Horn, Jr., M.D., Secretary, Cancer Commission, University of Pennsylvania School of Medicine, Philadelphia.

Research Grant.—The Federal Security Administration has approved a grant of \$35,000 for an Environmental Cancer Study in Industry. This work will be carried on under the direction of Joseph Shilen, M.D., director of the Bureau of Industrial Hygiene.

This research project will consist chiefly of (1) the statistical study and evaluation of all male cancer deaths which occurred in Pennsylvania in 1947, and the determination of the relative incidence of cancer in the various industries; (2) field epidemiologic engineering, chemical, and statistical studies of a selected industry in which a known or suspected single carcinogenic substance exists.

Practicing Physician's Activity

Detection Center. — The Cancer Detection Center represents the practicing physician's attempt to stem the rising tide of cancer. Since the cure of cancer is a race against time, the early detection of this disease is about the greatest contribution that the medical profession can make towards cancer control at the present time.

Two means are available for the early detection of cancer: (1) the education of the lay public with reference to the early symptoms and signs of this disease, and (2) the periodic physical examination of presumably well individuals.

Cancer Detection Centers are directed towards this latter end. They are established for the examination of presumably well individuals for the evidence of pre-symptomatic cancer or for the evidence of conditions in which cancer is prone to develop—leukoplakic areas in the mouth, erosions of the cervix, rectal polyps, etc.

If presumptive evidence of cancer is detected, the examinee is to be referred to a Cancer Diagnostic Clinic for definitive diagnosis. If lesions predisposing to cancer are discovered, the examinee is to be referred for appropriate treatment of these conditions.

There are, today, approximately two hundred Cancer Detection Centers located in various parts of this country. Of the many thousands of presumably well individuals who have been examined, cancer has been detected in approximately 1 per cent; conditions in which cancer is apt to develop have been detected in approximately 25 per cent. From this it appears that these centers may serve to prevent cancer as well as to detect it.

A history form for use in Detection Centers has been prepared by a committee of the Cancer Commission of The Medical Society of the State of Pennsylvania. Printed forms for use in Detection Centers and for such examinations in doctors' offices are available. The committee asks that these forms be given a thorough trial and invites suggestions for their improvement.

Hospital Staff to Treat and Teach

Tumor Clinic.—The patient with known or suspected malignant disease is properly a candidate for the services of a Tumor Clinic. The specialty of oncology is a complex amalgamation of pathology, radiology, surgery, internal medicine, and all the sub-specialties of the profession, so that it is rare indeed that any one individual can function as a competent expert in the differential diagnosis and treatment of cancer. The staff of the Tumor Clinic, composed as it is of men representing these various phases of medical work, stands in the role of a consultant body to give aid to patients who present problems in differential diagnosis or in the proper therapy of cancer. In general, the consultative services of this group are available to doctors and their patients on exactly the same basis as are the services of any individual consulting specialist. For private patients, there is a standard consultation fee. For indigent patients, the service is gratis. The patients benefit by the consolidated advice of a group of men specially trained or interested in the management of cancer; the doctors benefit by the educational virtues of attending the sessions held by such a group; and the long-range activities of such a clinic constitute a valuable contribution to clinical and statistical research in oncology.

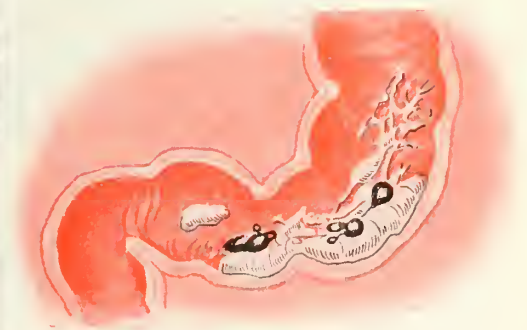
TREATMENT OF CONSTIPATION IN **mucous colitis**

"The treatment of the constipation in mucous colic does not differ from the treatment of uncomplicated constipation. It is, as always, of great importance to avoid irritating aperients, . . . The stools should be rendered soft and more bulky and therefore more easy to expel with . . . and unirritating vegetable mucilages."

—Hurst, A., in Portis, S. A.: *Diseases of the Digestive System*, ed. 2, Philadelphia, Lea & Febiger, 1944, p. 692.



MUCOUS COLITIS. In this x-ray is shown the distinctive string-like appearance of the descending portion of the lower bowel in mucous colitis, a condition frequently accompanying severe degrees of spastic or atonic colon. In the sagittal section is shown the over-secretion of mucus adhering to the bowel wall.



By providing soft, demulcent, water-retaining, mucilloid bulk, Metamucil—the "smoothage" treatment of constipation—promotes a return to normal elimination.



METAMUCIL® is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%), as a dispersing agent.

SEARLE *Research in the Service of Medicine*

G. D. SEARLE & CO., CHICAGO 80, ILLINOIS

VENEREAL DISEASE NOTES

Published Through the Cooperation of the Pennsylvania Department of Health
and The Medical Society of the State of Pennsylvania

There should be no syphilis in Pennsylvania since this disease can be sterilized in twenty-four hours and cured in ten days (or even less). Why, then, should the killer run wild? The reason is simple. Too often "he" is not discovered until he has let loose poison enough to kill countless people. When he is caught, too often he is not kept in a corner until he has been destroyed. When this occurs, it is many times due to neglect on the part of some person who is employed to solve such problems.

The doctor who happens to come in contact with syphilis has a responsibility to everybody else, whether he practices his art in a private office or in a public clinic. It may properly be said that the public clinic often is neglectful of its duty. Proper facilities for a one hundred per cent follow-up of patients with syphilis do not exist anywhere. In the public clinic such facilities are available to a degree, but many times are inadequate. Until a one hundred per cent investigation and follow-through service is made available to both the public clinic and private medicine, syphilis, the killer, will go merrily on his way.

Quarantine should be invoked more generally. Persons who refuse to take measures for the protection of others should be quarantined and treated. Persons who through ignorance are neglectful of others should be instructed properly and should be given the opportunity to receive treatment. When such persons refuse to heed instructions, they should be kept in quarantine until by means of treatment they are cured or rendered harmless. Afterwards they should be followed up until all danger of transmitting infection has passed.

This requires a trained and specialized investigation service. No other duties should attach to personnel employed in such a service. This service should be made available to private medicine as well as to public agencies. Utmost care should be exercised in the selection and training of the personnel. The service need not be large, but it must be of high caliber. It would be of untold value in the investigation of contacts, the follow-up of neglectful patients, and the expediting of proper quarantine measures.

Syphilis is an aggregation of small epidemics. If each epidemic is stopped at its source, syphilis would cease to exist. Syphilis should become as much a rarity in Pennsylvania as is smallpox today. No one may say that such an attainment cannot be reached.

The following from a diligent state clinician in a well-operated clinic is of interest:

"In checking with the local physicians, I have come to the conclusion that since the introduction of penicillin and its success in treatment of syphilis the physicians have been treating more of these patients rather than referring them to the clinic as they had done previously during the time of long schedules of treatment.

"The main criticism that I can see is that in these privately treated cases very little attention is given to the history of contacts. All of our doctors should be aware that if they send a list of the contacts to us (the clinic), we will make the necessary investigations, but there are very few of the local doctors who do this."

Another physician of the same type states:

"Your letter brings up again a question which the nurses and I have discussed several times during the past year—the decrease in size of our Venereal Disease Clinic.

"Several factors contribute to this decrease. It is not a 'Chamber of Commerce' spirit that indicates to me an extremely small venereal disease rate in our county, for I take routine blood serologic tests for syphilis on my patients, and in the past two and a half years have had but one positive report—this in a patient with known infection. Conversations with other physicians in active practice confirm this finding.

"Again, with the advent of penicillin, the various men in practice are taking care of more of these patients in their offices, especially the cases of gonorrhea. More than half the men in practice in our county served in the World War and are acutely conscious of the problem presented by venereal infections. They have seen the value of the treatments outlined by the Army Medical Corps and are following these outlines. (The Army uses penicillin alone.—Ed.)

"I take opportunity at the monthly county medical society meetings to bring to the attention of the society the presence of the Venereal Disease Clinic, and we often have some rather forceful arguments—as does every group of doctors—on the merits and demerits of the various forms of treatment. I plan to present to the local hospital staff a summary of some twenty cases of *primary* and *secondary* syphilis that we have treated with POB at the local clinic, and our results.

"I believe that the checking of contacts by the nursing service and their interviews in the clinic are quite good. During the past year we had five male cases of syphilis reported giving a common contact; *the girl involved was examined, found infected, and treated, and now all show negative serologic tests.* To accentuate the social angle, the girl is now marrying one of her five boy friends!

"I believe that the real cause for the small size of this clinic is the small number of cases of venereal infection, especially syphilis, in the county. In conclusion, let me say that we in the clinic are all looking for infections constantly, and we try to keep everybody, including the doctors, aware of the facilities offered by the Department of Health for the treatment and detection of contacts."

The State is gratified when reports are received to the effect that persons with venereal disease are turning to the private physicians for treatment.

EDGAR S. EVERHART, M.D., Chief, Venereal Disease Division.

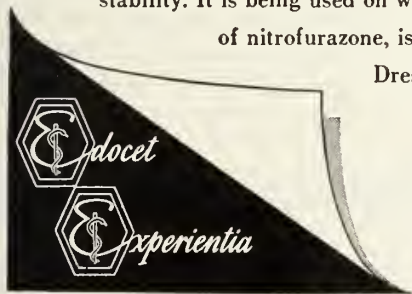
For mixed infections



When a topical antibacterial in liquid form is indicated, Furacin Solution offers this convenience while retaining all the advantages of Furacin Soluble Dressing: a wide antibacterial spectrum including many gram-negative and gram-positive organisms; water-solubility to dissolve in wound exudates; low surface tension to penetrate fissures; non-staining of skin and fabrics; stability. It is being used on wet dressings and as a spray on painful burns. Furacin® brand of nitrofurazone, is available as Furacin Solution (N.N.R.) and Furacin Soluble Dressing (N.N.R.) containing Furacin 0.2%. These preparations are indicated for topical application *in the prophylaxis or treatment of infections of wounds, second and third degree burns, cutaneous ulcers, pyodermas and skin grafts.*

Literature on request.

EATON LABORATORIES, INC., NORWICH, N. Y.



TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the co-operation of the Pennsylvania Tuberculosis Society
and The Medical Society of the State of Pennsylvania

ROUTINE chest x-rays of all hospital admissions is a "mass-survey" method of great importance—comparable in numbers of subjects available only to surveys of industries, communities, or the armed services. While used primarily to find cases of tuberculosis, such surveys also uncover other lung, heart, and chest lesions and increase hospital efficiency.

THE CURRENT STATUS OF ROUTINE CHEST X-RAYING IN GENERAL HOSPITALS OF THE UNITED STATES

The x-raying of general hospital admissions started in 1935 when the Wisconsin General Hospital and the University Hospital in Michigan began x-raying all admissions for a trial period. In 1938 no hospital was taking chest films of all patients, but by 1943 a total of 56 teaching hospitals professed to be taking routine chest x-rays and in 1945 eight per cent of general hospitals indicated that they were taking routine films.

The Current Survey

When information on the subject was sought in the spring of 1948, the data available from groups such as the National Tuberculosis Association, the Public Health Service, the American Hospital Association, and the Veterans Administration were incomplete. It was decided, therefore, to proceed with an independent survey which, even if incomplete, might show trends and supplement the information already at hand.

It seemed wisest to seek information from the state health departments, 42 of which now have tuberculosis divisions and control directors, many of whom are working closely with the Public Health Service. Miraculously, reports were received during August, 1948, from every one of the 48 states. Additional help was received from physicians and from officials of tuberculosis associations.

A brief questionnaire was used to obtain the data and to explain the purpose of the survey. One question was stressed as being most important—"Which general hospitals in your state are now taking routine chest x-rays of all admis-

sions?" Other questions were aimed at finding out whether plans were under way for an increased use of the method; what size film was being used; who paid for the original equipment and for maintenance; and whether cost data were yet available.

The term "general hospital" was used advisedly. There were 6276 registered hospitals in the United States in 1947, of which 4539 were general in type; specialty and federal hospitals were excluded. The patients of general hospitals, moreover, included 93 per cent of the 15,829,514 patients admitted to *all* hospitals, even though they had only 42 per cent of the bed capacity. It is this population—14,665,000 patients, plus another huge number of outpatients each year—which it would be most logical to examine routinely, and about which we would like to know.

Of the 4539 general hospitals in the United States, 247 replied that they were taking routine chest x-rays. Several additional hospitals stated that they had plans and equipment for starting such a program. The equipment for routine chest x-rays was provided by the hospital in 33 instances, by the state for 110 hospitals, by the federal government for 49, and by the city and county for four. The funds for equipment for 40 hospitals were supplied by tuberculosis associations. The survey was supported by the hospital in 92 instances, by the state in 59, and by the city or county in 11. All or part of the cost was borne by the tuberculosis association in nine instances and by a direct charge to the patient in 20 instances.

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to human milk . . . because it may be used either complementary to or in place of human milk . . . because for the normal healthy baby it requires no changing of formula (except an increase in quantity) as the baby grows older. Complete information and samples will be mailed on request.

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The best data for costs in a large-scale operation and the best evidence that a low cost is possible come from the Johns Hopkins Hospital. The operating expense for a 70 mm. unit, including all factors, was 34 cents per patient when 1400 films a month were taken, and 25 cents when 2100 were taken. In community-wide surveys, which compete in some ways with hospital surveys, the Public Health Service has found the usual cost to be about 55 cents per person.

The actual efficiency of the method in the hospitals is highly variable. The term "routine" is a misnomer. Factors which contribute to this partial usage include difficulties of administration, technical inconvenience, lack of an interested director, opposition of staff members, and the exclusion of certain patient groups (infants, obstetrical patients, very ill patients, surgical patients, and private patients). Administration is a more difficult obstacle than the cost of equipment. Since the actual efficiency of the camera film, the 4 x 5 film, the 14 x 17 single film, and paper x-rays is said to be practically the same, cost and convenience are the real criteria for choice.

Summary and Conclusions

A survey has been made to determine the current use of routine chest x-rays in general hospitals of the United States. State boards of health were used as the principal source of infor-

mation. Two hundred and forty-seven of the 4539 general hospitals in the United States are reported to have a program in action. Numerous other hospitals have equipment or plans for starting a program. The number of hospitals now taking routine films is double the number said to be doing so in 1945. Few of the hospitals include all of their patients in these "routine" surveys. Use of the method must be extended to more hospitals, and to more of the registrants of the hospitals if it is to approach its real value. The source of funds for equipment is largely civic, with voluntary groups giving valuable assistance. The "drive" has come from federal, voluntary, and hospital groups. Funds for maintenance of routine x-raying come from both subsidies and charges. Not enough data are available yet to determine the cost of taking the various kinds of x-rays under the diversity of conditions. Charges, where made, are not yet based on an accurate estimation of costs. There is evidence that costs may be decreased. Lack of funds, lack of information, inertia, and the chores of administration are the barriers to wider usage of the method. For each of these problems, there seems to be a solution.

The Current Status of Routine Chest X-raying in General Hospitals of the United States, William H. Oatway, Jr., M.D., Arizona Medicine, January, 1949.

THE INTERN SHORTAGE

The intern shortage is becoming more acute year after year. Many hospitals which provided excellent opportunities for the intern find that they not only cannot secure interns but graduates do not even apply for these positions. These hospitals claim that larger hospitals and those which have a teaching affiliation with a medical school or which are owned by the university of which the medical school is a part absorb such a large number of the graduates that none remain for hospitals not in this class. It must be remembered that ordinarily, in normal times when there is not acceleration of academic years, only about 5200 students are graduated. With some acceleration still in force this number is stepped up to about 5800. But there are approximately 8000 approved internships. Then, too, there are two-year internships, which reduces the number of internships available every year somewhat.

Then there enters another factor—the internships offered by the Army, the Navy, and the U. S. Public Health Service. These internships offer special inducements, particularly financial, thus making them more attractive than what an intern receives from a civilian hospital. The Surgeon General of the Army reports

that his service has received 741 applications for an internship beginning July 1, 1949. Fifty-eight schools were represented. All but 71 of the applicants were physically qualified. Of the 230 who accepted appointments, 119 were in the upper third of their class, 107 in the middle third, and 4 in the lower third. The U. S. Public Health Service received 600 applications and appointed 121 interns for duty in 11 marine hospitals.

Some hospitals have been forced to employ house officers—former interns or young practitioners who wished to have further intern training. Even graduates of foreign medical schools have accepted house officer positions. Of course, it has often been said that some hospitals seeking interns are not entitled to such service, nevertheless these hospitals do seek interns. It has been suggested by hospitals that some plan be devised which would place the approval of hospitals for internships in the hands of one agency. It is felt that it would unsnarl some of the tangles. It has also been suggested that some plan be devised which would set up a quota system for all hospitals, because it is charged that many hospitals take on many more interns than their services actually require.—*Journal of the Association of American Medical Colleges*, January, 1949.

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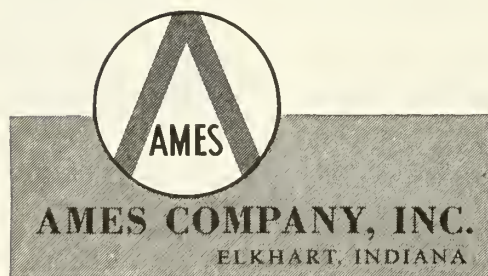
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THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

547 Water Street

Indiana, Pa.

PERSONAL PUBLIC RELATIONS



The February PENNSYLVANIA MEDICAL JOURNAL, in the Auxiliary section (page 542), contained an article by a member who was sufficiently concerned about the problems which face the medical profession to take time to prepare a paper and to give it before a lay group. Some time before this clear and concise bit of writing appeared in print, your president sent a typed copy to one of our councilors, Mrs. William J. Jacoby. She returned the copy, dog-eared and worn, with this comment about its use:

"You will never know how *many* hands this copy has reached since you sent it to me. Mrs. I. E. Smigelsky, executive assistant, and I discussed it with several groups. Then one of the members of her club, not an Auxiliary member, was so interested that she took it to her friends, and their group of about twenty members discussed it thoroughly. All in all, it has reached people who will not allow the subject to die."

Mrs. Kice's "Operation Freedom" and Mrs. Beals' timely sample of this plan of action, appearing in this issue, should stimulate more of us to carry on personal public relations, as did the members who are here mentioned. Whether you talk before an organized group or pass the word along informally, tell the story. There is no more effective way of influencing public opinion. Are you doing your part?

(Mrs. PAUL C.) CATHARINE PALMER CRAIG,
President.

A.M.A. AUXILIARY

A few more months, and the members of the Woman's Auxiliary to the American Medical Association will be arriving in Atlantic City, N. J., for their annual convention, June 6 to 10.

Have you made your reservations? If not, send your request *at once* to Dr. Robert A. Bradley, Chairman, Subcommittee on Hotels, 16 Central Pier, Atlantic City, N. J.

"OPERATION FREEDOM"

This is an urgent appeal for action—immediate and all-out action!

Auxiliary members well know the purpose and aims of the bills S. 5, H. R. 783, and H. R. 345 now being readied for Congress. If these should pass, it would mean compulsory health insurance—a plan which is utterly abhorrent to the American way of thinking.

In the past we have been doing what we could to help combat all attempts to set up a compulsory insurance plan. Now we are called upon to make a supreme effort. This measure may be given to Congress in a matter of weeks.

Our task is to mobilize within the Auxiliary and help mobilize without, to bring the truth to millions of Americans whose concerted voice can be raised in opposition to the proposed bill. This has been spoken of as a war, but it is more than that. War is destructive. Our plan is constructive. We are not on the defensive, nor are we merely going on record as opposed to an idea. We are proposing an alternative—voluntary health insurance. We are engaged in "Operation Freedom."

Who is better qualified to bring this story to the people of our country than the wives of doctors? We must propel their ideas—the program of the American Medical Association—to the public, the man and woman on the street. They want to know how this important matter will affect them as individuals. They are ready to listen. If we fail to take advantage of this opportunity, we alone are to blame. Further, we have a definite duty to acquaint the public with the facts. This measure is not just a threat to the medical world. It is a threat to the people.

That is why this appeal is being taken to every member of the Auxiliary, on every level. It is a matter that must reach down to the grass roots. The last national election taught us the value of keeping in touch with the average American. It is a lesson that we cannot afford to ignore.

There is no question about where we stand. We must warn everyone we meet against this idea which has been well described as "pernicious political medicine." But we must be factual. *We must educate, not antagonize.*

First, the public must be alerted and warned as to what the results of compulsory insurance would be. Every Auxiliary member should know the provisions of S. 5 and its possible effect upon the medical structure of our country. There is no question that a definite problem exists, but compulsory insurance is not the answer. It is not possible to legislate health. The solution, as the American Medical Association plan points out, is dependent upon other factors and the further development of voluntary health insurance plans.

The medical world is not opposed to government participation in the fight against disease and sickness. The government has its place in the health picture and can



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work with the medical profession in complete cooperation and agreement. But government *control* is not a substitute for good medical care.

These points we must bring out by every means at our disposal, and without delay. The respect our legislators have for us is in direct proportion to the respect that the general public has for us. We can gain that respect only through a clear, understandable explanation of the facts.

A plan is being provided for us. The final result will depend upon our application of that plan. We should not forget that our aim is not only the defeat of this measure but expansion of the voluntary health insurance system as well.

The rallying call must be heeded now by every member of the Auxiliary. Our position in this final and challenging contest is clearly defined. Our special part in this program will be provided for us in detail, and will call for endorsement from women's organizations, distribution of literature, assignment of speaking engagements, and development of publicity. Our role will be one of helping our parent organization carry this campaign to a rapid, successful, and definite conclusion, but we must make no mistake about it—our role is vital to the entire program.

Our attention and efforts are naturally focused on this major task of defeating compulsory health insurance, but we cannot ignore our other duties as Auxiliary members. Perhaps the most important of these is the necessity for realizing that we are a great, unselfish organization devoted to the betterment of human beings.

Never has there been so urgent a need for the American people to hear our message and know our program.

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We can best fill this need by turning our efforts toward cooperation with other health agencies. For example, we have won recognition by helping to create interest in the forming of local health units. Your president attended each of the three conferences on the forming of local health units, and was proud to hear Dr. Haven Emerson give credit to the Woman's Auxiliary for its efforts in this direction. This program can be extended throughout the country. Attendance at the Rural Health Conference convinced me that here is fertile ground for Auxiliary activity.

Our program is charted for us. Our sights are raised to a high level. Our goal is to help the medical profession bring to our fellow Americans the finest in health and medical care. This we can accomplish only if we acknowledge our duties, realize our potential strength as a medium of truth, and pledge ourselves to carry out our obligation to help in this most critical time. If we were to do anything less, we would not be worthy of our position.

(MRS. LUTHER H.) HENRIETTA STEWART KICE,
President, Woman's Auxiliary to the American
Medical Association.

"THE FREE MAN VS. THE PUPPET MAN"

Today sweeping against the Statue of Liberty and across our great nation are strong winds of socialism, communism, materialism, and atheism. These subversive forces and influences which are hostile to the ideals and institutions on which our great nation was founded, have been spreading until today they constitute a real and increasing danger to our national life.

One of the greatest bulwarks of American life has been private enterprise. Every page in our history reveals to us that there is but one source of progress, namely, the independent man in a free world. "We are free Americans; free to speak without fear; free to worship God in our own way; free to stand for what we think right; free to oppose what we think wrong." The right of liberty means every man's right to individual action, individual initiative, and freedom of choice.

We who are true Americans in spirit are vitally interested in the preservation of our freedom. We are one of the last remaining countries defending the sanctity of the free active man in a free world. Here we have the highest standard of living of any nation in the world. Why? You have heard it said that it is because of our huge natural resources; yet did not the American Indian have all these resources available before the country was settled by the white man? Do not Russia, China, and India have more natural resources than we have? Yet their standard of living is so much lower than ours that there is no comparison. So it cannot be a question of natural resources, although we admit that they have been a vital factor in the progress and achievements of the American people. However, these tangible, material things are but a part of America. The things that have counted the most in her past, and that will count the greatest in her future, are the great intangibles of the spirit of the people—our sense of freedom and of liberty, our traditions of past glory and sacrifice, our lofty ideals and spiritual appreciation, all of which spell greatness and the true glories of the American people.



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From the beginning of history two antagonists have stood face to face. One is the free active man, the other is the passive governed puppet. Every type of good work, from laying bricks to writing a symphony, is done by the free active man; the puppet man would live softly and easily from the toil and hardship of others. Let me give you a few examples of the free man in a free world:

Andrew Carnegie came to the United States in 1848 as a 13-year-old boy, and because our Constitution offered him freedom of choice and individual initiative, he became one of the greatest leaders in our nation; from a poor bobbin-boy in a cotton factory he became a self-made multimillionaire. And he so appreciated what America had done for him that before he died he had given away to his fellowmen \$350,000,000.

Henry Ford, under our system of private enterprise, became the father of mass production, of world-wide, low-cost transportation which has extended all men's horizons and brought citizens together as neighbors; friend of the working man and the farmer; America's great citizen who built an industry by enriching the world, whose honest life is an inspiration to youth everywhere, and who, like Abraham Lincoln, climbed from poverty to the service of mankind.

Dr. George Washington Carver was one of the most remarkable men of this age. Born in slavery with obstacles almost insurmountable, he climbed to a position of equality with the foremost scientists of the world. To this great scientist the peanut yielded marvels ranging from food to dyes, wood stains, face powder, and ink. From the clays he has produced over one hundred tints and shades of colors; from wood shavings and other waste materials he has produced synthetic marble; from peanut hulls he has made insulating boards for houses. Many other common things usually thought of as waste products have been turned into useful commodities. He was not only a scientist but a botanist, chemist, musician, artist, and educator. And where under God's sun would a man born of Negro parents and in slavery have such a chance for success except in the good old United States? These men—these souls in bodies of different colors, of all races and all faiths—were given, in America, the greatest gift to mankind—FAITH!—faith in a great God, faith in the ability of people to govern themselves, and the belief that they are capable of building a richer, fuller, and happier life! All of this means *faith in the value and potentialities of the common man.*

Who is the Puppet Man? He is not an individual but a serial number, owned by the state, regardless of ability or effort. That is what socialism means. It makes the individual dependent upon the state in all material, social, and political matters! "It nullifies ambition by putting restrictions on choice of occupation and reward of attainment, and smother's initiative—the backbone of progress." The result is impersonal service and indifference. It is the death knell to all that we hold most dear—individual liberty and progress!

This is what some officials in Washington, D. C., are trying to bring about in America, so that today we are faced with the danger of the socialization of one of the greatest examples of private enterprise of our nation—the medical profession!

Mr. Oscar Ewing's report to the president last spring, entitled "The Nation's Health; a Ten-Year Program," is nothing more than compulsory sickness insurance, which has only one meaning—political medicine controlled by the bureaucrats at an overwhelming expense to each and every citizen. Do you realize that since 1930 tax-eating Federal job-holders have increased

from 2 per 100 families to 5 per 100 families in 1947, and now a total of more than 2 million job-holders are living on the taxpayers? Senator Harry F. Byrd stated: "These politicians calculate a million job-holders can be counted upon to swing three or four million votes to keep the spenders in power."

Sir William Darling, a member of the House of Commons in England, made the following remarks to the Senate of the United States on Dec. 8, 1947:

"Before I go back to my country with its shilling's worth of meat, its declining standard of life, its business desperately entangled, please let me tell you, my friends in the United States and in Canada, that the road Great Britain is traveling is the road you should not travel. The experience is not worth while. It is a road which has led to degradation and lowering of our human standards in which you and we believe. I believe that the organization of communities on a large scale is the greatest danger with which the world is faced. There is a deep-rooted conviction that somehow government can do things better than the people themselves. So our Socialist government in Britain is attempting it. I can tell you the result very simply by quoting the remark made by one of my electors: 'This nationalization is a very queer thing. The more you own, the less you have. We own now the Bank of England in Britain, but I am no better off. We own the coal mines, and I have less coal. We own the railroads, but I can't get a train for my holidays. This is socialism; the more we own, the less we get.'

"All that my friend said is true—and more. We discover that we are approaching a real dictatorship, because the British citizens have no choice but to accept what is offered them, and even then they have less of the satisfaction which they formerly enjoyed."

New Zealand has been described by some as the socialistic laboratory of the world; this may or may not be true. The following is part of an editorial which

appeared in the *Oil City Derrick* of Oil City, Pa.: "The government of this country is seriously considering whether that country's free physician service will be continued. The record of New Zealand's compulsory insurance shows that they have been unable to keep its cost of operation on an even keel, due to the fact of the human tendency to take advantage of benefits offered under a compulsory system; another is the political pressure for increase in rates and duration of benefits. New Zealand has had compulsory health insurance since 1939, and in these years of trial its operation has become more costly with every passing year."

This is something for America, now burdened with a Federal debt of nearly 300 billion, to think about when it considers entering the field of socialized medicine. If the Federal government is so concerned with the welfare and the health of its people (which incidentally is the best in the world as proven by surveys), why doesn't it take care of the American Indians who are legally and technically its wards? Have we forgotten the shameful facts which received national attention through the newspapers and *Time* and *Life* magazines in regard to the Navajo Indian just this past year? There are about 70,000 Navajo Indians, much the largest of the surviving tribes, living on an immense but arid area of 30,000 square miles. It was pointed out that the Navajos are existing on 1000 calories and less a day, less than the Germans are getting under U. S. control, and that many of them are so weak that they cannot stand even moderate exertion.

They have been so plagued with illness and their mortality rates are so high that only an amazingly high birth rate has kept the tribe on the increase. For instance, the rate of tuberculosis infection is fourteen times the average of the country as a whole. The single tuberculosis sanatorium has only 100 beds. There is only one doctor for every 6000 Navajos.

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know and talk with a Christian Navajo Indian who has just come from the reservation in Arizona, where he has been a missionary for the past two years. The revealing things we learned from the color films he showed here in our community were heartbreaking. We saw one-room shacks built without any windows and without any floors, known as hogans. We were told that as many as 16 people live in one of these hogans and that in most instances water has to be carried long distances. One family has to carry its water a quarter of a mile up the hillside from a spring that is also a watering place for hogs and a stamping ground for cattle. Thousands of school-age children have never seen the inside of a schoolhouse. Hundreds of Navajos are so far away from the government hospitals that they only go there in case of life or death. The means of transportation are so poor and the roads so bad that many of them die on their way to the hospital.

Most Navajos depend almost completely on their sheep for a living. But even this meager source of income has been cut by the government. *Life* magazine puts it in this way: "It has been estimated that a small Navajo family could get by on 250 sheep. But the government's cold arithmetic proves that the range can support only 600,000 head, or enough for only 2400 of the 11,000 Navajo families. More than nine-tenths of the other Navajo families have less than is needed to sustain even the simple way of life they value above all else."

If the present helpless and desperate situation of the American Indians, who are wards of the Federal government, is a picture of the paternalistic management of our government, then it behooves each one of us to beware of government-controlled medicine.

(MRS. NORMAN K.) ALICE S. BEALS.

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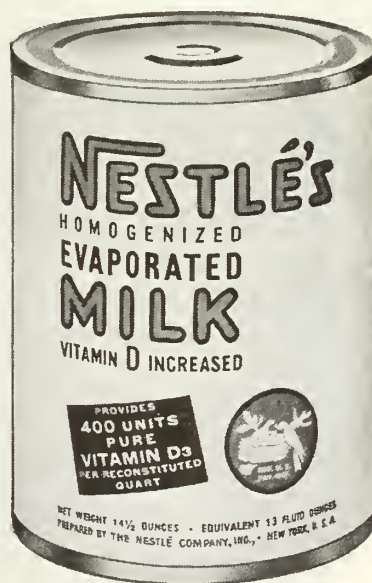
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Implications of the National Health Assembly and the Ewing Report

MAURICE H. FRIEDMAN, M.D.

Washington, D. C.

I should like to give you some of the salient features of the Ewing Report and tell of the kind of things it contains. I think the public has the idea that Mr. Ewing garnered an assembly of health experts in Washington and got these outstanding, unbiased scholars in health matters to discuss the questions confronting American medicine, and out of this non-partisan scholarly group came scholastic answers to controversial questions, and these allowed the sound, reliable, non-partisan thoughts that made up the report.

Mr. Ewing has made so many statements that, statistically, it would be impossible if some of them weren't true. I could not analyze all of them nor do I intend to. Actually, it's the same old stuff. Mr. Ewing did not need to call that assembly in the City of Washington to reach the conclusion that 300,000 people die annually in this country "needlessly." Mr. Malmberg, in a vicious piece of propaganda a year before, all by himself, had reached the same conclusion. Mr. Ewing is still beating his breast about 40 per cent of counties being without hospitals. He concludes that this means an antiquated and inadequate system of medical care. I don't pretend for a moment that our system is perfect. However, I think we should take an honest look at it and see how

good or bad it is. Wherever we can make improvements, I think we should do so.

Mr. Ewing states that only seven million people in this country live in communities with public health systems that meet the minimum standards set up for public health services. If we assume that New York City has a population of seven million people—and it does—and if we are generous enough to assume that New York City has an adequate public health system, then the other "villages" such as Boston, Philadelphia, Baltimore, St. Louis, Washington, D. C., San Francisco, and Los Angeles, must have inadequate public health systems. I don't know whether the public health systems in these "villages" are adequate or not. If they are not, perhaps we should ask, are these "grass root villages" too small; are they so sparsely settled that they can't afford public health systems; or is it just Mr. Ewing's contention that they should surrender control of local affairs to a federal agency?

Let's look at this "40 per cent of our counties without an adequate general hospital." These counties actually number about 1200 and have a total population of about 15,000,000. This is an average of about 12,000 people per county. If you calculate how many hospital cases a year such counties would have, it comes out to about 700 for 12,000 people. A typical 50 bed hospital with an average daily census of 33 takes care of about 1500 cases per year. What sort of a daily census would a 50 bed hospital have with only 700 cases per year? But Mr. Ewing lets his foot slip a bit. When he lists the grandiose plans for remaking American medicine, even he does *not* propose to have a hospital in every county, let alone an "adequate general hospital." His

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plans call for one hospital for about every 15,000 to 20,000 people. Even though one general hospital for every 20,000 people would be somewhat uneconomical, if we admit this ratio to be a permissible one, it would allow for the supply of 750 hospitals for the 1200 counties that comprise the "40 per cent." There would, therefore, still be at least 450 counties without hospitals to supply more political slogans—for that is just what this is. For years the United States Public Health Service has admitted that a county is a poor unit on which to base a health survey. Even the statisticians in Mr. Ewing's own department have made this same admission. Any survey of health facilities by counties is apt to exaggerate the deficiencies. It does not furnish a true picture, but a politically useful one.

Another slogan that Mr. Ewing uses in his report is that the "poor are sicker than the rich and get less care." I do not want to minimize the plight of the low income groups in this country, but the actual data available do not justify this political slogan. The Committee on the Cost of Medical Care, in a study conducted by Isidore Falk, did *not* find that the poor were sicker than the rich. Mr. Falk's own tables clearly indicated that *with every increase in family income there was an increase in the frequency of illness*. I am not saying that this is correct, but I am citing Mr. Falk's findings. He said one thing, in print, in 1933, and is saying just the opposite right now. He can't be right both times.

The National Health Survey of 1935-36 did not agree entirely with Falk's findings. Their methods and their definitions of illness were somewhat different. From their findings it must be admitted that the people on

relief had a much higher incidence of illness than self-supporting families. If you compare, however, the incidence of acute illness of people with family incomes of as little as \$1,000 per year with the incidence in families earning \$5,000 or more per year, the difference from top to bottom is less than 10 per cent. For chronic illnesses there was no difference whatsoever between those earning \$1,000 per year and the highest income groups.

What about the distribution of medical services? According to the tables published by Falk for the CCMC, families earning about \$3,000 per year had 20 per cent more house calls and office visits than the lowest income group which earned less than \$1,200 per year. That is a definite difference, but we should be perfectly clear as to its magnitude. When it comes to hospital services, there was no difference at all between the lowest income groups and the highest. On this point the national Health Survey of 1936 and the CCMC agree. When you hear that old bromide about the "poor being sicker than the rich and getting less care" you should keep these things in mind.

Mr. Ewing makes much of "300,000 preventable deaths" each year. He gives no explanation of how these people are to be saved, or how these deaths could be prevented simply by making every doctor in this country a salaried governmental worker subordinate to the directives of Mr. Ewing and Mr. Falk. I wrote Ewing a long time ago asking if he would explain the methods by which this figure of 300,000 was reached. Ewing can be very voluble, but he has not answered my letter up to the present time. However, if you read Mr.



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Ewing's monograph carefully, you can see something of the technique used. For example, they take a state with the lowest mortality from tuberculosis, and compare this mortality with that for tuberculosis in all other states. Then, they say, if we could lower the mortality from tuberculosis in all states to the level of that in the lowest state, we could save so many lives. Mr. Ewing ignores all the many potent factors which influence mortality and morbidity rates. He assumes that the only factor operating is the supply of doctors and hospitals. He implies that the reason for these "preventable" deaths is because we have faulty medical facilities or because the people can't pay for them. Included in Mr. Ewing's inventory of 300,000 preventable deaths are 120,000 from communicable diseases. Presumably he was using the 1945 figures when there were about 170,000 deaths from these diseases. Undoubtedly the 1945 record can be bettered over a period of years, but how Mr. Ewing arrived at the figure of 120,000 is not explained.

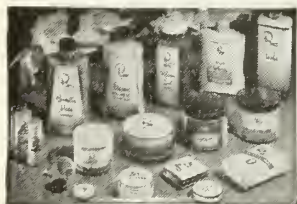
In this country progress is so rapid, even with our "inadequate" medical services, that Mr. Ewing's figures are already out of date. In 1947 when the total number of deaths was about the same as in 1945 (about 1.5 million) the number of deaths from communicable diseases was only 137,000, i.e., a decrease of 33,000 from the figures of 1945. Actually, it would be presumptuous for the medical profession to take full credit for this record, for we all know that mortality rates are influenced by factors other than medical services. It is quite possible that the contribution of doctors and hospitals was small in comparison to the effect of many other factors which may be of equal or greater importance.

Incidentally, included in Mr. Ewing's 300,000 preventable deaths are 40,000 due to accidents. The average physician will find it difficult to understand the logic of this inclusion.

Another example of Mr. Ewing's method is his handling of maternal mortality statistics. He compares the maternal mortality in South Carolina with that in New York, which of course is much lower. He draws the conclusion that the reason, the only reason, for this difference is the fact that the people of New York have much more money and therefore much more medical

care. He further points out that even in the State of South Carolina the maternal mortality rate for colored women is 170 per cent higher than that for white women. In his usual manner he concludes that the reason for this difference is that most white women have their babies in hospitals, or at least under a doctor's care, while colored women, for the most part, do not have such services. Mr. Ewing conveniently ignores other data which are not altogether in tune with his theme song. In 1944 practically all non-white births in the District of Columbia were attended by physicians. In the adjacent state of Maryland only 75 per cent of Negro births were so attended. In the District of Columbia 90 per cent of all Negro births occurred in hospitals. In the state of Maryland only 46 per cent of Negro births took place in hospitals. Nevertheless, the maternal mortality rate for non-white births in Maryland was only 20.9 per ten thousand live births compared to 40.3 in the District of Columbia. In this case 90 per cent hospitalization is associated with twice as many maternal deaths as 46 per cent hospitalization. During the war when 40 per cent of our doctors were in the armed services the maternal mortality rate for the country as a whole dropped almost 50 per cent from 1940 to 1945. Gentlemen, I tell you these things only to emphasize what you already know. Morbidity and mortality rates are not determined solely by doctors and hospitals. These rates by themselves are no measure of medical care.

I have a lesson for you—a lesson to teach you Mr. Ewing's technique. I want you to remember this. In the United States, for white births only, the infant mortality for males is 41.2 and for females 32.4 per thousand live births. In other words, male babies have a 30 per cent higher mortality rate than female babies. The obvious conclusion (a la Ewing) is that female babies get better medical attention than male babies. And why don't male babies get as good medical attention? Obviously, female babies have more money than male babies. But that isn't all. The factor of discrimination raises its ugly head. American medical men are a bunch of reactionaries. They *discriminate* against people. This is no minority they are discriminating against. They



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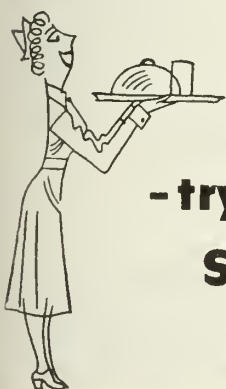
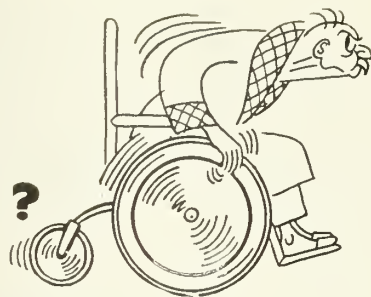
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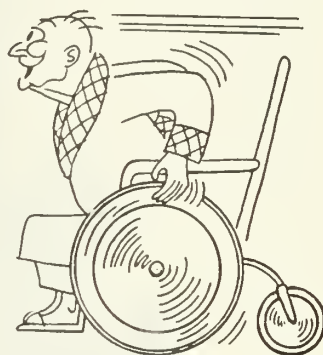
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are discriminating against almost 50 per cent of all of our babies! Why? Because of testicles! That sounds funny, but actually, to a man trying to make a sober analysis of statistics, it is no funnier than the Ewing report. It is impossible to take a look at differing morbidity or mortality rates and say that "this" or "that" is the only reason for the difference. One must give careful study to all possible factors, and even after long and careful study it might not be possible to identify the most important one. There are important factors other than doctors or hospitals which determine the health of this Nation. They are public health services, public and personal hygiene, housing, sanitation, education, and purely local and geographic factors. Some of these things are frequently of greater importance than anything we as doctors can do.

Mr. Ewing's report undoubtedly will be used as heavy ammunition in the drive to have the Federal government take over the entire medical care of this country. I have no quarrel with those who sincerely believe that this should be done. In this country we don't shoot them—we try to outvote them. I do, however, object to the misuse and distortion of statistics to mislead our people into doing something which may not be the correct thing for them to do.

After the latest polls, I hesitate to make any predictions. But the people are being given the impression that under a completely federalized medical program they will be given something for nothing. I think that this piece of propaganda is something we must combat more vigorously than any distortion of statistics such as exemplified by my discussion of male and female infant mortality.—*The Montgomery County Medical Bulletin.*

VITAMIN B₁₂ EFFECTIVE TREATMENT FOR ANEMIA

Vitamin B₁₂, part of the B complex, is extremely effective against pernicious anemia, nutritional anemia, and tropical sprue, a disease characterized by anemia, three studies reported in the February 19 issue of *The Journal of the American Medical Association* show.

The studies were made at the Nutrition Clinic of the Hillman Hospital, Birmingham, Ala., the General Calixto Garcia Hospital, Havana, Cuba, and the School of Tropical Medicine, San Juan, Puerto Rico.

The studies were made by Tom D. Spies, M.D., Robert E. Stone, M.D., and Sam Kartus, M.D., Birmingham, Ala.; Ramon M. Suarez, M.D., San Juan, Puerto Rico; and Guillermo Garcia Lopez, M.D., Fernando Milanes, M.D., Ruben Lopez Toca, M.D., and Tomas Aramburu, M.D., Havana, Cuba.

Vitamin B₁₂, per unit of weight, is the most effective antianemic substance known, the doctors say. It produces regeneration of the blood and remittance of the degeneration of the nervous system which sometimes occurs in pernicious anemia, they found.

"If it is so difficult to pay once for medical care, what shall be said of the difficulty of paying twice—once in taxes, and a second time in order to have the kind of treatment one desires?"—A. J. Todd, Manager, Christian Science Committee on Publications, Washington, D. C.

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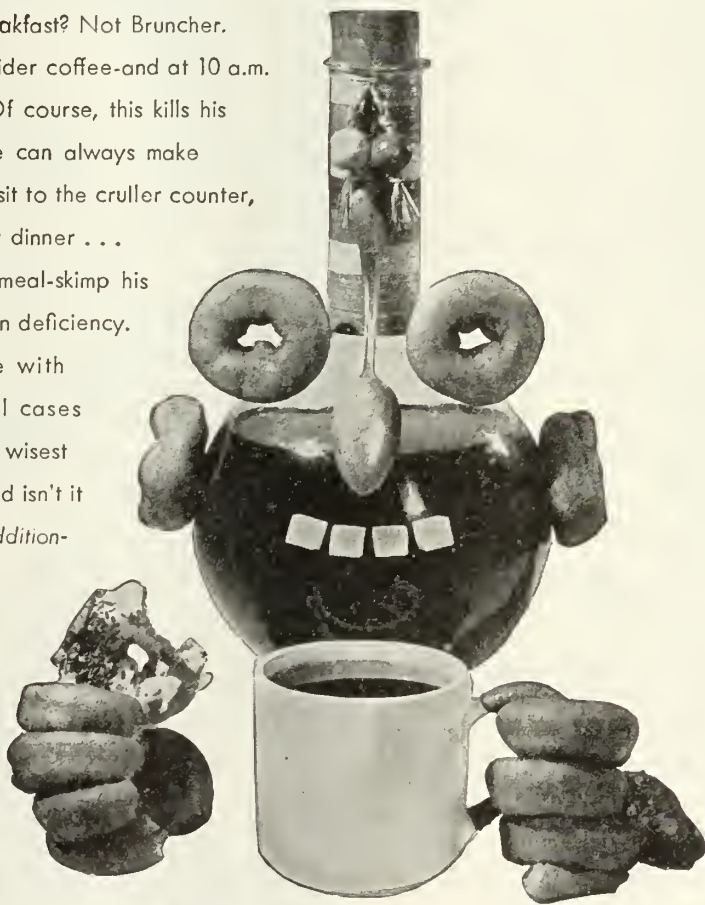
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Deaths from Selected Causes in Pennsylvania, November, 1948

County	All Causes, Excluding Stillbirths	Still- births	Infant Deaths	Maternal Deaths	Cancer	Heart Disease	Intra- cranial Lesions of Vascular Origin	Nephritis	Pneu- monia	Tuber- culosis
Adams	21	3	0	0	2	6	3	1	1	1
Allegheny*	1301	83	85	0	162	423	114	73	48	29
Armstrong	58	1	5	0	7	23	9	3	2	0
Beaver	108	5	10	0	10	30	13	3	4	5
Bedford	33	1	1	0	3	9	5	6	0	0
Berks*	200	7	10	0	26	77	21	9	7	2
Blair*	114	4	6	0	7	43	13	8	2	2
Bradford	40	1	1	0	11	11	4	3	0	0
Bucks	95	2	5	1	18	37	7	2	2	0
Butler*	91	5	4	0	5	42	9	4	3	1
Cambria*	137	9	13	0	17	49	6	8	4	3
Cameron	1	1	0	0	0	0	0	0	0	0
Carbon	53	0	1	0	6	24	3	4	2	1
Centre*	66	2	4	1	12	22	7	3	0	1
Chester*	122	3	13	0	26	31	5	14	2	3
Clarion	20	2	1	0	4	7	2	3	1	0
Clearfield	64	1	5	0	9	26	5	3	2	1
Clinton	30	1	3	1	4	8	3	1	1	0
Columbia	34	3	5	0	3	10	4	2	0	0
Crawford	76	2	6	0	13	27	7	5	1	1
Cumberland	67	4	3	0	4	32	4	3	1	1
Dauphin*	200	12	9	1	26	74	19	24	6	3
Delaware	222	11	16	0	28	69	18	14	7	3
Elk	17	2	2	0	5	4	3	0	0	0
Erie*	163	4	14	1	29	58	14	7	2	6
Fayette	151	19	14	1	27	49	12	4	6	1
Forest	2	0	0	0	0	0	0	0	0	0
Franklin*	51	2	3	0	9	20	6	2	0	0
Fulton	6	1	0	0	1	1	1	0	1	0
Greene	33	0	2	0	4	16	1	3	2	0
Huntingdon	40	2	1	0	5	14	2	4	1	0
Indiana	50	0	3	0	6	17	5	0	0	1
Jefferson	37	2	0	0	4	12	4	5	3	0
Juniata	7	0	0	0	0	2	0	1	0	1
Lackawanna	247	11	10	0	39	95	13	6	8	5
Lancaster	199	7	16	2	26	52	17	13	3	2
Lawrence	75	6	6	0	11	17	13	2	4	1
Lebanon*	58	2	4	0	4	26	3	5	2	1
Lehigh*	170	13	11	0	21	70	19	8	1	4
Luzerne	344	15	31	0	32	132	28	19	11	5
Lycorning	91	4	9	0	12	33	8	2	0	0
McKean	47	0	5	0	4	21	6	1	2	0
Mercer	96	5	8	0	11	35	13	3	3	0
Mifflin	42	5	8	0	5	10	3	4	3	0
Monroe	34	3	1	0	4	11	9	1	0	0
Montgomery*	232	14	14	0	41	84	18	8	8	7
Montour*	25	1	2	0	6	4	0	0	1	0
Northampton	102	4	7	0	26	39	12	3	0	0
Northumberland	99	1	6	0	10	39	6	7	6	1
Perry	11	0	0	0	1	5	0	0	0	0
Philadelphia*	1858	75	95	5	306	658	126	105	37	70
Pike	9	0	0	0	0	4	2	0	0	0
Potter	20	0	1	0	5	7	0	1	1	0
Schuylkill	190	9	4	0	26	69	16	10	2	2
Snyder*	17	0	1	0	3	4	2	2	2	0
Somerset*	60	4	5	0	8	10	6	6	2	2
Sullivan	6	0	0	0	2	2	0	0	0	0
Susquehanna	23	2	0	0	6	6	0	1	0	0
Tioga	21	1	2	0	2	6	0	1	0	1
Union	18	0	2	0	2	6	1	0	0	2
Venango*	45	2	2	0	4	19	6	1	1	0
Warren*	27	0	0	0	5	15	0	1	1	0
Washington	130	6	7	0	19	50	17	9	3	0
Wayne*	17	0	0	0	4	5	2	1	1	1
Westmoreland*	182	12	10	0	20	60	25	7	9	2
Wyoming	16	0	0	0	4	5	1	1	0	0
York	154	8	8	1	21	53	16	17	2	2
State and Federal institutions	273	0	0	0	16	85	11	9	19	49
State totals	8648	405	520	14	1199	3010	728	476	243	223

* Exclusive of State and Federal institutions except general hospitals.

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PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12 mg.	COPPER	0.5 mg.

*Based on average reported values for milk.

MEDICAL NEWS

Future Meeting Calendar

PENNSYLVANIA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY—Harrisburg, April 22-24, 1949.

REGIONAL CONFERENCE ON PREMEDICAL EDUCATION—Syracuse, N. Y., May 6-7, 1949.

PENNSYLVANIA RADIOLOGICAL SOCIETY — Bedford Springs Hotel, Bedford, Pa., May 20-21, 1949.

AMERICAN GOITER ASSOCIATION—Madison, Wis., May 26-28, 1949.

INTERNATIONAL CONGRESS ON RHEUMATIC DISEASES—New York City, May 30-June 3, 1949.

PENNSYLVANIA TUBERCULOSIS SOCIETY — Pittsburgh, May 25-27, 1949.

AMERICAN COLLEGE OF CHEST PHYSICIANS—Atlantic City, N. J., June 2-5, 1949.

AMERICAN ASSOCIATION OF RAILWAY SURGEONS—Chicago, Ill., June 30 to July 2, 1949.

Birth

TO DR. AND MRS. ALBERT H. BUCHER, of Harrisburg, a son, March 20.

Engagements

MISS ELOISE ELIZABETH HUNT, daughter of Dr. and Mrs. Henry F. Hunt, of Danville, to Mr. James Howe Comerford, of New York.

MISS PAMELA COTTIER, of Greenwich, Conn., to Mr. Charles Budd Forcey, Jr., son of Dr. and Mrs. Charles B. Forcey, of Sewickley.

MISS EUGENIA PRESLER BIRDSALL, daughter of Dr. and Mrs. Joseph C. Birdsall, of Haverford, to Mr. Spencer Raymond Stuart, of Chicago.

MISS NINA L. BLUMENTHAL, of New York, to N. William Winkelman, Jr., M.D., son of Dr. and Mrs. Nathaniel W. Winkelman, of Philadelphia.

MISS FRANCES TABOR McDONALD, of St. Davids, to Mr. A. Jay Cadwallader Sands, son of Dr. and Mrs. Joseph E. Sands, 2d, of Rosemont.

MISS BIANCA DEITZ, daughter of Dr. and Mrs. George W. Deitz, of Philadelphia, to William Whitlock Mattson, Jr., M.D., son of Dr. and Mrs. William W. Mattson, of Tacoma, Wash.

MISS PENNY ELAINE RECHTMAN, daughter of Dr. and Mrs. Abraham M. Rechtman, of Elkins Park, to M. William Yarrow, M.D., son of Dr. and Mrs. Benjamin F. Yarowsky, of Wilmington, Del.

Marriages

MISS ROSEMARY METCALF VARKER, of Berwyn, to Mr. Horace Pettit, Jr., son of Dr. and Mrs. Horace Pettit, of Gladwyne, March 16.

MISS MARGARET JANE BLACKBURN, daughter of Dr. and Mrs. Walter J. Blackburn, to Mr. Robert Dunbar Darrach, all of Philadelphia, March 26.

MISS MURIEL SWIFT REYNOLDS, daughter of Dr. and Mrs. D. Duer Reynolds, of Kennett Square, to Mr. George W. Derrickson, of New Castle, Del., April 2.

Deaths

⊙ Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

⊙ **Joseph Scattergood**, West Chester; University of Pennsylvania School of Medicine, 1894; aged 79; died March 18, 1949, of a heart attack. The oldest practicing physician in West Chester, Dr. Scattergood was the first physician on the staff of the Chester County Hospital. He was also a member of the staff of the Darlington Sanitarium at West Chester. He was secretary of the Pennsylvania Railroad Surgeons Association for twenty-five years, and had been secretary of the Chester County Medical Society for sixteen years. Surviving are his widow, a son, and a daughter. Another son, Dr. Joseph Scattergood, Jr., died last June.

⊙ **Thomas P. Martin**, Carbondale; Medico-Chirurgical College of Philadelphia, 1905; aged 72; died March 13, 1949, after a brief illness. Dr. Martin was one of the founders of St. Joseph's Hospital in Carbondale, and for years served as chief surgeon and chief of its medical staff. He also was surgeon for the Scranton Division of the New York, Ontario and Western Railroad. During World War I, he was chief brain surgeon at Base Hospital 84, Bordeaux, France. He was a Fellow of the American College of Surgeons. Surviving are his widow, a son, four brothers, and three sisters.

⊙ **James H. McKee**, Philadelphia; University of Pennsylvania School of Medicine, 1892; aged 78; died March 24, 1949. Dr. McKee was a member of the staff of the Chestnut Hill Hospital, and was a member of the American Academy of Pediatrics. In 1943 he was honored by the State Medical Society for having completed fifty years of service in the medical profession. A major in the Army Medical Corps during World War I, Dr. McKee was among the first surgeons to make a coast-to-coast flight with an Army squadron in 1918. He is survived by a son and two daughters.

George F. Phelps, Drexel Hill; Jefferson Medical College of Philadelphia, 1907; aged 78; died March 10, 1949. Dr. Phelps was a member of the neurologic staff at Jefferson Hospital until 1934. For many years he served as visiting chief to the psychiatric department of Philadelphia General Hospital, and also had been associated with the New Jersey State Hospital, Trenton, and the Pennhurst State School, Spring City, Pa. His widow and a sister survive.

⊙ **Charles M. Watson**, Pittsburgh; University of Pittsburgh School of Medicine, 1900; aged 73; died March 11, 1949, in Tucson, Ariz. Dr. Watson was senior staff member at Presbyterian, Women's, and Passavant Hospitals, and was a member of the Pittsburgh Surgical Society. Surviving are his widow and two sons, Drs. James R. and William S., both Pittsburgh surgeons.

⊙ **Arthur G. Davis**, Erie; University of Buffalo School of Medicine, 1913; aged 62; died Feb. 20, 1949. Dr. Davis was a member of the American Orthopedic Association, the American Academy of Orthopedic Sur-

Most practitioners of medicine are consulted occasionally for general advice on the causes, prognosis, and management of deafness. The paper appearing on page 698 of this issue bristles with helpful information, access to which is the right of every person, young or old, whose hearing is impaired, much or little.

geons, and a Fellow of the American College of Surgeons.

John M. Toomey, Lancaster; Hahnemann Medical College and Hospital of Philadelphia, 1923; aged 52; died March 15, 1949. Dr. Toomey practiced in Coatesville until about twelve and a half years ago. He is survived by his widow and two sons.

Louis Kimmelman, Philadelphia; University of Pennsylvania School of Medicine, 1910; aged 62; died March 20, 1949. Dr. Kimmelman retired twelve years ago. His widow and two sons survive.

George C. Berkheimer, Windber; College of Physicians and Surgeons of Baltimore, Md., 1905; aged 77; died March 4, 1949. He was a past president of the Somerset County Medical Society.

Oscar W. Renz, Erie; College of Physicians and Surgeons of Baltimore, Md., 1915; aged 56; died Feb. 3, 1949.

George F. Drum, Mifflinville; Baltimore University School of Medicine, 1900; aged 75; died Feb. 1, 1949.

Eugene J. Schachter, Braddock; Indiana University School of Medicine, 1926; aged 46; died Feb. 3, 1949.

Miscellaneous

A BONE BANK, WHICH WILL BE AVAILABLE TO ALL hospitals and physicians in Philadelphia, has been established at St. Luke's and Children's Medical Center, Thompson and Franklin Streets.

ON MARCH 17 THOMAS A. RUTHERFORD, M.D., resigned as superintendent of the Farview Hospital for the Criminal Insane at Farview, a post that he held since 1941. The board immediately named John P. Shovlin, M.D., who had been his assistant, to succeed him.

THE PENNSYLVANIA ACADEMY OF PHYSICAL MEDICINE held a Seminar on Physical Medicine, Saturday, March 12, at Reading under the sponsorship of the Committee on Physical Medicine of the Berks County Medical Society. George Morris Piersol, M.D., Philadelphia, was chairman of the meeting.

THE ANNUAL MEDICAL MEETING OF THE BARTON MEMORIAL AND WHITE HAVEN DIVISIONS OF JEFFERSON MEDICAL COLLEGE AND HOSPITAL was held at the White Haven Sanatorium, White Haven, Pa., on Wednesday, March 30. A very interesting program on

pulmonary diseases was presented under the direction of Jacob J. Kirshner, M.D., program chairman.

THE SOUTH ATLANTIC ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS announces the establishment of "The Foundation Prize." Authors of papers on obstetric or gynecologic subjects desiring to compete for the prize may obtain information from Emmett D. Colvin, M.D., secretary-treasurer, 1259 Clifton Road, N. E., Atlanta, Ga.

THE BOARD OF EXAMINERS OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS announces that the next oral and written examinations for Fellowship will be held in Atlantic City, N. J., June 2, 1949. Candidates for Fellowship in the College, who would like to take the examinations, should contact the Executive Secretary, American College of Chest Physicians, 500 North Dearborn St., Chicago 10, Ill.

THE STAFF OF THE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA will hold a clinic for medical alumni Saturday, June 18, in the medical amphitheater of the hospital from 9 a.m. to 12 noon. The medical alumni will then join the other alumni for luncheon in the Quadrangle, and for the parade to Franklin Field, where Pennsylvania will play Dartmouth in an Ivy League baseball game.

THE REGIONAL FRACTURE COMMITTEE will meet in Pittsburgh, April 27, at the Pittsburgh Athletic Club at 2 p.m. There will be a conference on fractures with emphasis on fractures of the hand and wrist, and those who attend are invited to bring x-rays and histories of troublesome cases. A social hour is scheduled at 5 p.m. with dinner at 6 p.m., following which the guest speaker, Sumner L. Koch, M.D., Chicago, will talk on "Compound Fractures of the Bones of the Hand—Immediate and Late Treatment."

NORMAN R. INGRAHAM, M.D., chief of the Municipal Division for Control of Venereal Diseases in Philadelphia, was honored Wednesday night, March 30, at a testimonial dinner in the Broadwood Hotel. Speakers included Drs. Norris W. Vaux, State Secretary of Health; Edgar S. Everhart, head of the State Division for Control of Venereal Diseases; John H. Stokes, professor of syphilology at the University of Pennsylvania; Hubley R. Owen, chief of the medical services for public schools in Philadelphia; and Judge Nochem Winnett, of Municipal Court. Rufus S. Reeves, M.D., head of the Philadelphia Department of Health, presided.



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RAYMOND E. MASTERS, M.D., of East McKeesport, was appointed plant medical director of the new Atomic Power Division of the Westinghouse Electric Corporation, effective March 1. Dr. Masters is a graduate of the School of Medicine, University of Pittsburgh, class of 1935. In 1940 he joined the medical staff of the Westinghouse Electric Corporation at the East Pittsburgh Division. He was engaged in military medical service from 1941 to 1946. From 1947 to 1948 he was assigned to the Atomic Energy Commission for duty at the School of Medicine and Dentistry, University of Rochester.

IRWIN M. POCHAPIN, M.D., Pittsburgh, a member of the Committee on Disaster Emergency Medical Service, recently took a course in "The Medical Aspects of Special Weapons and Radioactive Isotopes" at Bethesda, Md. He was the only civilian in attendance with 150 Navy medical officers in uniform. A navy magazine subsequently spoke in complimentary terms of the foresight thus displayed by The Medical Society of the State of Pennsylvania.

Dr. Pochapin also represented the State Medical Society at the semi-annual meeting of the American Medical Association Council on National Emergency Medical Service in Chicago on March 21.

THE MEDICAL ALUMNI SOCIETY OF THE UNIVERSITY OF PENNSYLVANIA will hold its annual meeting at its Alumni Dinner in the Hotel Claridge, Atlantic City, N. J., on Wednesday, June 8, at 6:30 p.m., during the A.M.A. convention. Cocktails at 6 p.m. (cash bar). Ladies are cordially invited.

Tickets, \$7.00 each, must be purchased in advance, as a definite number of reservations must be guaranteed to the hotel. Your reservation accompanied by your check, made out to the Medical Alumni Society, should be sent to Miss Frances R. Houston, Executive Secretary, Medical Alumni Society, 36th and Pine Streets, Philadelphia 4, Pa.

THE SIXTY-FIRST ANNUAL MEETING OF THE AMERICAN ASSOCIATION OF RAILWAY SURGEONS will be held

at the Drake Hotel, Chicago, Ill., on Thursday, June 30, Friday, July 1, and Saturday morning, July 2.

An exceptionally interesting and instructive scientific program has been arranged, which will be given from 10:00 to 12:30 on each of the three mornings, and from 2:00 to 4:30 on the first two afternoons. The morning sessions will include twelve papers on various medical and surgical subjects, given by outstanding authorities. The two afternoon sessions will be devoted to symposia on "Lesions of the Bones and Joints" and "Intrathoracic Disorders."

The annual dinner will be held at the Drake Hotel on Friday evening, July 1.

THE FIFTY-SEVENTH ANNUAL MEETING OF THE PENNSYLVANIA TUBERCULOSIS SOCIETY will be held May 25, 26, and 27 at the Hotel William Penn, Pittsburgh. Of special interest to physicians will be the medical program on Thursday morning, May 26, which is being planned by the Pennsylvania Trudeau Society—the medical section of the Tuberculosis Society. Dr. Thomas Parran, dean of the School of Public Health, University of Pittsburgh, will address the group at luncheon that day. On Thursday afternoon, George James, M.D., director of the Ulster County (N. Y.) Department of Health, will speak on "The Advantages of a Local Health Unit in the Tuberculosis Control Program." On Friday morning a panel composed of directors of various official and other agencies will discuss how tuberculosis affects the program of their organizations. At luncheon the problem of tuberculosis in mental hospitals will be considered.

THE GENERAL ORAL AND PATHOLOGY EXAMINATIONS (Part II) for all candidates for the American Board of Obstetrics and Gynecology will be conducted at Chicago, Ill., by the entire board from Sunday, May 8, through Saturday, May 14, 1949. The Hotel Shoreland in Chicago will be the headquarters for the board. Formal notice of the exact time of each candidate's examination will be sent him several weeks in advance of the examination dates. Hotel reservations may be made by writing direct to the Shoreland.

Candidates for re-examination in Part II must make



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The above studies should be supplemented, when possible, with courses in mathematics, qualitative analysis, physical chemistry, foreign languages (Spanish, French, or German), and sociology.

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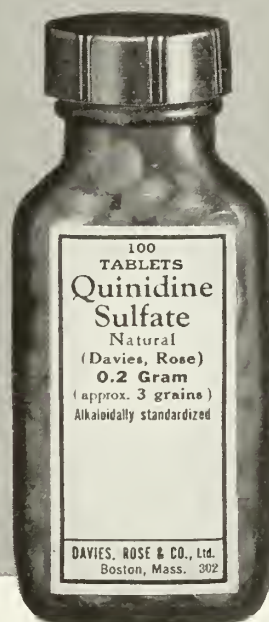
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written application to the secretary's office not later than April 1, 1949.

Candidates in military or naval service are requested to keep the secretary's office informed of any change in address.

Applications are now being received for the 1950 examinations. Application forms and bulletins are sent upon request made to: American Board of Obstetrics and Gynecology, Inc., 1015 Highland Building, Pittsburgh 6, Pa.

THE JEFFERSON MEDICAL COLLEGE announces the institution of courses in the basic medical sciences leading to the degrees of Master of Science and Doctor of Philosophy, beginning in September, 1949. The courses offered are in the major fields of anatomy, physiology, biochemistry, bacteriology and immunology, pharmacology and toxicology, and pathology. The baccalaureate degree is a necessary requisite for admission to all courses except pathology, which requires the degree of Doctor of Medicine. Heads of the six departments who will direct the courses are: George A. Bennett, M.D., professor of anatomy and director of the Daniel Baugh Institute of Anatomy; J. Earl Thomas, M.D., professor of physiology; A. Cantarow, M.D., professor of biochemistry; Kenneth Goodner, Ph.D., professor of bacteriology and immunology; Charles M. Gruber, Ph.D., M.D., professor of pharmacology; and Peter A. Herbut, M.D., professor of pathology.

A TWO-YEAR CROSS-SECTIONAL SURVEY OF INDUSTRY'S HEALTH FACILITIES, embracing 277 plants in 33 states, and just issued by Industrial Hygiene Foundation, discloses sweeping advances in occupational medicine and hygiene during the past twenty-five years.

The field study, covering an industrial population of 1,180,551 employees, was conducted by Clarence O. Sappington, M.D., of Chicago. The report is published as

a medical bulletin under the title, "Industrial Health Department Functions and Relationships," by Industrial Hygiene Foundation, located at Mellon Institute, Pittsburgh. Copies, priced at \$2.00, can be obtained from the Foundation.

In commenting on the study, John F. McMahon, managing director of Industrial Hygiene Foundation, stated:

"This factual study inventories industry's existing health facilities, procedures, and policies for conserving human resources in the world of work. Dr. Sappington's important investigation fills in gaps in existing knowledge and supplies information needed by industrial management. It is anticipated that the survey will help to accelerate the development and expansion of health departments in industry."

ART OF MEDICINE BECOMES SUSCEPTIBLE TO EXPERIMENTATION

The average doctor of medicine in glancing at this issue of the *Pennsylvania Medical Journal* may shy away from articles with portentous titles involving such words as psychosomatic, mechanisms, and phenomena.

Don't cast aside lightly the opportunity here encompassed, in high-sounding titles, to modify your own interpretation of the gulf between "science" and "art" in the practice of medicine.

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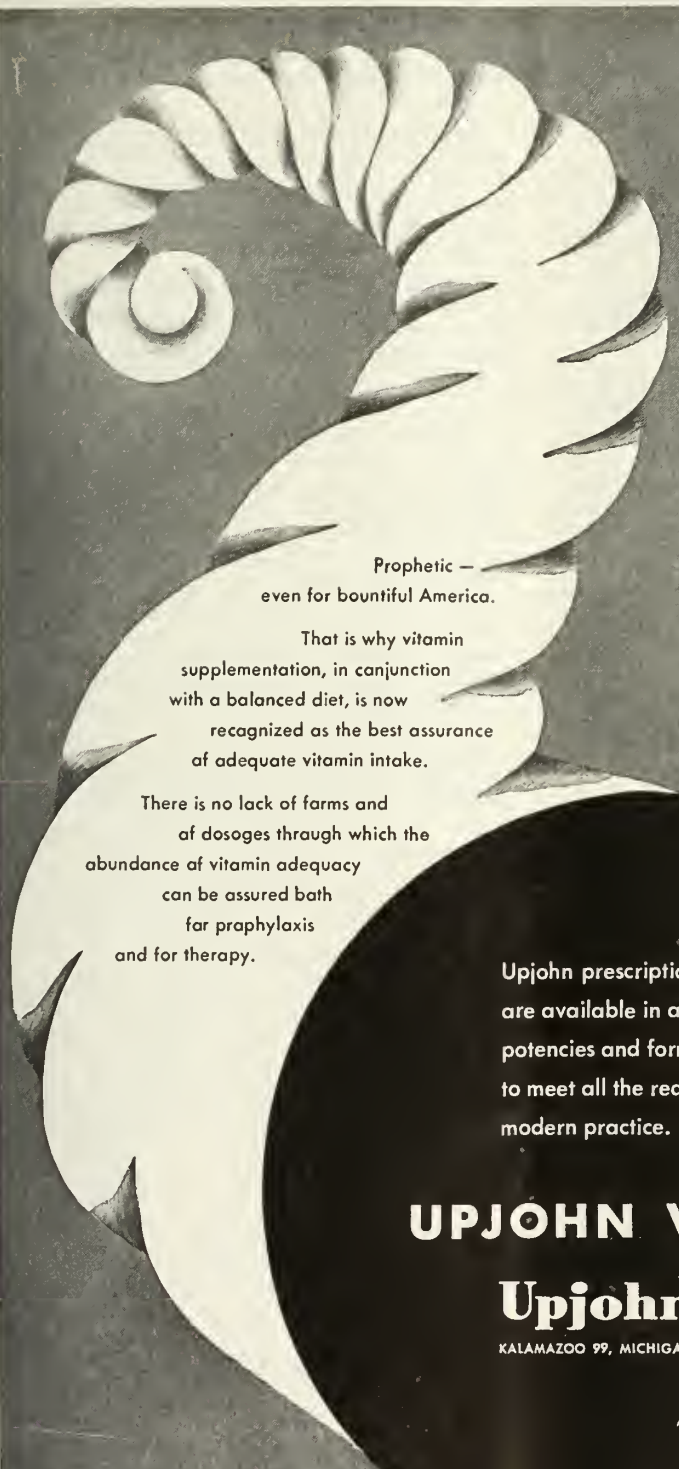
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Wanted.—General practitioners for rural practice in Juniata County. Contact ROBERT P. BANKS, M.D., Secretary, Juniata County Medical Society, Mifflintown, Pa.

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Wanted.—Registered laboratory technician, specially trained and experienced in histologic technique; 350 bed hospital; salary open. Write GEORGE J. HEID, JR., M.D., Lancaster General Hospital, Lancaster, Pa.

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Wanted.—Locum tenens or assistantship to busy general practitioner for three months prior to commencing graduate work. Available July 1, 1949. Young, capable, graduate of grade A school. Write Dept. 158, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Army medical officer leaving service August 15, 1949, desires assistantship or association with older well-established physician in Pennsylvania. Preferably north central area. Write Dept. 159, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Physician for general practice in a good Pennsylvania town with 700 population; no doctor at present; 1600 drawing population; hospital facilities 15 miles away. Good roads. Contact MR. J. RUSSELL CONDO, Centre County, Box 25, Spring Mills, Pa.

Wanted.—General resident immediately at the A. C. Milliken Hospital, Pottsville, Pa. Bed capacity 200. Monthly salary \$300 plus full maintenance. Write SISTER M. AVELINDIS, R.N., Superintendent, The A. C. Milliken Hospital, Pottsville, Pa.

Location Wanted.—Otolaryngologist, age 30, Navy combat veteran, excellent training, eligible for Boards, seeks location or association in eastern Pennsylvania. Available now. Write Dept. 156, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Four rotating internships, men or women, available July 1, 1949. Class A hospital of 260 beds located in Pittsburgh. Stipend \$100 monthly and full maintenance. Approved residencies. Write Dept. 157, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Resident physician, licensed to practice in Pennsylvania, for an 80-bed general hospital. Salary \$250 per month and maintenance. Write SUPERINTENDENT, Memorial Hospital of Chester County, West Chester, Pa.

Wanted.—Resident or house physician, male or female, licensed to practice in Pennsylvania, for a 120-bed general hospital. Excellent opportunity for varied experience and observation. Salary \$300 per month and full maintenance. Write ADMINISTRATOR, Bloomsburg Hospital, Bloomsburg, Pa.

For Rent.—Fully equipped office of deceased general practitioner. Central Pennsylvania town of 6000 with large surrounding rural area. Hospital available. Excellent opportunity for young man. Contact Mrs. JOSEPH L. DOUGHERTY, 54 East Main St., Mechanicsburg, Pa.

Wanted.—Chief medical officer for 382-bed general hospital in metropolitan area. Varied administrative duties. Young man preferred. Salary \$4,800 with full maintenance if single. House on grounds available free to married man. Write Dept. 161, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—A Philadelphia allergist, diplomate in internal medicine, Fellow of American Academy of Allergy, will instruct in clinical allergy in his office. Instruction includes history-taking, proper dilutions for testing, preparation of dust and pollen extracts, desensitization treatment. Write Dept. 160, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—Home and office combination of deceased physician. Located in Coaldale, Schuylkill County. First floor contains three-room office suite, living room, dining room, and kitchen. Second floor contains six rooms and bath. Two car garage. Price \$22,500; down payment \$5,000, balance payable monthly. For further information write THOMAS B. McDYER, 430 S. 54th St., Philadelphia, or call Sherwood 2222 or Granite 2792.

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For Sale.—Home and office combination located at 5259 Whitaker Ave., Philadelphia, facing Sears and Roebuck. First floor contains large sun porch, modern doctor's waiting room and private office, large sunny dining room, and modern kitchen in the rear. Basement contains a cellar and large garage. Second floor contains a beautiful living room and three bedrooms with an up-to-date bath. Oil hot water heat. Hardwood floors throughout. \$1,500 cash; 4½ per cent mortgage on the balance. Total price \$12,500. For further information write THOMAS B. McDYER, 430 S. 54th St., Philadelphia, or call Sherwood 2222 or Granite 2792.

ANTIBIOTIC MISTS YIELD VARIABLE RESULTS AGAINST SINUSITIS

Daily treatment with fine mists of penicillin or streptomycin apparently gives most sinusitis patients no more relief than do other treatments which doctors have been using against the disease for years, according to three New York doctors.

Writing in the March 19 issue of *The Journal of the American Medical Association*, the doctors (Eduardo R. Pons, Jr., Walter M. Glass, and Bettina Garthwaite, of the Departments of Medicine and Otolaryngology of the College of Physicians and Surgeons, Columbia University, and the Presbyterian Hospital) say:

"In the ordinary case of chronic purulent sinusitis, antibiotic aerosol therapy given once daily appears to have no superiority over accepted methods of treatment of sinusitis."

Antibiotic aerosols appear to be extremely useful in treating patients with long-standing chronic sinusitis who have had repeated sinus irrigations or extensive surgical treatment with poor response, patients who do not tolerate sinus irrigations, and patients who have chronic bronchopulmonary disease as well as sinusitis, they say.

The doctors treated 23 patients with penicillin aerosol, 23 patients with ephedrine, a drug that contracts the mucous membranes and has been widely used for sinusitis, and 10 patients with streptomycin aerosol.

All of these patients had had sinusitis continuously for six months, and the average duration of the disease in all except those treated with streptomycin was eleven years.

Treatments were given once daily, six days a week, and were continued up to four weeks.

Relief from sinusitis was about the same in penicillin-treated patients as in ephedrine-treated patients, among comparable cases, the doctors indicate, adding:

"Symptomatic improvement of sinusitis during treatment in cases studied apparently does not depend on the administration of penicillin, but is the result of the im-

proved ventilation and drainage of the sinuses which both methods of treatment provided."

On the basis of symptoms, 8 patients treated with penicillin, 5 patients treated with streptomycin, and 8 patients treated with ephedrine were considered decidedly improved. Seven treated with penicillin, two treated with streptomycin, and six treated with ephedrine were moderately improved.

Eight treated with penicillin, three treated with streptomycin, and nine treated with ephedrine had slight or no improvement in symptoms.

Most of the patients receiving streptomycin complained of severe nasal irritation, but no systemic toxicity was noted. Relief of chronic headache and of severe, long-standing symptoms was noted in patients treated with penicillin and in those treated with ephedrine.

Follow-up observations of 20 penicillin-treated patients were made in the first month after treatment. Although ten maintained the improvement they had made during therapy, seven others showed recurrence of symptoms.

Of the 18 ephedrine-treated patients seen during the first month after treatment, two maintained improvement, six had recurrences, and ten showed such poor results that they were given penicillin aerosol.

A rate of recurrences similar to that among penicillin-treated and ephedrine-treated patients occurred among patients treated with streptomycin.

"It is apparent that the United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country. This progress is now reflected in low mortality and morbidity rates of infectious diseases and in increased life expectancy. There is every reason to believe that these trends will continue unabated under our present system of medical care."—Report of The Brookings Institution on "The Issue of Compulsory Health Insurance," 1948.



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BOOK REVIEWS

ACUTE INTESTINAL OBSTRUCTION. By **RODNEY SMITH, M.S., F.R.C.S.**, Assistant Surgeon, St. George's Hospital, London; Consulting Surgeon, Wimbledon Hospital; Hunterian Professor, Royal College of Surgeons. With a chapter on radiologic diagnosis by **Eric Samuel, M.D., F.R.C.S., F.F.R., D.M.R.E.**, Late Radiologist, The Middlesex Hospital, London. 259 pages with 102 illustrations. Baltimore: The Williams & Wilkins Company, 1948. Price, \$5.00.

This new work is another of the recent texts that have come to these shores from England. Such a book is of interest because it affords some insight of the caliber of medical practice abroad. In particular this small but concise book is for the general surgeon, and the author and his colleagues have always kept this thought in mind.

The book is well organized, clearly written, and the procedures advocated are based upon the author's own experience in this field. However, in passing, several points must be mentioned. In discussing the treatment of protein deficiency in acute obstructions, mention of blood transfusion is conspicuous by its absence. Again, in the chapter concerning the place of chemotherapy, newer methods now at our disposal are not included. The references also are dated, the latest being 1946.

The book's contents comprise 29 chapters which are arranged into several large groups as follows: pathology, diagnosis, treatment, and individual varieties of acute intestinal obstruction.

This work should be of interest to those for whom it was intended, but only to make one realize the comparison of surgery here and abroad.

CLINICAL UROLOGY. Essentials of Diagnosis and Treatment. By **LOWRAIN E. MCCREA, M.D., F.A.C.S., F.I.C.S.**, Clinical Professor of Urology, Temple University Medical School; Attending Urologist, Philadelphia General Hospital. Second edition. 503 pages with 263 illustrations, including 7 in color. Philadelphia: F. A. Davis Company, 1948. Price, \$6.50.

This second edition appears only two years after publication of the first edition, which reflects the merited popularity of the text. The author has taken the opportunity offered to include recent advances made in the field, and this is reflected in the expansion of the text and the increase in number of illustrations.

The contents of the book are logically presented as follows: (1) the study of the patient, (2) diseases of the penis and the urethra, (3) scrotum and its contents, (4) prostate and the seminal vesicles, (5) bladder, (6) ureters, (7) kidneys, (8) impotence and sterility, (9) urology in the female, (10) urology in children. An enlarged index completes the book. The material is well written, and the printing, paper, and illustrations are very satisfactory.

For the purposes for which this book was written, namely, the what, how, and when of clinical urology for the general practitioner, intern, and student, this book is recommended.

CANCER OF THE ESOPHAGUS AND GASTRIC CARDIA. Edited by **GEORGE T. PACK, B.S., M.D.**, Clinical Professor of Surgery, New York Medical College; Attending Surgeon, the Memorial Hospital for Cancer and Allied Diseases, New York, N. Y. 192 pages, illustrated. St. Louis: The C. V. Mosby Company, 1949. Price, \$5.00.

This small book is a monograph of a symposium on cancer of the esophagus and gastric cardia which was

first published in the June, 1948 issue of *Surgery*. The various contributors, by the presentation of their individual opinions, afford a valuable summary of the scope of radical surgery at the present time, for contained within this compendium are papers by surgeons from all major surgical centers.

Each paper in this book is based upon the author's own experience. Each paper is well written and illustrated. References and an index supplement the material contained within the various papers. Altogether this is a rather well integrated book and is recommended for the general and abdominal surgeon.

CLINICAL ASPECTS AND TREATMENT OF SURGICAL INFECTIONS. By **FRANK LAMONT MELENEY, M.D., F.A.C.S.**, Associate Professor of Clinical Surgery, College of Physicians and Surgeons, Columbia University; Associate Visiting Surgeon, Presbyterian Hospital, New York City. 840 pages with 287 illustrations. Philadelphia and London: W. B. Saunders Company, 1949. Price, \$12.00.

This book is a monograph based upon the author's long experience in the field of surgery of bacterial infections. The text discusses the various areas, tissues, and organs which may be the seat of pyogenic and necrotizing organisms causing infections related to surgery, each phase being clarified by significant case presentation. Truly this book may be considered of more than passing interest and help to surgeons and general practitioners, as also the companion volume previously published in July, 1948.

The contents of the book are systematically presented within 18 chapters, all rather well written and illustrated. At the end of each section is a list of references which provide a source for further information. The printing and paper on the whole are good. On page 735 the heading of the graph needs revision, and this is the only criticism that this reviewer can make.

The author and his collaborators have had many years of clinical experience with the measures they discuss so well, and for these reasons this book is recommended.

BRITISH SURGICAL PRACTICE. Under the general editorship of **SIR ERNEST ROCK CARLING, F.R.C.S., F.R.C.P.**, Consulting Surgeon, Westminster Hospital, and **J. PATERSON ROSS, M.S., F.R.C.S.**, Surgeon and Director of Surgical Clinical Unit, St. Bartholomew's Hospital; Professor of Surgery, University of London. In eight volumes (with index volume). Volume 4. London, England: Butterworth & Co. (Publishers), Ltd. St. Louis: The C. V. Mosby Company, 1948. Price, \$15.00.

Upholding the high standards demonstrated in the earlier volumes of this set, this book covers subjects from facial palsy to hiccup. As before, each contributor is an eminent authority of the British Isles who also has the knack of writing well, so that there is little that can be offered as criticism. The material presented reflects the current advances in the various fields covered; and because the delineation of the surgical field covered in this book is so well organized, it may be considered as recommended reading for both student and practitioner.

The contents of the book are alphabetically and systematically presented as follows: facial palsy, faciomaxillary injuries and deformities, fallopian tubes, fascial grafts, fat necrosis, fibrositis, filariasis, fistula in ano, focal epilepsy, foot—surgery of, fractures, dislocations, and allied injuries, frostbite, gallbladder and bile

passages, ganglion, gas gangrene, gastrocolic fistula, gastrostomy, genital organs, gland—puncture and biopsy, glanders, glaucoma, glomus tumors, glottis, gonorrhea, gout, gunshot wounds, hands, heart and pericardium, hematoma, hemophilia, hemorrhage, hernia, herpes zoster, heterotopia, hiccup, and index.

SURGERY OF THE EYE. By MEYER WIENER, M.D., Emeritus Professor of Clinical Ophthalmology, Washington University School of Medicine; Honorary Consultant in Ophthalmology, Bureau of Medicine and Surgery, U. S. Navy. Second edition. New York: Grune & Stratton, 1949. Price, \$12.00.

This new and revised edition appears ten years after the first edition was printed. In part it presents recent developments in the surgical field of ophthalmology such as the preparation of sutures preliminary to the incision for cataract, Barkan's technique for congenital glaucoma, and Burch's implantation in evisceration. The author maintains his intention of presenting an atlas for the practicing ophthalmologist and student, and not a book of reference. In this he has been successful.

In passing, certain pointed criticisms must be noted. The chapter concerning the preparation of the patient needs modernization. Spelling here and there needs correction. The section on supplementary anesthetic agents is antiquated, as are the sections on instruments and supplies and on control of infections. There is a chapter without pictures; in other places the pictures are repetitious. Among the good features noted are satisfactory printing and paper and, on the whole, the illustrations throughout the book are good; the contents are logically and systematically presented.

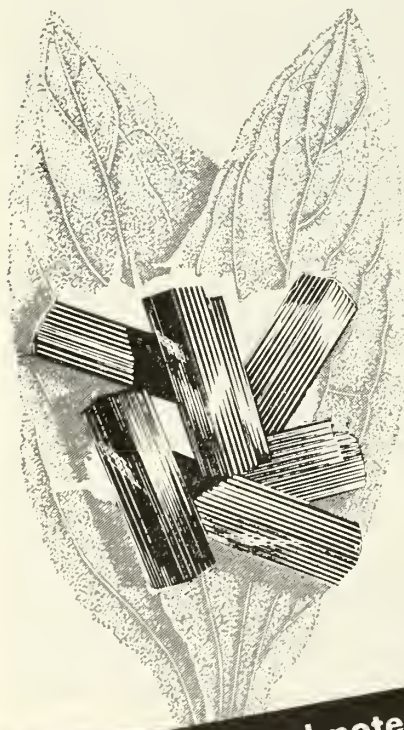
Within the scope of the purpose for which this book is presented, it is recommended for the practicing physician and student.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

DOCTORS OF INFAMY. The story of the Nazi medical crimes by ALEXANDER MITSCHERLICH, M.D., head of the German Medical Commission to Military Tribunal No. 1, Nuremberg, and FRED MIELKE. Translated by Heinz Norden with statements by three American authorities identified with the Nuremberg medical trial: Andrew C. Ivy, M.D., Vice-President, University of Illinois; Medical Scientific Consultant to the Prosecution, Military Tribunal No. 1, Nuremberg; Telford Taylor, Brigadier General, U. S. Army, Chief of Counsel for War Crimes; Leo Alexander, M.D., Psychiatrist, Consultant to the Secretary of War and to the Chief of Counsel for War Crimes; and a Note on Medical Ethics by Albert Deutsch (including the new Hippocratic Oath of the World Medical Association). Illustrated with 16 pages of photographs. New York: Henry Schuman, Inc., 1949. Price, \$3.00.

DIABETES AND ITS TREATMENT. By JOSEPH H. BARACH, M.D., F.A.C.P., Associate Professor of Medicine, University of Pittsburgh; Senior Medical Staff, Presbyterian Hospital; Medical Director, Outpatient Department of the Medical Center Hospitals, School of Medicine, University of Pittsburgh; President, American Diabetes Association (1944-6); Chairman, Metabolism and Endocrinology Study Section, Research Grants Division, U. S. Public Health Service (1946-51). New York: Oxford University Press, 1949. Price, \$10.00.



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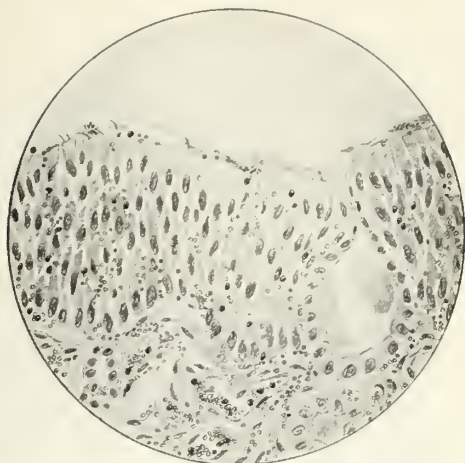
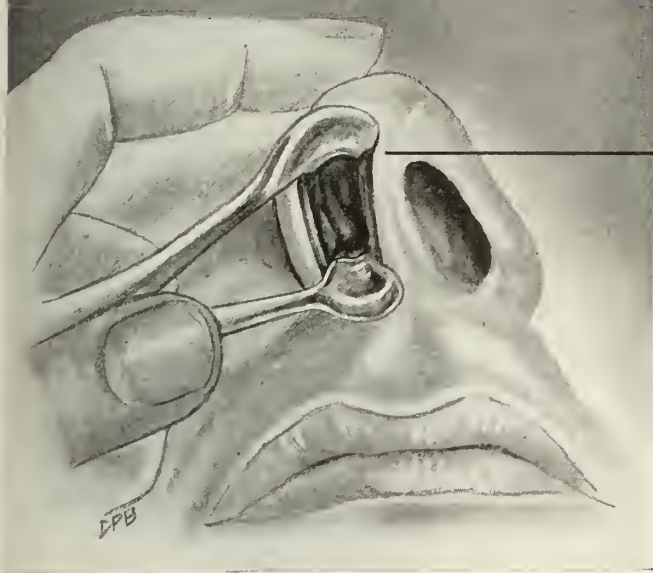


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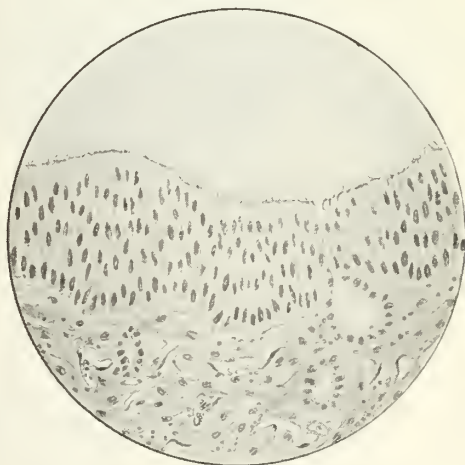
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HANDBOOK OF DISEASES OF THE SKIN. By RICHARD L. SUTTON, M.D., Emeritus Professor of Dermatology and Syphilology, University of Kansas Medical School, and RICHARD L. SUTTON, JR., M.D., Associate Professor of Dermatology and Syphilology, University of Kansas Medical School. With 1057 illustrations. St. Louis: The C. V. Mosby Company, 1949. Price, \$12.50.

OPERATING ROOM TECHNIQUE. By EDYTHE LOUISE ALEXANDER, R.N., Supervisor of the Operating Rooms of the Roosevelt Hospital, New York City; formerly Supervisor of Operating Rooms, Mountinside Hospital, Montclair, N. J.; Supervisor of Private Pavilion Operating Rooms, New York Hospital, New York City. With 668 illustrations. Second edition. St. Louis: The C. V. Mosby Company, 1949. Price, \$10.00.

CLINICAL ORTHOPTICS — DIAGNOSIS AND TREATMENT. By MARY EVERIST KRAMER, Supervisor of Orthoptic Department, George Washington University Hospital, Washington, D. C. Edited by Ernest A. W. Sheppard, M.D., Professor of Ophthalmology, George Washington University School of Medicine, Washington, D. C., and Louisa Wells-Kramer, Certified Orthoptic Technician, Washington, D. C. 147 illustrations. St. Louis: The C. V. Mosby Company, 1949. Price, \$8.00.

PRACTICAL ASPECTS OF THYROID DISEASE. By GEORGE CRILE, JR., M.D., F.A.C.S., Department of Surgery, Cleveland Clinic. Illustrated. Philadelphia: W. B. Saunders Company, 1949. Price, \$6.00.

ATLAS OF PERIPHERAL NERVE INJURIES. By WILLIAM R. LYONS, Ph.D., Associate Professor of Anatomy, University of California Medical School, and BARNES WOODHALL, M.D., Professor of Neurosurgery, Duke Medical School, Durham, N. C. Philadelphia: W. B. Saunders Company, 1949. Price, \$16.00.

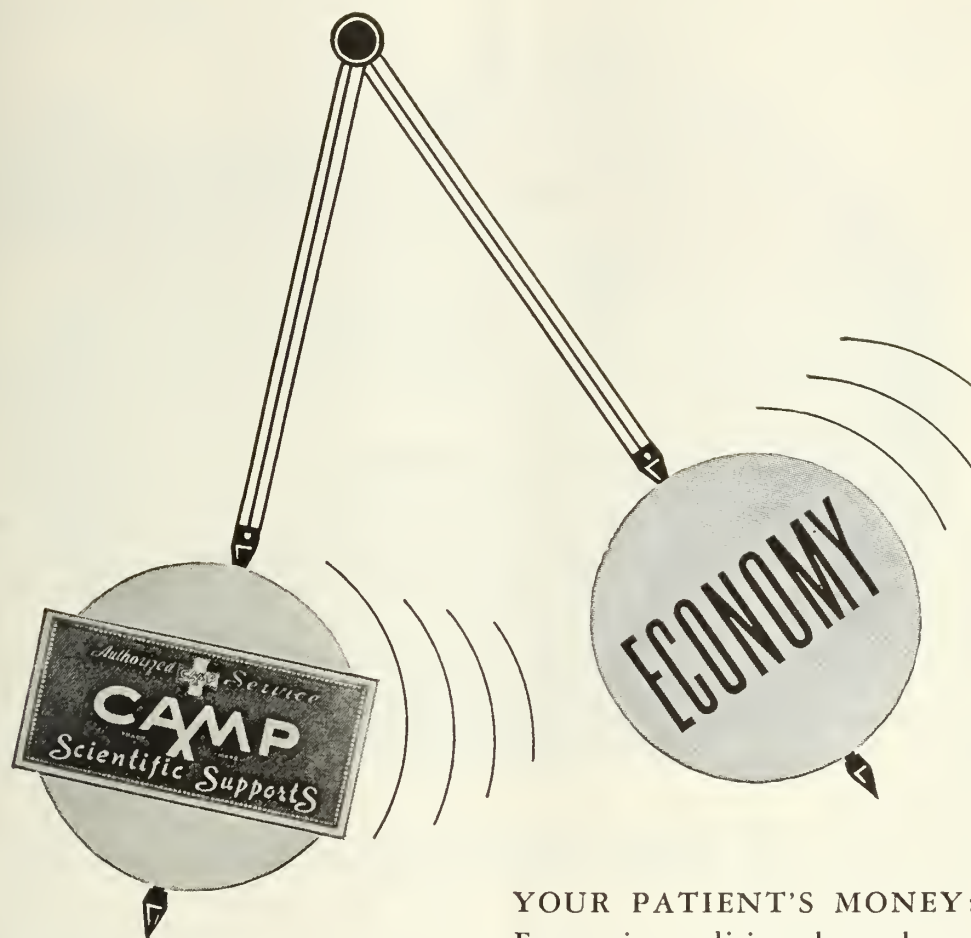
ATLAS OF NEUROPATHOLOGY. By WILLIAM BLACKWOOD, M.B., F.R.C.S.E., Assistant Pathologist, the National Hospital, Queen Square, London; formerly Senior Lecturer in Neuropathology, University of Edinburgh, Neuropathologist to the Scottish Mental Hospitals' Laboratory, the Royal Infirmary, Edinburgh, and Edinburgh Municipal and Emergency Medical Services Hospital; T. C. DODDS, F.I.M.L.T., F.I.B.P., F.R.P.S., Laboratory Supervisor, Department of Pathology, University of Edinburgh; Lecturer to the Society of Radiographers (Fellowship Course), Scottish Branch; and J. C. SOMMERVILLE, A.I.M.L.T., Senior Technician, the Department of Neuropathology, University of Edinburgh, and Scottish Mental Hospitals' Laboratory. Foreword by Professor A. Murray Drennan, M.D., F.R.C.P.E., F.R.S.E., Professor of Pathology, University of Edinburgh. Baltimore: The Williams & Wilkins Company, 1949. Price, \$9.00.

THE PHARMACOLOGIC PRINCIPLES OF MEDICAL PRACTICE. A textbook on pharmacology and therapeutics for medical students, physicians, and the members of the professions allied to medicine. By JOHN C. KRANTZ, JR., Professor of Pharmacology, School of Medicine, University of Maryland; Secretary of the General Committee of Revision of the United States Pharmacopoeia. Baltimore: The Williams & Wilkins Company, 1949. Price, \$10.00.



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THE PENNSYLVANIA MEDICAL JOURNAL

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NUMBER 8



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Prostatectomy for Carcinoma of the Prostate

George Gilbert Smith



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An Editorial



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1949 Scientific Program Planned by Surgery
and Its Allied Specialties

Officers' Department



Responsibility of a Local Society
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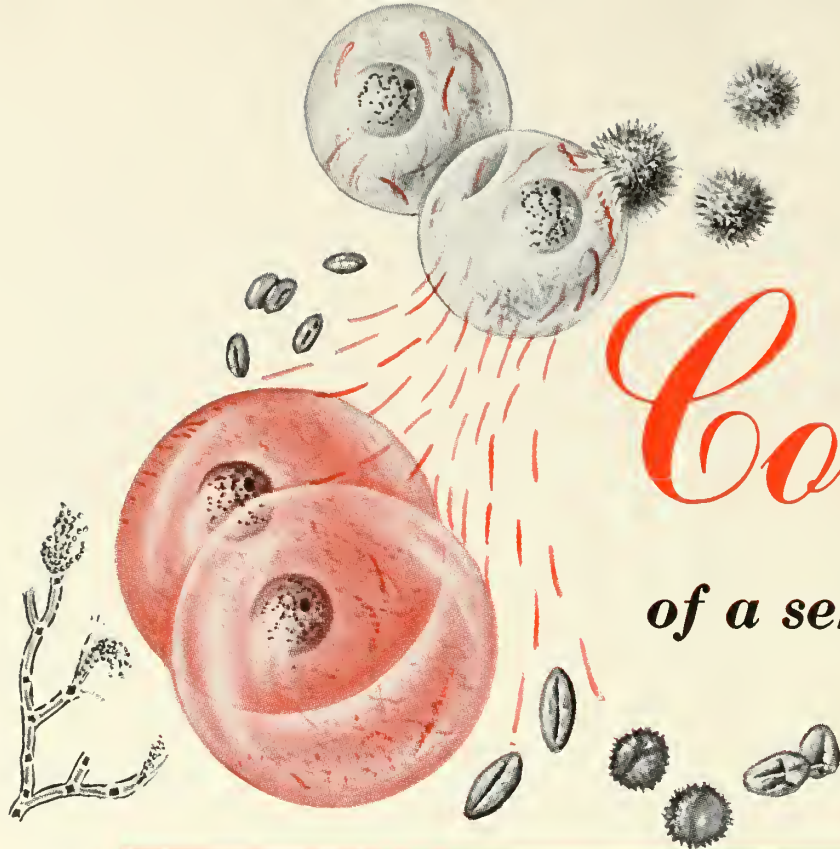
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Conditions for which the treatments were given included sinusitis, coryza, bronchitis, chronic rhinitis, bronchial asthma, laryngitis, allergic rhinitis, hay fever, and pharyngitis. The treatments consisted of the inhalation of finely nebulized saline-alkaline, naturally carbonated mineral waters, and medicated oils.

The relief obtained bore a definite relation to the number of treatments taken. In

acute conditions, from four to six treatments were necessary to obtain consistent improvement while in chronic conditions, twelve to fifteen treatments were usually required.

Inhalations are taken without discomfort, which is an important factor in therapy.

The safety of the therapy can be stressed. Reactions of significance occurred in only three patients. One patient may possibly have had a sensitivity to chlorenan, one developed an acute asthmatic paroxysm, and the third noted a general reaction to epinephrine.

Attention to the general condition of the patients suffering from respiratory disorders is an important factor. Inhalations have a definite place in the general "cure" regimen of a spa.

* As printed in the New York State Journal of Medicine, 44:1214 (June 1) 1944.



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Listed by the Committee on American Health
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As Invert.	37.66
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Call Again

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A. A. MANNING, Lt. Colonel, AF NGUS,
Post Office Box 187,
New Cumberland, Pa.

Medical Service in European Theater

Attention! Prospective Military Medical Officers

GENTLEMEN:

The present letter is written at the request of Dr. Henry M. Thomas, Jr., who suggested that views of the civilian consultants to the Surgeon General, who visited the European Theater in 1948, may be of interest to medical officers and others in the United States.

In April, 1948 I visited the medical installations in Munich, Frankfurt, Würzburg, Bremerhaven, Salzburg, Nürnberg, Vienna, and Heidelberg. While the assignment pertained essentially to the aspects of internal

medicine, there were opportunities to inspect the general facilities and discuss with medical officers and their families the attitudes and experiences both in and out of the Army circle. I was especially interested in finding out the chances for medical officers to improve their knowledge of medicine, and to compare the military experiences in peacetime with those of military conditions during World War II.

I found that the hospital buildings in the European Theater were remarkably satisfactory and well preserved notwithstanding the ruins that marked Germany and Austria as a whole. The United States Army has adapted the existing architecture and facilities in a practical manner, and provided equipment and supplies for the adequate study, treatment, and comfort of the soldiers. While the housing facilities were limited, the Army used every possible arrangement for the comfort of the officers and their families.

I was impressed and gratified with the attitudes and ability of the medical officers. The majority were recent graduates and they served in a manner not often equaled by older and more experienced officers. The chiefs of the medical services in particular demonstrated a marked degree of alertness, ability, and enthusiasm. The ward rounds and conferences were conducted with maturity and there was no single example of unsatisfactory clinical judgment or inappropriate treatment. This was remarkable since the formal training of these medical officers was acquired under the accelerated program of medical schools, the periods of internship having been limited to nine months. While it appeared that "the responsibility made the officer," I wish to emphasize that supervision through the office of the chief surgeon was timely, effective, and definitely contributory to success. There were several occasions during the tour when it was possible to witness the management of obscure cases. The chief of service communicated with the office of the chief surgeon for advice and definite instructions in a manner that would be characteristic of an intern asking the advice and guidance of the chief resident physician located in the same building. In one instance the consultant came to the hospital by airplane; in the other the patient was transported to the nearest diagnostic center. I mention these cases because of the remarkable opportunity for the young medical officer to study difficult problems under the appropriate checks and balances of older and more experienced officers. The Army in being forced to utilize younger men for important and responsible positions was making a very important step in training medical personnel. It appeared that the young medical officer was thriving under the influence of responsibility, thoughtfully supported by the chief surgeon. It occurred to me that interns in civilian hospitals are being stifled somewhat by excessive supervision.

It was interesting to note that a wide variety of diseases and conditions existed in most medical services. This was possible largely through the admission of civilian personnel. Naturally the wide variety of diseases was greatest in the general hospitals where diagnostic proceedings and therapeutic measures were more elaborated.



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PENNSYLVANIA

Regarding evidences of dissatisfaction with the Army as reported during the winter and spring of 1948, I may state that the criticisms in the European Command as of April, 1948 were extremely rare—in fact, striking because of their infrequency. There were a few examples of discontentment because of prolonged assignments to dispensary service. In one installation there was tension resulting from the rigid and overzealous policies of the commanding officer. These situations were in the process of adjustment at the time of my visit. I found that officers were being rotated rather freely throughout the Command and there was remarkable freedom from participation in drilling and maneuvers. It was interesting that only one medical officer complained of boredom and disinterest due to lack of medical work. I mention this observation particularly because it is in marked contrast with the situation observed during World War II when innumerable officers were unable to participate in medical activities and had been assigned to administrative posts. I would add that the European Command reflected, no doubt, the judgment of the Surgeon General in carefully adjusting factors that would be disconcerting to medical officers. There is the attitude "let's practice good medicine in a systematic manner, and eliminate 'snafu' and disinterest." While some of the medical officers in the European Theater were looking forward to the day when they would be discharged from the Army, I found, in general, that there was a remarkable degree of contentment, interest in the localities and in the type of medical work available to them. Their families in general were contented.

The opportunities for graduate courses in Vienna as provided by the Army have aroused great interest. I talked to a number of officers who have taken courses in anatomy, pathology, and internal medicine, and they were most enthusiastic. Since their return to the United States they have mentioned that the combination of medical responsibility and graduate courses was the outstanding opportunity since their graduation from medical school.

The Surgeon General has assigned well-qualified and understanding surgeons to supervise the medical activities and as a result "hit and miss methods" are not employed. Supplemented are the opportunities for graduate courses in civilian hospitals and the visits of the civilian consultants to the Surgeon General. I wish to note with special emphasis that medicine in the United States Army is in close parallel with the very best in civilian practice, and an assignment to serve in the European Theater should be regarded as an extremely attractive, interesting opportunity.

BURGESS L. GORDON, M.D.,
Philadelphia, Pa.

School Health Survey

GENTLEMEN:

The secretary of each county medical society will soon receive in the mail a questionnaire on school health services in his community. The American Medical Association in cooperation with the U. S. Office of Education is making a study of school health services through its Bureau of Health Education. The survey is a preliminary step in efforts designed to bring about improvement of school health programs within the framework of the private practice of medicine. For this reason, it is most important that each county medical society complete and return the questionnaire.

The U. S. Office of Education in Washington will concurrently query the schools. Two different questionnaires which supplement and reinforce each other and

contain no duplicate questions are being used. The information requested is needed to determine present strengths and weaknesses in school health services, to indicate needs, and to point up action for the future. The questionnaire has been tested prior to printing and all unnecessary questions eliminated.

Publication of the above statement in your state medical journal will be much appreciated.

WILLIAM W. BOLTON, M.D., Associate Director,
Bureau of Health Education,
American Medical Association.

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The first school of medical illustration in the southeastern United States has been opened at the University of Georgia School of Medicine. The courses are designed to equip illustrators for all types of scientific illustration.

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University of Georgia School of Medicine,
Augusta, Ga.

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At the present time the New Cumberland General Depot has vacancies for two medical officers and two psychiatrists, P-5, at \$6,235.20 per annum.

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DAVID E. HOLLENBAUGH,
Civilian Personnel Officer,
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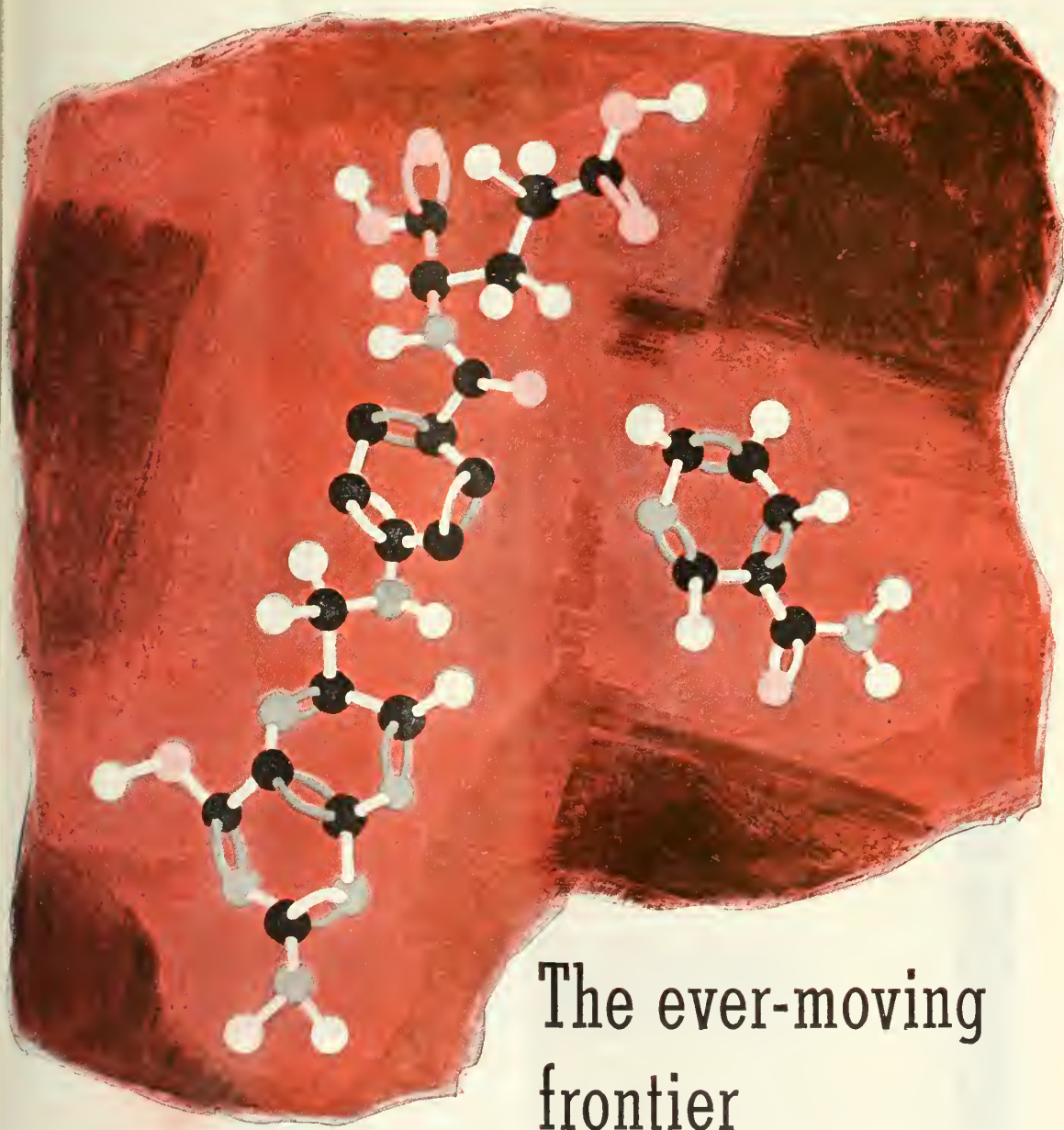


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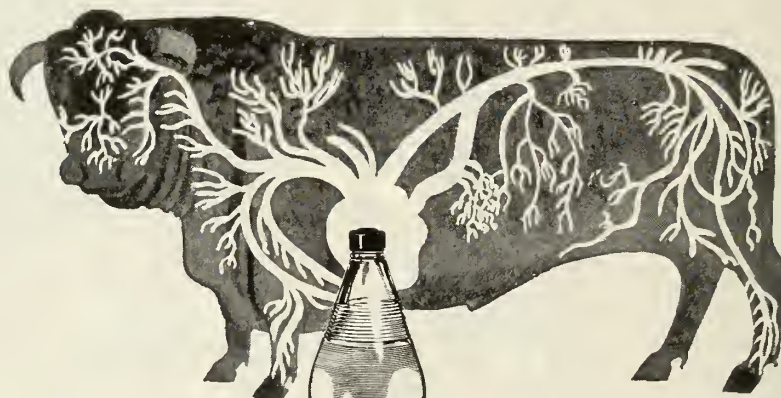


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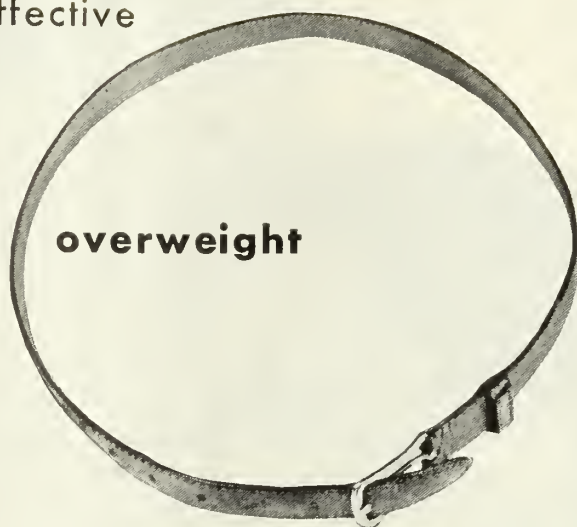
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1. Christensen, H. N., Lynch, E. L., Decker, D. G., and Powers, J. H. (1947), The Conjugated, Non-Protein, Amino Acids of Plasma.
IV. A Difference in the Utilization of the Peptides of Hydrolysates of Fibrin and Casein, J. Clin. Invest., 26:849, September.

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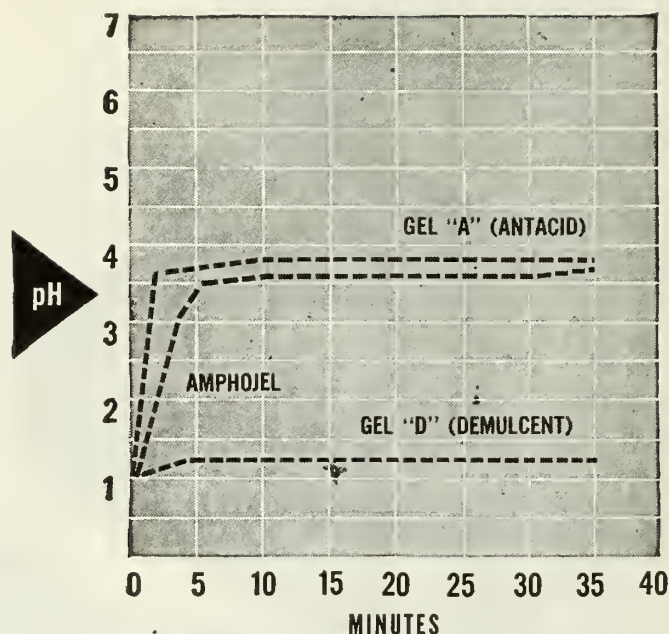
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*Meyer, K. A., and Kozoll, D.D.: Progress in the Treatment of Carcinoma of the Stomach and Esophagus, South Dakota J. Med. & Pharm. 2:39 (Feb.) 1949.

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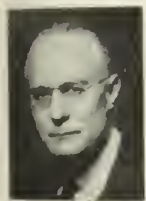
VOLUME 52

MAY, 1949

NUMBER 8

Experiences and Results in Total Perineal Prostatectomy for Carcinoma of the Prostate

GEORGE GILBERT SMITH, M.D.
Boston, Mass.



ALTHOUGH removal of the prostate and vesicles for the cure of prostatic cancer had been done by European surgeons a few times during the last quarter of the 19th century,¹ the operation as we know it today was developed by Hugh Young. Dr. Young did the operation in 1904 and described it in the *Johns Hopkins Hospital Bulletin* in 1905.² For many years this operation was seldom employed except by Young and the men associated with him, but with the passage of years the appearance in the literature of increasingly large series of total prostatectomies and the teaching of the technique of perineal surgery by Young's disciples resulted in the adoption of this operation in a number of urologic centers.

The medical profession in general has become aware of the possibility of curing early cases of prostatic cancer by radical surgery. Students should be taught the necessity for rectal examination in all men of 50 or more years of age and should learn to recognize the signs of early prostatic malignancy. Then we may expect to see an increasing number of patients in whom total prostatectomy can and should be done.

Doctors also should be made aware of the danger of indiscriminate use of testosterone in middle-aged men. Baron and Angrist³ examined the prostate by serial sections in a series of unselected consecutive autopsies on fifty men over 50 years of age, none of whom died of prostatic cancer; they found occult carcinoma of the prostate in 46 per cent. If their findings are at all representative of the situation, there must be many men in whom the administration of androgens may activate such microscopic foci of prostatic carcinoma.

In the selection of cases for total prostatectomy, two groups of criteria must be considered. One concerns the general operability of the patient, the other the extent of the carcinoma. The age of the patient is an important factor. I did not appreciate this when I first began to do this operation; of the six hospital deaths in this series, four were in men over 75 years of age. The other two were in men in their early seventies. In all, 11 patients 75 or more years of age were operated upon. Of the seven who were discharged from the hospital, four died of carcinoma within four years, one died a cardiac death in four years, one died of senility in seven years, and one is apparently well six years after operation. The life expectancy at 75 is around six years; I have had several patients who, under hormonal therapy, have lived and are in good health six years after the beginning of this treat-

Read before the Section on Urology at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 6, 1948.

Dr. Smith is a member of the Board of Consultation of the Massachusetts General Hospital, and urologist to the Palmer Memorial Hospital.

ment. It would seem that most men of 75 with cancer of the prostate stand a better chance with conservative than with radical treatment.

The operation in my hands requires from one and a half to two hours. The exaggerated lithotomy position, which is quite essential, places a burden upon the heart, especially if the patient is obese; a reasonably sound cardiovascular system is therefore necessary. So also is good renal function.

The extent of the carcinoma is of major importance. I do not believe that total prostatectomy should be attempted if it can be shown that the growth has extended beyond the prostate and vesicles. Metastases to the bones, as shown by x-ray, or to the pelvic lymph nodes as suggested by pain radiating to the thigh or by edema of the thigh, are contraindications to this operation. Involvement of the trigone, discovered at cystoscopy, should be very carefully considered; because it is possible to remove a good portion of the trigone or a segment of bladder wall adjacent to the prostate, one is tempted to operate upon patients who show such lesions, but the likelihood of being able to remove all of the growth is slight.

There should be a free sulcus between the lateral surfaces of the prostate and the pelvic wall; it is most important that the sulcus between the apex of the prostate and the perineum is not invaded, for there must be sufficient membranous urethra free from growth to allow for its anastomosis to the bladder. The base of the prostate must be well differentiated from the soft

base of the bladder; induration which extends upwards over the bladder base contraindicates total prostatectomy.

Palpable involvement of the seminal vesicles presents a problem. The vesicles are usually the first structures to be involved when the cancer breaks out of the prostatic capsule. In this series of around a hundred cases I removed the vesicles entirely in 71 patients; in eight neither vesicle was removed. In 21 cases one entire vesicle or considerable portions of both were removed. It is unfortunate that in only a small percentage of vesiculectomies was there a report by the pathologist as to the involvement of the vesicle. There were 17 cases in which the vesicles were definitely affected as proved either by the presence of induration or by microscopic examination. In some vesicles which felt normal, carcinoma was discovered on pathologic examination; it is probable that in many more there was similar microscopic involvement. Of the 17 cases known to have vesicular involvement, 2 cases early in the series were treated with radium; both were unsuited for total prostatectomy. Ten patients died of cancer within three years, one in four years, one in six years, one in seven and one-half years. One died a cardiac death in ten years with malignancy in his spine; one is still alive eleven years after operation, although he has a malignant stricture of the rectum due to recurrence of his prostatic cancer.

Among the 29 patients in whom total vesiculectomy was not done, eight died of cancer within four years and one each in six, seven, eight, and fifteen years. Three died of other causes: pulmonary embolus, ten days; cerebral embolus, six years; and cardiac disease, ten years. Eight are alive and apparently well after one, four, five, five, nine, ten, twelve, and thirteen years. Twelve patients, therefore, whose vesicles were not removed have lived an average of 8.8 years after operation. Ten patients showed no local recurrence.

From these somewhat inconclusive statistics one may draw at least two conclusions: (1) involvement of one or both vesicles makes the prognosis definitely less good; (2) every effort should be made to remove both vesicles entirely, including their tips. In spite of absence of induration, the vesicle may be invaded by cancer.

Perhaps the most difficult problem which faces the urologist interested in radical prostatectomy is that which he must answer when he examines a patient whose prostate feels suggestively but not definitely malignant. We cannot put everyone whose prostate feels firmer than is normal through a perineal biopsy, nor is biopsy always

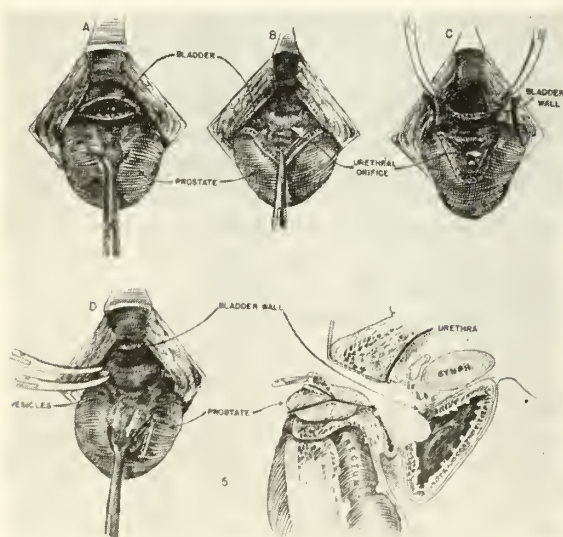


Fig. 1

- A. Incision through anterior bladder wall.
- B. Incision carried down to trigone on either side.
- C. Trigone divided transversely close to bladder neck.
- D. Vasa and vesicles exposed from above. Clamp on right vas.

a reliable guide. I believe that repeated rectal examinations, done perhaps every month, may be necessary to build up in the mind of the examiner a positive opinion. He should not delay decision until the diagnosis is certain, for that may be too late; but when the diagnosis of malignancy becomes a probability instead of a possibility, he should advise operation.

If operation is done, the lateral as well as the posterior aspects of the prostate should be exposed and the gland carefully palpated. From this the operator will probably be able to decide whether the gland is malignant, but if he is still in doubt, he may excise from the firmest area a piece of tissue at least a centimeter in diameter for frozen section and microscopic examination. Even this test may not be always reliable. In 24 questionably malignant prostates on which biopsy was done, there were three in which I had not suspected malignancy before operation. All three had positive biopsies. There were five in which I was doubtful of the diagnosis before operation, four of which proved positive; the fifth gave a negative biopsy, but as the gland was obstructive I removed it. Later examination failed to show cancer. There were three with negative biopsy which were removed because I still thought them to be malignant; later examination proved this to be the case. A similar experience has been reported recently by Frank Hinman, Jr.⁴ In one of my patients the biopsy was positive, the prostate and vesicles were removed, and no carcinoma was found at later examination.

Needle biopsy through the perineum has been found helpful by several writers. My own experience with this method has not been satisfactory, and I doubt if in early carcinomas it will prove accurate in a sufficiently large percentage of cases to be relied upon. Some, perhaps only a few, will be missed, and that we must do all in our power to avoid. I am in favor of doing a total prostatectomy if palpation both before and at operation shows characteristic changes in the prostate.

The total removal of a prostate which is fibrotic may be in fact a sound procedure. There are in my records the histories of four patients who, having had conservative perineal prostatectomies with pathologic reports of fibrosis in two and benign hyperplasia in two, were proved to have cancer of the prostate six, eight, ten, and twelve years later.

The fact that carcinoma not infrequently develops in those portions of the prostate not removed by the conservative operation, whether the operative route be suprapubic, perineal, or

transurethral, has led me to do total prostatectomy, though not vesiculectomy, in a number of patients in whose prostates there is no suggestion of malignancy. Only when this is done can I assure the patient that he will never have further trouble from his prostate. The only objection to this procedure is the almost certain loss of erectile power. This phase should be fully understood by the patient so that he may choose which course he prefers.

Technique

The operation which I have done is essentially the same as that described by Hugh Young. It has seemed advisable to remove the fascia of Denonvillier; in some cases it is adherent to the capsule of the prostate and may be invaded by the carcinoma.

The inferior and lateral borders of the prostate are exposed; the membranous urethra, which measures a centimeter in length between the apex of the prostate and the upper layer of the triangular ligament (or urogenital fascia as it is sometimes called), is drawn forward by a right-angled clamp and is divided at the apex of the prostate. A Markley tractor is passed through the prostatic urethra and its blades are spread; this enables the operator to draw the prostate well down into the field of operation. The anterior surface of the gland is then easily freed of loose connective tissue and the anterior bladder wall adjacent to the prostate is exposed. An incision into the bladder is made upon one blade of the rotated tractor; this incision is extended downward upon each side close to the bladder neck. The tractor is removed, the ante-

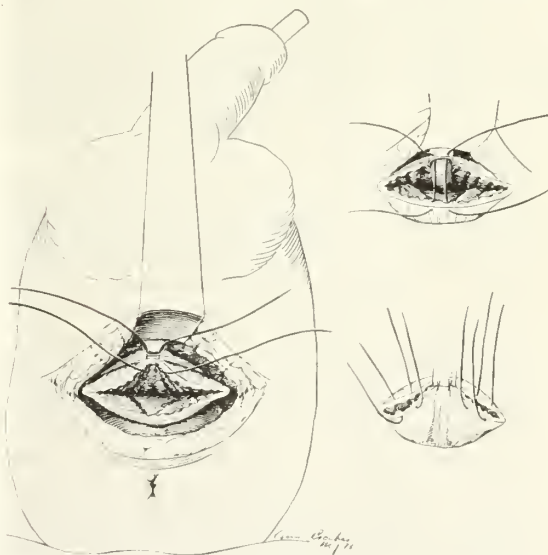


Fig. 2. Method of closing bladder neck.

TABLE I
TOTAL PROSTATECTOMY

	<i>Cases</i>		
Died of cancer	45		
<i>Length of life after operation</i>			
	<i>Cases</i>		
Under 1 year	8	5-6 years	3
1-2 years	9	6-7 years	5
2-3 years	5	7-8 years	2
3-4 years	5	9-10 years	2
4-5 years	3	11-12 years	3
No hormonal treatment	40		
Hormonal treatment	5		
Vesicles known to be involved in 15	(33%)		
Thirteen patients developed paraplegia from spinal metastases			

rior commissure of the prostate is grasped with a Jacobs forceps and drawn forward, thereby exposing the trigone. The lower ends of the lateral incisions are joined by a transverse incision extending across the trigone, and the trigone is easily stripped upward. This exposes the upper surface of the vesicles and the ampullae of the vasa, as well as the intervesicular plateau. These structures are freed from the pelvic wall, the blood supply to the tips of the vesicles and to the prostate are clamped; the vasa are clamped and cut. Prostate, vesicles, and ampullae are then removed.

In closing the defect between the bladder neck and the cut end of the membranous urethra, the anterior segment of the vesical neck is sutured to the corresponding segment of the urethra by three interrupted sutures of #00 chromic catgut. This is facilitated by passing a catheter through the urethra, drawing the tip of the catheter out of the incision, grasping the tip and the butt of the catheter with a clamp, and drawing their ends upward. A bulb retractor placed beneath the catheter as the latter emerges from the urethra brings the anterior segment of the cut end of the urethra into view.

In closing the defect which necessarily exists when the relatively large bladder neck is approximated to the much smaller circumference of the urethra, I employ a different method of closure from that described by Young. After the anterior segment of the bladder neck has been sutured to the urethra, instead of suturing the edge of the trigone vertically in the midline, I insert the end of the catheter into the bladder and suture the midpoint of the trigone to the posterior edge of the urethra, completing the closure by suturing together the edges of the bladder neck as they extend outward and posteriorly from the midline. In placing these sutures, one must

avoid the ureters which usually lie quite near the cut edge of the trigone.

To be avoided are: opening the peritoneum, which sometimes extends into the area lying between the ampullae; placing the sutures used to approximate the bladder neck to the membranous urethra too deeply so that they include the compressor urethrae muscle lying between the two layers of the urogenital fascia; including the lower ends of the ureters in the sutures used to close the bladder neck; failure to ligate all bleeding points in the retrovesical space.

There is less danger of entering the rectum in total prostatectomy than in the conservative operation, as the exposure is better and the rectum is more completely mobilized.

In closing the incision, the edges of the levator ani muscles should be approximated as far up as possible. The superficial perineum is repaired by a layer of catgut sutures in the superficial fascia and by vertical mattress sutures to the skin. At least one, sometimes two, cigarette wicks are left in the areas from which the vesicles were removed.

Results

In a series of 95 total prostatectomies covering the last twenty-five years, there were six hospital deaths. Five of these were in poorly selected patients and occurred in the first 43 cases. The sixth death, the only fatality in the last 52 cases, was due to a massive pulmonary embolus.

Forty-five patients died of carcinoma of the prostate. The duration of life after operation is shown in Table I. Fourteen died of other causes, without evidence of recurrence; five of these lived more than five years, two dying between six and seven years, one after nine years, one after fourteen years, and one after fifteen years.

Five patients are living but with recurrence four, seven, eight, ten, and twelve years after operation. Four of these are in reasonably good health and have responded well to hormonal therapy. Twenty-five are living, apparently without recurrence. Table II shows their duration of life since operation.

TABLE II
TOTAL PROSTATECTOMY

				<i>Cases</i>
Living apparently without recurrence				25
				<i>Cases</i>
Under 1 year	3	7-8 years		3
1-2 years	1	8-9 years		2
2-3 years	3	9-10 years		1
3-4 years	2	10-11 years		2
4-5 years	1	13-14 years		1
5-6 years	5	18-19 years		1

The total number of those who lived more than five years after prostatectomy is thirty-nine (41 per cent).

If recurrence takes place, castration is done and estrogen therapy is instituted. These measures have prolonged from three to six years the lives of a number of patients. After total prostatectomy, it is unusual for patients to develop further obstruction to urination. A few have required occasional dilatation of the urethra to control a stricture at the site of anastomosis of bladder neck and urethra.

An objection to total prostatectomy which is sometimes advanced is the alleged lack of urinary control that may result. Of the 89 patients who were discharged from the hospital, control was good in sixty-four, fair in eight, poor in eight. The degree of control in nine is not known. Control, therefore, was known to be satisfactory in 90 per cent. In the last 50 cases only three were known to have poor control; these three required some apparatus for their incontinence. There were no instances of perineal* or of recto-urethral fistula.

Conclusions

Early diagnosis of cancer of the prostate makes total prostatectomy possible in certain cases.

Invasion of the vesicles makes the prognosis much less favorable.

The factors governing the selection of cases for this operation are discussed and the technique of the operation is reviewed.

The operative mortality of the operation is not excessive. In this series of 95 cases it was 6.3 per cent, but there has been only one death in the last 52 patients operated upon.

Urinary control has been satisfactory in 90 per cent; there have been no perineal or recto-urethral fistulas.

In this series of 95 cases of prostatic carcinoma subjected to radical prostatectomy, 39 patients (41 per cent) lived more than five years after operation. Eleven patients (11.5 per cent) have lived more than ten years.

If recurrence of the carcinoma develops, it is possible in a limited number of cases to prolong life by means of hormonal therapy.

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* One patient operated upon in 1931 had a small fistula which was entirely healed in two years.

ABSTRACT OF DISCUSSION

GEORGE H. STRONG (Philadelphia): Dr. Smith has again admirably called to our attention a most important fact, the ability to eradicate and not palliate the second most common cancer in the adult male. He has shown without equivocation an apparent cure rate of 26 per cent with patients alive from one to nineteen years after operation, 41 per cent living more than five years, and 11.5 per cent more than ten years. I must emphasize that *no other form of therapy thus far advanced has cured a single case of cancer of the prostate*. The mortality and morbidity have been greatly exaggerated. The operation is not a difficult one in the hands of those properly trained in perineal surgery. During the past four years we have had at the Jefferson Hospital 17 cases in which the radical operation was performed with satisfactory results and with no deaths. Six of these patients were 70 or more years of age. We feel that age alone is no contraindication to the radical operation. The cardio-respiratory system is usually impaired in such individuals. The exaggerated lithotomy position necessary for the performance of this operation entails a reduction in vital capacity of approximately 18 per cent, yet this is compensated by increased venous return and by supplementary oxygen inhalation.

The urgent problem continues to be the early recognition of the disease. I have been pleased to note within the past few years the increasing awareness of general practitioners of the importance of the faintest suggestion of induration in the prostate *in the absence* of obstructive symptoms. It becomes the sacred duty of the urologist to use every available means to substantiate or disprove the suspicion of carcinoma in such cases. I cannot agree entirely with Dr. Smith as to the value of repeated rectal examinations. Why not subject every such patient to perineal biopsy? Although it may not be 100 per cent perfect, it is still the best procedure we have available. If negative, the patient is not harmed. An additional diagnostic procedure now available, of proved and increasing merit, pioneered at Jefferson Hospital by Drs. Herbut and Lubin, and referred to briefly by Dr. Smith, is the cytologic study of the prostatic secretion stained by the Papanicolaou technique. Thus far, 520 cases have been studied. There were 66 cases of carcinoma in which a positive diagnosis was rendered in 81 per cent by cytologic study alone. Three false positives occurred during the early studies. With a competent cytopathologist available, I submit that this test be used in all suspected cases.

I heartily agree with Dr. Smith's attitude in regard to the possible danger of indiscriminate use of hormone therapy in the male. The use of testosterone for its constitutional and so-called supportive effects without realization of its potential carcinogenic activating properties must be enthusiastically condemned.

I have used a technique of urethrovesical anastomosis similar to that of Dr. Smith's. It has consisted essentially of a modification of the Vest method of closure described by him in 1940 (*Surg., Gynec. & Obst.*, 70: 935, 1940), except that a fourth traction suture is placed through the edge of the divided trigone. The lateral defects are then closed, thus reconstructing the vesical orifice prior to anastomosis to the urethra, which is then completed easily by placing the traction sutures within the membranous urethra and tying them in the perineum after their emergence through the wall of the urethra well above the urogenital diaphragm.

Surgical Treatment of Hyperthyroidism

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BEFORE considering thyroid conditions which lend themselves to appropriate surgical treatment, it is not amiss to mention some which frequently are subjected to surgical intervention and which should be treated conservatively. Colloid or endemic goiters of adolescence are rarely surgical problems. Neither are those slightly enlarged thyroids which, seemingly, are producing hyperthyroidism, the diagnosis being based on inaccurately obtained basal metabolic rates. Nor should we always advocate surgery for that interesting group of patients in whom there is definite hyperthyroidism but yet no discernible goiter. These patients have incipient hyperthyroidism frequently controllable by measures other than operative, although such a statement could not have been possible prior to the introduction of thiourea and its derivatives.

We turn to the types of goiter in which surgical intervention offers the greatest promise of prompt cure with a minimum of disability and mortality. Nodular masses, toxic or not, ranging in size from 6 to 7 centimeters in diameter to those so large as to become strikingly disfiguring, are all surgical problems. These goiters should be removed for other than cosmetic reasons—first, as a prophylactic measure against the production of carcinoma, and second, because many ultimately become associated with hyperthyroidism. Approximately 11 per cent of non-toxic nodular goiters and over 24 per cent of non-toxic, solitary tumors become malignant.

Large multiple nodules are rarely "adenomas" though frequently so called. True fetal adenomas occurring in but 5 to 6 per cent of all nodular goiters can be demonstrated histologically. The majority of nodular goiters are not adenomas and are made up of masses of colloid accumulations—the result of abnormal hyperplasia-involution cycles. As to the origin of fetal adenomas, there are two schools of thought: the chief is that they start from multiple embryonal cell

rests which are found throughout the gland; the other, and the one accepted by most pathologists, is that they develop from adult normal thyroid epithelium. Confusion still occurs as to the classification of these nodules pathologically and many regarded as fetal are actually only varieties of colloid adenomas with one blending closely into the other.

Whether true adenomas hyperfunction as has been claimed or whether toxemia associated with these types results from hyperplastic para-adenoma or para-nodular acini are questions which do not especially concern the surgeons. We are correct, however, we feel, in assuming that nodular goiters are surgical problems and should be subjected to thyroidectomy for the reasons mentioned.

A second group of patients for whom thyroidectomy is indicated is composed of those patients with toxemia in whom there are well-defined evidences of Graves' disease plus a goiter. Of 3440 goiter patients admitted to the author's service, 67 per cent had hyperthyroidism; 27 per cent were patients with classical hyperplastic goiter, the remainder belonging to that group of nodular goiters associated with toxic symptoms. Such patients should receive over a period of six to eight weeks or longer preoperative preparation with propyl thiouracil until the basal metabolic rate reaches an irreducible minimum, following which a bilateral resection is performed.

The preoperative treatment is readily carried out at home following a complete examination of the patient at the hospital or clinic, where the extent and severity of the disease are determined and the preoperative treatment planned. During this period the patient reports at intervals for progress checks, when the appropriate time for hospital admission and operation is determined. During the last three weeks prior to admission the patient receives, in addition to the propyl, Lugol's solution, 10 drops three times a day. This is given to involute the gland and thereby facilitates the operation.

A third group comprises those patients with carcinoma. Fortunately, it is small, constituting

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not over 3 per cent of all goiter cases. With these patients must be included those with so-called "aberrant thyroids," which we now know to be lymphatic cervical metastases from primary lesions in the thyroid itself. Patients with carcinoma require extensive excision of the affected lobe frequently with block dissection of the neck on the involved side and removal of the jugular vein, followed by extensive x-ray irradiation. The carcinoma group is mentioned, for it is an important one in which hyperthyroidism is frequently associated.

For recurrent hyperthyroidism, further thyroidectomy is indicated providing sufficient tissue was not removed at the first operation. If the recurrent thyroid enlargement is minimal, the process can usually be controlled with propyl thiouracil.

For years efforts have been made to discover a substance which would reduce the activity of the thyroid gland. Interest was reawakened six years ago by the work of the MacKenzies at Johns Hopkins on goitrogenic drugs and that of Richter and Clisby on goiter-depressant substances such as sulfaguanidine and thiourea. Clinical applications led to the brilliant work of Astwood with cases of hyperthyroidism. Those drugs having the greatest effect are derivatives of thiourea (NH_2CSNH_2), all having in common the thioureylene radical NH-CS-NH . Continued investigation finally resulted in the synthesis of propyl thiouracil, a drug more active than thiouracil and having not only a more lasting action but one relatively free of side effects.

There has thus been placed in the surgeon's hands a specific drug far more effective than iodine, one of inestimable value in the preparation of the patient who is to be subjected to a thyroidectomy. This therapy has proved markedly effective in causing a rapid amelioration of the disease as revealed especially by a rapid fall in the basal metabolic rate. It is rarely curative, however, as in the majority of instances a thyroidectomy is necessary.

The mortality of the thyroidectomy has dropped markedly since the advent of the anti-goiter drugs. It now rarely exceeds 1 per cent. In the last 491 consecutive patients operated upon at the Geisinger Memorial Hospital, the mortality was 0.2 per cent. Pre-thyroidectomy ligations and multi-stage operations are things of the past. Postoperative crises probably will never again be seen in any well-organized thyroid clinic.

Operative technique has not changed greatly in the past few years. The procedure carried out in the average case of hyperthyroidism is a bi-

lateral resection. The ribbon muscles are divided in nearly every case. The anesthetic of choice is oxygen and ether. Intratracheal anesthesia is invariably relied upon if the goiter is large, substernal or intrathoracic, or if there is the slightest evidence of respiratory impairment from tracheal compression or deflection. Cyclopropane is an especially pleasant anesthetic from the patient's standpoint; induction is easy, but the gas possesses potential dangers, especially if the patient is toxic, for the drug increases irritability of the cardiac muscle, frequently producing ventricular fibrillation. For this reason we have ceased using it except in non-toxic patients, preferring to use pentothal followed by oxygen and ether which, at the present writing, we believe to be by far the safest procedure for patients suffering from marked hyperthyroidism and who are to undergo a thyroidectomy.

The anesthetic management of the toxic patient presents special problems. With the increased basal metabolic rate the oxygen demands are high, consequently the patient tolerates periods of anoxia poorly. Troublesome reflexes—laryngeal spasm or bronchiolar spasm—may be produced when the vagus is stimulated by the necessary manipulations of the operation.

Toxic patients are apprehensive and exceedingly nervous. For them, adequate preoperative sedation is important. Seconal or nembutal in $1\frac{1}{2}$ to 2 grain doses the evening before guarantees the patient a good night's sleep. If she is apprehensive in the morning, the drug may be repeated two hours preoperatively; yet if she is relatively calm, it is best to omit the second dose, giving one hour preoperatively either $\frac{1}{6}$ gr. of morphine or 100 to 150 mg. of demerol with possibly $\frac{1}{50}$ of a grain of scopolamine. These doses will have to be varied according to the basal rate and the level of the patient's reflex irritability.

In our opinion regional anesthesia in thyroid surgery has little to recommend it. Rectal anesthesia by means of avertin fluid, long popular, and still used in some hospitals is a method we have long discounted. It is difficult to control and may markedly depress the patient's respiration. Patients having it frequently sleep for hours upon return to the ward, thus requiring an unnecessary amount of nursing attention. If it is desirable to put the patient to sleep in his room preoperatively, pentothal intravenously is far superior.

Pentothal intravenously is ideal for induction for all thyroid patients to be supplemented by 50 per cent nitrous oxide and oxygen. Pentothal alone is hazardous and should never be so used in toxic cases.

Inhalation anesthesia with ether and oxygen is, by all odds, the anesthetic method of choice. Nitrous oxide is, we feel, a poor agent, as is ethylene, since to bring the patient into the first plane of surgical anesthesia with these substances it is necessary to heavily premedicate the patient or to give anoxic doses of the gases.

Indications for intubation are clear. If there is the slightest possibility of difficulty in the maintenance of an adequate airway, an endotracheal tube should be passed before the operation is undertaken and the anesthetic administered through it.

In no type of surgery is it more desirable that the anesthetic be administered or directly supervised by a trained physician anesthetist.

For many years catgut was our choice of ligature material. Five hundred thyroidectomies were later performed using silk throughout. In two patients, after interminable treatment of draining sinuses, it was necessary to reopen the wound completely and remove many ligatures. We then returned to catgut for several hundred cases. This material is satisfactory, yet it tends to produce drainage.

Of late we have used nothing but spool cotton and at present believe that we will never abandon it. It has been used in the last consecutive 160 thyroidectomies without the slightest difficulty with wounds. There has been no drainage, and no necessity of removing suture material. It is slightly harder to handle, yet it is the most innocuous material that may be placed in the tissues. It is strong and produces less tissue reaction than is the case with silk and especially catgut.

As a surgical procedure, thyroidectomy is not devoid of dangers. Delicate and important structures are dealt with. The thyroid is associated closely with the parathyroid glands, the recurrent laryngeal nerves, the jugular veins, the carotid arteries, and upper medial sternum. Damage to any of these structures can lead to serious complications. If the greatest care is not observed, the final state can be worse than the disease for which the operation is performed. It

goes without saying that the operation must be carried out with skill and with all the inherent dangers of the procedure constantly borne in mind.

Once the patient is on the table a thyroidectomy should never be proceeded with if there is marked fibrillation, respiratory difficulty, or an elevated pulse rate persists above 140.

Operations on the thyroid should be carried out with celerity, by a perfectly coordinated team. Rarely does a bilateral resection require over thirty-five minutes. Blood transfusion or intravenous therapy of any kind is seldom necessary while the goiter patient is on the table. Unlike extensive operations on the stomach, pancreas, or colon, a thyroidectomy on a properly prepared goiter patient is attended by little or no shock or blood pressure change. Once the patient has returned to his bed, however, intravenous injection of saline and glucose during the first few hours is desirable in maintaining fluid balance. Following the operation, as with other surgical patients, early ambulation has proved a real contribution. Most patients are out of bed on the third or fourth day. Skin clips, which we feel furnish an ideal means of closing the skin, are partially removed within twenty-four hours, all being out by the third day. Wounds are closed without drainage.

Naturally these patients should receive the utmost care throughout the postoperative period.

Patients operated upon for hyperthyroidism should be re-examined every three months for at least one year to one and one-half years. The majority will have no further trouble, experiencing prompt and complete relief from their former symptoms. A small number may, during the immediate postoperative months, become slightly hypothyroid; the symptoms are readily controlled, however, by small amounts of thyroid extract administered until the gland is restored to normal balance. With propyl thiouracil administered in the preoperative stage followed by thyroidectomy the results of surgical treatment of hyperthyroidism are extremely satisfactory and are as miraculous as any obtainable in the whole field of surgery.



THE FUTURE OF CESAREAN SECTION

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THE purpose of this paper is to consider current trends in the use of cesarean section, with a view to attempting to discern future developments. To this end, a few condensed and summarized figures will be cited from published surveys of maternity work, and from a study of our experience with this operation during the past decade at the University of Pennsylvania.

Current Status of Cesarean Section

An estimate of the frequency with which cesarean section is currently being performed in large cities of the United States indicates that there is about one such operation per 35 total births—an operative rate of approximately 3 per cent (Table I). This represents a fourfold increase in the rate that prevailed a generation ago. There is reason to believe, moreover, that the rate is still rising.

The present increased employment of cesarean section is due, as is well known, to a widening of the indications for this operation. This widening, however, represents a liberalization of traditional indications rather than an addition of radically new ones (Table II). Moreover, the relative importance of each of the principal earlier indications has not undergone much change. The most discernible trend is that a greater proportion of operations now being done is for placenta praevia. The increase in the absolute number of operations in all categories of indications has occurred principally as a result of the addition of so-called relative, borderline or alternative indications to the traditionally mandatory ones. This liberalized policy, in many instances, has apparently been prompted by the opportunity which an increasing safety of operation for the mother has provided for an increasing interest in the welfare of the fetus.

The diminution in operative risk for the mother during recent years has been truly remarkable (Table III). The post-cesarean maternal mortality rate in a number of large cities is now under 1 per cent. Reports of large institutional

series of consecutive operations without mortality are becoming commonplace.

Reduction of the fetal mortality rate associated with cesarean section has not been equally striking during the period in question, inasmuch as this rate appears to have been cut by less than 50 per cent (Table IV). The current rate, moreover, is at least double that of the coincident fetal mortality rate for all births.

Evaluations

In the light of our present liberal practice in resorting to cesarean section in obstetrics, and the excellent results associated therewith, what is to be regarded as sound in these developments, and what course should future developments take?

TABLE I
OPERATIVE RATES IN CESAREAN SECTION
(Combined Data)

<i>Sections</i>	<i>1925</i>	<i>1945</i>
Per 10,000 births.....	77	287
Ratio	1:130	1:35

The good results of present policies speak for themselves. A generation ago, maternal and fetal mortality rates in this country were among the highest in the world. Interim improvements in standards of obstetric practice and in the provision of prenatal care, and increases in the proportion of confinements conducted in hospitals, have served to reduce maternal mortality and morbidity so remarkably that our present position is an enviable one. If the attainment of that position has included an increasing dependence upon surgical solutions for some of the problems that have had to be met, the major reduction of morbidity, including much of the increased safety of operative measures, must be credited to improvements in obstetrics.

With respect to the widening of indications for cesarean section, it can be argued that at least a part of this trend has been necessary. Advances in preventive and clinical obstetrics have

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TABLE II
INDICATIONS FOR CESAREAN SECTION
(Combined Data)

Indications	1925	1945
	Per cent	Per cent
Dystocia	55	53
Previous section	21	23
Hemorrhage	11	17
Miscellaneous	13	7

been effective in solving many, but by no means all, of the problems confronting us. For the solution of many of these, further advances in fundamental research are necessary, requiring, for example, a better understanding of the anomalies of uterine action that are responsible for so many failures of vaginal delivery. If interim advances in the prevention and therapy of infection and shock have invited a resort to surgery for the management of problems for which obstetrics has not yet found satisfactory solutions, few can deny that a good deal of maternal and fetal morbidity has thereby been spared. An increasing resort to surgery under these conditions, therefore, has represented a practical and common-sense compromise with circumstances.

If the present situation is a defensible one, however, the factors that have made it seem necessary remain as challenges to continuing efforts in research. Moreover, the current high incidence of cesarean section contains a number of undesirable features. Despite the present excellent results of operation, current post-cesarean maternal mortality is several times greater than the general maternal mortality. Under modern conditions of improved obstetric practice, operative mortality tends to become more a matter of surgical risk than of the obstetric disorder for which operation is done. There is, so to speak, a law of diminishing returns applicable to a high operative rate as further advances in practical preventive obstetrics are made.

Similar considerations apply to post-cesarean operative morbidity. At the present time every

TABLE III
MATERNAL MORTALITY OF CESAREAN SECTION
(Combined Data)

Deaths	1925	1945
	Per cent	Per cent
All deliveries	0.7	0.2
Cesarean sections	9.5	0.8

cesarean section that is done is likely to make advisable the performance of another cesarean in a subsequent pregnancy of the same patient. Apart from the obstetric "crippling" which this entails, there are surgical and gynecologic sequelae that are coming to be recognized as highly undesirable. Formerly, it was frequently necessary to choose abdominal operation as a preferable alternative to almost certain vaginal or cervical injury of a major nature, but it is to be doubted whether this is true today.

TABLE IV
FETAL MORTALITY OF CESAREAN SECTION
(Combined Data)

Deaths	1925	1945
	Per cent	Per cent
All deliveries	8.0	3.3
Cesarean sections	11.0	7.8

With respect to the fetus that is delivered by cesarean section, it has been shown that there has not been as conspicuous a fall in mortality rates in recent years as might have been hoped for. This is particularly significant in the light of the fact that so many operations have recently been undertaken primarily in the infant's interest. When pertinent data are analyzed, it is seen that a good deal of current post-cesarean section infant mortality is to be found in the premature infant group. Although survival rates have been excellent among premature infants delivered by section in patients with placenta praevia and diabetes, the opposite is true under nearly all other circumstances in which operation has been resorted to for premature termination of an abnormal pregnancy. In disorders other than those mentioned, therefore, there would seem to be little reason for choosing cesarean section as a method of terminating pregnancy except when this procedure is demanded solely in the maternal interest.

A further undesirable feature of the currently high number of cesarean sections that are being performed is the probability that the figures include a substantial number of wholly unnecessary operations. One of the inherent weaknesses of any liberal operative policy in obstetrics is that it may undermine clinical judgment in subtle ways and foster poor practices, if not abuses.

The Future

In the light of the foregoing facts and considerations, it is possible to view the present liberal employment of cesarean section in this country

as a necessary, but temporary phenomenon in the evolution of our advances in obstetrics. There are indications that present practices are more radical than conditions warrant. Careful evaluation of the results of operation by conscientious local hospital staffs and community groups of obstetricians can serve to reduce current operative rates, not only without prejudice to the interests and welfare of prospective mothers and their infants but to their benefit. The almost certain fruits of future research in obstetrics will be to reduce still further the necessity for resort to cesarean section. Advances in other fields will contribute to this end, for whatever will improve the childhood and adolescent health of prospective mothers, and encourage early marriage, will tend to make childbearing the natural and healthy function that it fundamentally is and should be.

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ABSTRACT OF DISCUSSION

CHARLES J. BARONE (Pittsburgh): Dr. Bachman's paper actually brings out an increase in the indications for cesarean section, which is probably due to many factors. One, especially, is the improvement in prenatal care. As an example, the x-ray takes care of the cephalopelvic disproportions that years ago used to result in difficult labor as well as infant mortality. Another factor is better appreciation of the hemorrhages, especially those of placenta praevia. In the old days the absolute indication for cesarean section, so far as hemorrhage was concerned, was a complete or central type of placenta praevia, while women with the marginal and partial types were permitted to be delivered normally in a good many instances. Today we know that even a marginal type of placenta praevia leads to much loss of blood, jeopardizing both the baby and the mother, especially in those cases in which dilatation is rather slow.

On that point there is the matter of how dilatation of the cervix takes place. Some physicians feel that the lower uterine segment and the cervix have a good deal of muscular tissue, while others believe that it is an elastic tissue. That has been a controversial subject for centuries. Histologically, we do find a great deal of muscle tissue in the cervix and lower uterine segment, and if it is true that there is traction and retraction of the muscle fibers up toward the body of the uterus, dilatation of the cervix may be accomplished. With the placenta located in the lower uterine segment, naturally, as labor progresses, there will be more separation and

more bleeding that will be jeopardizing to both the patient and the baby. The end result in some of these cases is not very good, especially from a fetal standpoint, and from a maternal standpoint will necessitate a number of blood transfusions.

In the management of premature separation of the placenta in cases permitted to go into labor, there is a separation of the muscle fibers and considerable blood and serum between the fibers which interferes with the contractility of the uterus and which results, at the time of emptying of the uterus, in complete relaxation and a postpartum hemorrhage that is quite severe. That has been definitely proven histologically, but, naturally, there is a difference of opinion also as to the management of these cases. I feel that section is the logical procedure, in the interest of the mother, even if the baby is dead.

There has been an increase in the incidence of cesarean section in the toxemias of pregnancy, that is, before the patient goes into eclamptic seizures.

I wish we knew more about the etiology of the inertial type of labor. Such patients have an agonizing type of labor but do not progress. The contractions although painful are not effectual, so that dilatation of the cervix is slow. If cesarean section is not resorted to early, the uterus becomes fatigued and will not contract when emptied.

If more versions were performed in certain types of pelvic dystocias and inertial labors, we would be lowering the incidence of cesarean section, morbidity, and mortality.

We have had an increase in sections because of some understanding of the Rh factor. In the presence of a rise in the titer, agglutinins, and antibodies, cesarean section has been performed in the interest of the baby.

Whether the incidence of cesarean section is going to rise in the future, one cannot predict. We do know that American people are definitely increasing in stature. This, then, may diminish the number of cases of dystocia.

JAMES S. TAYLOR (Altoona): I should like to inject at this point a partial report from the Commission on Maternal Welfare, which met yesterday. We thoroughly discussed the problem of cesarean section, and, if you will bear with me for just a minute, I will let you know some of the figures on maternal deaths in Pennsylvania last year.

In going back to 1933, our maternal death rate per thousand total births in Pennsylvania was 5.8. Last year was the first year we ever reached 1 maternal death per thousand total births, and if we had eliminated from that septic abortions, ectopic pregnancies, and non-obstetric deaths, we would have had 0.78 per thousand, which is a very good rate.

I should like also, in this discussion on cesarean section, to show where we could still further reduce these maternal deaths. There were 243 maternal deaths in Pennsylvania last year out of a total of 248,000 live births. In 13 per cent (32 cases) of those maternal deaths a cesarean section was an important factor. If you added to those 32 cases the 9 cases of uterine rupture which occurred in cases which had had previous section, you would have a total of 41 maternal deaths in Pennsylvania last year in which cesarean section was either the sole cause of death or was a large contributing factor.

GERIATRICS

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THE increasing recognition, in the past decade, of the importance of the medical care of those of advanced years is an indication of the broadening conception of the responsibilities of the medical profession. There was a period not so long ago when the rapid advances of science, particularly in the field of bacteriology, focused attention on the acute disturbances that so disastrously affected the young and vigorous. It was but natural that the insidious and apparently inevitable diseases of the aged should receive scant attention. Today such is not the case. The medical profession now recognizes that a great deal can be done for older people, both psychologically and physically, and the importance of this type of practice has resulted in the acceptance of it as a specialty under the term of *geriatrics*.

It is manifestly impossible to deal with the many aspects of the subject in the allotted time. I therefore will limit this paper to a consideration of certain basic policies which should guide us in the medical care of those who are aged, not in point of years, but physiologically. They are the victims of arteriosclerosis and reduced glandular activity with the attendant depression, discouragement, lack of energy, aches and pains, and the many other widespread symptoms that we are prone to group under the term "the infirmities of old age." These individuals need help, and they deserve help, and we can best give it to them if we are at all times actuated by certain policies and attitudes.

First, and most important, is an attitude of optimism. To be effective, optimism must be real, not simulated; and to be real, it must be based on a willingness to give time, careful attention, and intelligent consideration to all phases of the patient's condition. Backed by experience and confident that much can be done that is useful, the physician transmits his optimism to an otherwise depressed and discouraged patient. This is one of the finest services that a physician can render—a helping hand extended to someone who feels that he has outlived his usefulness and

thinks he is facing only the discomforts and infirmities of old age.

Next in importance to optimism in the care of the aged, I place thoroughness. One must grasp the complete clinical picture if he is to render effective service. Minor symptoms, in particular, should receive careful attention, for they may mean little or much. Constant nagging discomfort, even though caused by a relatively unimportant condition such as an ill-fitting denture, a bursitis, or a tender hemorrhoid, may cause really serious effects, such as loss of appetite or insomnia, with resultant increasing fatigue and nervousness. Moreover, minor symptoms often cause worry, the patient fearing cancer or heart disease, and sometimes he will not admit such a fear. Only by a definite diagnosis of the nature of his discomfort, based on a careful examination, can the physician convincingly relieve the patient of his fear.

Above all, a minor discomfort may indicate the beginning of a serious lesion, not necessarily fatal, but one which perhaps can be helped or cured by prompt action. For example, an attack of substernal pain may be due to a gallstone lodging in the cystic duct, not to a coronary occlusion; or urinary frequency and pain may be found to be caused by a bladder stone, not an enlarged prostate. These are not imaginary examples—I have in mind specific instances when I mention them. We must be careful not to assume that some apparently characteristic symptom is the result of a development of old age. The interpretation of the symptom should be based on thorough study.

The third precept that I suggest is patience. This is often difficult. There are many reasons why elderly individuals are apt to be trying. Time may hang heavily on their hands, and they welcome the diversion of having a sympathetic listener. Their memory may be impaired or their cerebral processes slowed up enough to cause hesitation and retardation in presenting the details of their present and past history. Consequently, the examiner, even though he be optimistic and thorough, has a tendency to be abrupt and wave down, perhaps with a kindly smile, at-

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tempts at long recitals of evidently minor details. There are several reasons why a lack of patience interferes with the truly successful practice of geriatrics. In the first place, the aged patient quickly senses that he is not being given a chance to describe fully his discomforts, and this realization takes away his confidence in the physician's insight. Thus is lost the most important psychology hold that any physician can have over his patient, namely, the feeling that "my doctor understands my case."

Again, a lack of patience may prevent the description of some vague symptom that is actually of great importance. This was recently brought most forcibly to my attention. An elderly woman, after a tedious recital of many bizarre symptoms, mentioned so casually a vague rectal discomfort that we, in the office, apologized to the proctologist who was asked to examine her "just to relieve her mind." After accepting our apology, he informed us that he had found an early carcinoma of the rectum.

True patience requires time, tact, and sympathy. It is easy for me to emphasize its importance, but in the rush of a busy office practice it is difficult to observe. One finds it hard to listen attentively to the details of obstinate constipation when, in the next examining room, is a critically ill person with a suspected brain tumor. I once had to face that very situation, and I solved it by explaining to the elderly man that an emergency had developed that required my undivided attention and he would have to return at another time, when I could give his problem some real thought. I might say that he reacted in good spirit and returned the next day to cash in fully on what he considered his unselfish cooperation of the day before. I, in return, had to listen to all the details of an obstinate constipation extending back thirty or more years. There are times when patience is indeed a most difficult virtue.

So far, in this paper, I have had particularly in mind the establishment of a diagnosis, or to express it better, a complete understanding of the aged patient—not only his physical condition but also his psychologic state. But the purpose of diagnosis is to make possible rational and effective treatment, for, after all, treatment is the ultimate goal of medical services, the fruit of all examinations.

Rest Plans Must Be Workable

I will limit my discussion of treatment to some general principles and over-all procedures. Of these, I would first emphasize the importance of rest and relaxation. The aged patient is usually

subject to fatigue, both nervous and physical. Arteriosclerosis slows the circulation and impedes the exchange of metabolites and waste products in and out of the tissues. Recovery from the effects of effort is retarded, and if time is not allowed for recuperation, an increasing sense of tiredness and malaise will develop. Such incapacitating symptoms as stiffness and soreness of the muscles, shortness of breath, loss of appetite, etc., may be entirely due to fatigue.

Mental fatigue also may reach serious proportions, especially in the presence of cerebral arteriosclerosis. Forgetfulness, inability to concentrate, emotional instability, insomnia, even attacks of unconsciousness are some of the more common effects of the reduced cerebral blood flow. Superimposed on these primarily physiologic effects are psychic disturbances, such as apprehension, discouragement, and the feeling that the days of usefulness are ended.

In such cases the effects of rest, complete or even partial, are often magical. Memory and the capacity to concentrate improve, and with this returns a brighter outlook on the future.

To prescribe rest so that it can be followed and will be effective demands real thought and insight on the part of the physician. Consideration must be given to the home situation, the unavoidable responsibilities of the patient, and his capacities to turn to some form of diversion. What is the use of advising someone to "go away for a few weeks" when to do so would disorganize a home or result in the loss of a job? Or, if he or she can get away, why send them to a place where homesickness or loneliness or the lack of some form of recreation that they really enjoy only adds to their emotional stress?

Usually, the best way to prescribe rest is to have a frank conference with the patient and perhaps members of the family. The conference is opened with a very definite explanation of the necessity of rest. Thereafter, the physician should admit only such discussion as leads to the formulation of a régime that can be carried out without disastrous side effects. Home conditions, business responsibilities, and natural inclinations must all be considered. At first there are apt to be irritating objections to everything, but tact and firmness and resourcefulness in eliminating difficulties will usually result in a workable plan that insures a certain amount of time for rest and relaxation. There are all sorts of ways in which apparently impossible conditions can be modified. For the business man, half days at the office may solve the problem. For example, a few months ago there came to the office an accountant who was in charge of the difficult payroll records of

a small company. He was tired, depressed, and had so much trouble concentrating that his work capacity was seriously impaired. Finally, he had several episodes of unconsciousness, and only then did he consent to consult a physician. On the basis that his symptoms were due to cerebral arteriosclerosis, he was advised to take a prolonged rest, but he convinced me that to drop his business responsibilities would be almost disastrous both to the company and to his personal affairs. He was then advised to go home at noon each day and spend the rest of the day in bed. Under this routine, he improved remarkably, and within a few weeks he was again able to manage effectively the intricate details of the payroll, his confidence was restored, and he was cheerful and happy.

Another means of counteracting fatigue is to have the patient spend an entire day in bed, perhaps routinely once or twice a week. If he cannot be released from his work during the week, he can remain in bed Sundays while the wife takes over. The overworked wife may agree to such an arrangement somewhat reluctantly, but she often becomes quite enthusiastic about it as she sees his increased earning capacity and improved disposition. Needless to say, the reverse situation is just as effective where it is the worn-out mother who needs the day of rest and seclusion.

These two examples are merely illustrative of how effective rest may be prescribed without completely disorganizing the patient's affairs. Every case has its own difficulties which can usually be solved in a conference if the physician is adamant and helpful—adamant in his insistence that rest must be obtained in some way or other; helpful in suggesting ways of getting it.

The causes of fatigue are sometimes obscure. An elderly individual or couple may be retired and free of all business or financial worries, and yet they may be tied down by minor duties delegated to them because "they have nothing to do"; or they may be the victims of aggressive little bundles of energy (sometimes spoken of as children) who constantly demand stories, or participation in childish games, or walks to nearby candy and ice cream stores. Again, they may be living in a household of energetic, busy, talkative people, with no opportunity for the peaceful seclusion they crave and need. Under such conditions, fatigue may reach serious proportions. These people should be able to retire to their room where it is tactfully understood that they are not to be disturbed by either adults or loving little children.

Study Patient's Discomfort

Another important principle in the treatment of the aged is relief of pain and discomfort. In the acute states, even when the patient is confused or delirious, a nagging discomfort may be a serious handicap to recovery. One should develop the habit of routinely asking himself, before leaving the bedside, "Is this patient comfortable?" Often the ill patient is unable to explain why he is so miserable. It is up to the physician to consider such possibilities as position in bed, which may seem natural but is actually uncomfortable because of stiffness of the back or joints; or a distended bladder; or fecal impaction; or the many other minor disturbances that interfere with rest. A little thought about the matter and a careful examination may be of inestimable help in the recovery from an acute illness.

In the minor conditions, comfort also should be looked upon as an important part of the physician's responsibility. Hot tub baths or salicylates may be used to relieve stiff and aching muscles; ill-fitting dentures should be readjusted. Flatulence and constipation should be regarded as worthy of real treatment, not just something to be waved aside. Urinary frequency that interferes with recreation in the daytime and with sleep at night is certainly more than a minor matter and calls for relief.

The use of drugs in the treatment of minor complaints can be developed into an art. Sedatives may remove the terrors of long, wakeful nights. A cocktail or highball may stimulate the appetite and give a sense of well-being that promotes digestion. One must guard against over-dosage, of course, but the judicious use of drugs may change the entire clinical picture of old age.

Finally, I would emphasize the importance of giving careful attention and psychologic support to those aged patients who are suffering with some hopeless disease such as malignancy, heart failure, or hemiplegia. The tendency is to make the professional visits infrequent and perfunctory. Sometimes this reluctance to make frequent home calls is due to the laudable desire to spare the patient the expense of services which one feels are of little practical use. Such an attitude is wrong. The visit of a kind and tactful physician can be developed into the highest type of service that one human being can give to another. The patient, especially if he understands his condition fully, often leans more on his friend, the physician, than on anyone else, even the closest members of his family. The value of such a service is above financial recompense, and many a physician has been amply rewarded by an

eloquent look of gratitude or a few whispered, unforgettable words.

In conclusion, in our medical care of the aged, let us at all times be sincerely kind and consistently thorough. Let us give thoughtful attention to the effective treatment of minor as well as major symptoms. Guided by such principles, our services will be truly helpful, and we will develop a spirit of optimism that the aged patient will instinctively sense and for which he will be eternally grateful.

ABSTRACT OF DISCUSSION

JOSEPH T. FREEMAN (Philadelphia): It is a privilege to add a few words to this discussion of the general phases of geriatrics by Dr. Snowden. Permeating his paper is an air of kindness and understanding which promises well for any of the older age group who may be fortunate enough to come under such considerate treatment.

In 1939 it was my privilege to give the first formal paper on geriatrics for the Pennsylvania Medical Society meeting then in Pittsburgh. In the few years that have elapsed from then until today, when a Pittsburgh physician is reciprocating in Philadelphia, the new science has come of age, which may be illustrated in several ways. For one thing, there has been formed the American Geriatrics Society, a national organization, and the Gerontology Society. Both of these organizations have excellent publications. In Philadelphia we have the Central Committee for the Chronically Ill. In Indiana, Dr. King, head of the State Public Health Department, has founded a department of adult medicine in geriatrics. As a matter of fact, there is an international organization which had its meeting in France this summer and discussed the problems of the older patient.

The basis of an optimistic view of the old patient under the scope of geriatrics is the fact that a reasonable degree of health and well-being are compatible with a multitude of pathologic phenomena. As long as an adequate physiologic balance is maintained among the variably changing organs, the patient continues to be an individual enjoying life and able to contribute to it.

The essential need of treatment in geriatrics is to place a sound physiologic basis for diagnosis and treat-

ment under the aging structure. Evidence that this has been successful is to be seen in the changing attitude of everyone dealing with the higher-age group. The new confidence of surgeons, the increasing cooperation of social service groups, grants for research, and extensions of public health services are a few of the indications. Thus there is a paralleling drive for health as well as for economic and social security. However, there are indications that we are still in a pioneer period. The old pragmatic manner of dealing with an older individual still survives. The casual symptoms which are regarded as complaints rather than as true signals may be the only guide to basic destroying processes. The operating table and the pathologist's final report too often are the only recourses to lessen the frequency of diagnostic over-assurance. Little satisfaction can be derived post mortem from the statement that the patient was quite old and had lived a long life, in view of the development of therapeutic aids which could have increased the useful span of life.

In the old particularly a symptom may be compared to an iceberg; 90 per cent is submerged, but this should only add more emphasis to the little that remains above the surface of a multitude of benign complaints.

In diagnosis the physician will have to be conditioned to new diagnostic patterns because the very nature of the ailment may manifest itself in a modified manner compared with the flaring reactions of the younger body. Inasmuch as medical education consists of being conditioned to diagnosis, that is, conditioned to respond with a diagnosis to certain set patterns, it is important to realize that in the old individual these patterns are different.

In treatment, a sound aggressive policy is required to lessen the likelihood of therapeutic failure and to overcome older-age inertia.

In conclusion, it is our duty to utilize every possible aid in geriatrics, particularly in the light of Dr. Snowden's remarks which bade us maintain a view of the older patient as a thinking, feeling, and hopeful individual.

Certainly the physician must be in the vanguard to anticipate the changes in medical science as influenced by a changing social picture. Many elements besides medicine contribute to a change in the pattern of morbidity and mortality.

These will be some of the roles to be assumed by geriatrics in an increasingly complex medical world.

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The Experimental Background of Recent Attempts at Chemotherapy of Cancer

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EXPERIMENTAL attempts at chemotherapy of neoplastic diseases have received much impetus in recent years. Stimuli for the solution of human cancer problems based on molecular or chemical approaches arise from definite limitations that are necessarily implied in the available methods of present-day surgical and radiologic procedures. The ultimate and the desired goal in this method of attack is to seek out an agent or agents that will reach the individual cancer cell regardless of its location in the body and execute its cancerocidal effect without undue damage to the normal cells.

It is well known that numerous chemical and physical agents have been used in the past as cancer remedies. They were used empirically and covered a wide range of chemical substances as well as physical modalities. Needless to say, these agents did not withstand the test of time. However, there is evidence to believe that at least one of these substances, Coley's mixed toxin, justifies further investigation.¹ A portion of this paper will deal briefly with a discussion of a complex polysaccharide which represents a partially purified, active principle of Coley's mixed toxin.²

The oncolytic agents which have been studied experimentally within recent years can be categorically discussed under the following groups: (1) mitosis inhibitors, (2) cellular toxin, and (3) metabolic antagonists or competitors. The existing knowledge on the mode of action of these substances is, at best, fragmentary, and this classification is suggested merely for the sake of convenience in our discussion. The subject of endocrine therapy in neoplastic diseases will not be considered in this paper.

Mitosis Inhibitors

Colchicine.—Lits³ and Dustin⁴ independently described the mitosis-inhibiting property of col-

chicine in 1934. Amoroso⁵ observed that patients with gout receiving deep x-ray therapy for neoplasms responded beneficially when they had received colchicine. Subsequently, he demonstrated that colchicine alone is capable of producing regressions of a transplantable mouse tumor. Dustin⁴ stated that colchicine caused a marked increase in the number of mitotic figures in malignant tumors, but it was not until 1936 that Ludford⁴ demonstrated that the apparent increase in mitotic figures resulted from accumulation of arrested mitoses. His observations indicated that growth inhibition of transplanted tumors was not possible without the appearance of severe toxic symptoms. Guyer and Claus⁶ irradiated transplanted carcinomas (Flexner-Jobling) in rats which were given colchicine fifteen hours prior to x-ray therapy. Their results suggested that the combination of colchicine and x-ray therapy had greater cancerocidal effect than either treatment given alone. Since colchicine caused mitotic anomalies, it was thought to increase the radiosensitivity of neoplasms, but the results of many experiments indicate negative findings or confusion and nothing of practical value has emerged from a combined therapy of this type (Woglom). It is reported that topical applications of colchicine on condyloma acuminatum result in degenerative changes which, in part, are due to the inhibitory action of the alkaloid on mitoses.⁷

Urethane.—Hawkins and Murphy⁸ observed peripheral lymphocytopenia and increase in polymorphonuclear leukocytes when urethane was used as an anesthetic agent for rabbits and rats. The significance of this observation remained obscure until Haddow and Sexton⁹ demonstrated clinically that urethane will induce favorable changes in leukemia which are similar to the effects produced by radiation therapy of this disease. The mode of action of urethane is not known, but it has been observed to prevent the onset of mitosis in corneal epithelium¹⁰ and in the Lieberkühn glands of the small intestine.¹¹

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From the Institute for Cancer Research and the Lankenau Hospital Research Institute, Philadelphia, Pa.

There is evidence to suggest that blood-forming cells are especially sensitive to the prevention of the onset of mitosis by urethane.¹¹

Paterson et al.¹¹ reported their experiences with urethane in leukemia. Thirty-eight patients with myeloid leukemia and 26 patients with lymphatic leukemia were given an average of 4 grams of urethane per day (1.0 gram four times daily) and their maintenance dosages were adjusted according to tolerance and rate of drop in total white cell count. In patients with myeloid leukemia this agent caused a fall in total white cell count in which the greatest proportionate reduction occurred in the most primitive type of cells. The hemoglobin level showed a significant rise, but this depended upon the amount of urethane administered. Excessive dosage brought about serious damage to both the white and red cell series. Two-thirds of the patients in this group showed a reduction in the size of the spleen and the survival periods seemed better in those cases which registered disappearance of myeloblasts from the peripheral blood.

Of the 26 patients with lymphatic leukemia, urethane treatment brought about a similar reduction of the leukocyte count, and in about three-fourth of the cases a striking increase in the ratio of polymorphonuclears to lymphocytes was noted. The hemoglobin level increased in about one-half of the series, but the significance of this rise was not entirely accredited to the use of urethane. General clinical improvement occurred in a little more than one-half of the patients, and splenic enlargements were reduced in all. Less than one-third manifested diminution of enlarged lymph nodes. The authors are of the opinion that survival periods in patients showing disappearance of peripheral lymphoblasts were better than those in which these cells persisted.

The authors emphasize that these results provide no indication that urethane can produce permanent benefit in either myeloid or lymphatic leukemia. Relapses have been observed and immature cells may reappear in the blood.

Schulze¹² observed similar results in a small series of chronic myeloid and lymphatic leukemia.

The foregoing observations appear to indicate that urethane, when judiciously used, possesses palliative properties in the management of myeloid and lymphatic leukemia.

Nitrogen Mustards.—The historical and animal experimental aspects of (β -chloroethyl) amines or nitrogen mustards have been recently reviewed by Gilman and Philips.¹³ Friedenwald, Buschke, Scholz, and Moses¹⁴ studied the effect

of sulfur and nitrogen mustards on mammalian corneas. Their findings indicate that these agents are powerful inhibitors of mitosis in the corneal epithelium and they inhibit mitosis in doses far smaller than those required to produce clinical signs of damage. The inhibitory period can be made to last for several weeks by repeated instillation of the drug. The authors state that systemic administration of the mustards to rats in approximately minimum lethal dosage causes inhibition of corneal epithelium, bone marrow, and intestinal mucosa.

Several reports have appeared in the literature on the clinical use of nitrogen mustards in malignant diseases. Nitrogen mustard was first administered intravenously in humans by Gilman and Philips.¹³ Using tris (β -chloroethyl) amine hydrochloride (tris nitrogen mustard), they observed a depression of the hemopoietic system which was manifested clinically by neutropenia and lymphopenia. One case of lymphosarcoma observed by them showed partial tumor regression.

In 1946 Jacobson et al.¹⁵ noted a remarkable remission in Hodgkin's disease. Their observations included cases which had been considered resistant to further x-ray therapy. The toxicity of intravenously administered nitrogen mustards can be classified as immediate or delayed.¹⁶ The immediate reaction consists of nausea and vomiting that may last two to four hours. Delayed reactions are injury to the hemopoietic organs and thrombosis of recipient vein. Although bone marrow damage may be severe, it has been demonstrated that regeneration is orderly, active, and probably complete. The authors suggest that an effective total dose which will control the growth of tumor (lymphomas and allied diseases) but avoid dangerous leukopenia is about 25 mg. per course of four injections given on consecutive days. They believe that the toxic agent which develops within a few hours after injection of nitrogen mustard is an unstable cyclic ammonium compound formed with the β -chloroethyl group. This compound is present for a short duration, but is capable of exerting damaging effects on the hemopoietic system and the malignant tissue. They suggest that nitrogen mustards exert no differential selective toxicity for malignant tissue as compared to normal hemopoietic tissue.

The nitrogen mustards may be relatively useful in the management of carefully selected cases of Hodgkin's disease,^{16, 17, 18} lymphosarcoma, chronic lymphatic and myeloid leukemia, and polycythemia rubra vera.¹⁶ Karnofsky et al.¹⁷ suggest that nitrogen mustards, in general, be re-

served for cases of generalized Hodgkin's disease in which radiation therapy no longer seems feasible or effective. They point out that in the treatment of localized disease it is preferable to use roentgen therapy which can be concentrated on the area involved. Their observations indicate that nitrogen mustards cannot accomplish therapeutic effects which could not be induced by x-rays in the treatment of lymphosarcoma and lymphatic and myelogenous leukemia.

In practical application, great limitation is imposed by the toxic properties of the mustards. Until agents with greater selectivity can be found, wide usage of (β -chloroethyl) amines cannot be encouraged at this time.

Cytotoxin

It has been known for many years that occasional tumor regressions occur when cancer patients develop erysipelas. Busch observed and described the effect of erysipelas on cancer as early as 1868. William B. Coley made similar observations, and in 1892 described a combined toxin of *Streptococcus erysipelatis* and *Bacillus prodigiosus* which he suggested for the treatment of malignant tumors. Coley devised many modifications of the original mixed toxin and published favorable reports on the relative effectiveness of this agent in the management of cancer patients.

In 1943 Shear and Turner² isolated a polysaccharide-lipid complex from a simple culture filtrate of *Serratia marcescens* (*B. prodigiosus*). Preliminary tests of this polysaccharide indicated that it is capable of producing hemorrhage and necrosis in transplanted mouse sarcoma (sarcoma 37). Many interesting properties of this substance have been elucidated. Its exact chemical structure is unknown, but analysis indicates it to be a polysaccharide-lipid complex with a molecular weight in the magnitude of eight million. It is an antigen and, therefore, capable of inducing antibody formation in patients and laboratory animals. It is a toxin and, in large doses, lethal to animals. It induces hemorrhage and necrosis in many types of malignant tumors. The cytotoxic property of the polysaccharide was described by Diller (1947). In a tumor-bearing mouse an initial increase in the size of tumor nuclei (sarcoma 37) is caused as early as one and a half hours after intraperitoneal injection of this substance. This is followed by rapid shrinkage into clumped nuclear masses within four hours, while others are attenuated into filamentous bands and the nuclear material eventually disintegrates completely. Evidence is presented to indicate that tumor nuclei are most suscep-

tible to the polysaccharide during some stage of mitosis.

Clinical investigation by Brues and Shear (1944), Holloman (1947), and Oakey (1947) indicates that Shear polysaccharide elicits severe reactions in patients. These investigators were able to demonstrate partial tumor destruction by the use of this agent in patients with malignancy. Similar studies were conducted by us in a series of 44 cancer patients.* The toxicity encountered was identical to that described by our predecessors. In this series there were indications that led us to believe that sarcomas showed greater damage than carcinomas by cytologic examination of the biopsied materials (Diller). Complete tumor destruction was never observed. Although most of the patients are now dead (31), it is of considerable significance that a bacterial metabolite is capable of inducing hemorrhage and necrosis in many forms of malignancy and further pursuit along this line should be encouraged.

Metabolic Antagonists or Competitors

Lewisohn et al.¹⁹ investigated the effect of spleen extracts on transplanted and spontaneous mouse tumors. By subcutaneous administration of concentrated beef spleen extract, he and his associates were able to produce tumor regression in 60 per cent of mice bearing transplanted sarcoma 180, while 8 per cent regression occurred spontaneously in the untreated controls. By modification of this experiment, Lewisohn demonstrated that daily intravenous injections of "healed mouse spleen extract" can "heal" 30 per cent of mice with *spontaneous breast carcinoma*.

The studies on spleen extract led to the investigation of the influence of yeast and barley extracts on tumor growth in mice. Favorable results by the use of these agents directed their work to the use of inositol and fermentation *Lactobacillus casei* factor.²⁰ The former agent exerted slight influence by reducing the growth rate of mouse tumors (sarcoma 180), while the latter, when administered repeatedly by intravenous injections, caused 30 per cent tumor regressions in mice with spontaneous breast carcinoma. It is significant that studies by Pollack, Taylor, and Williams²¹ indicated relatively high concentrations of inositol and folic acid when various types of tumor tissue were quantitatively analyzed for their vitamin contents. The normal tissues corresponding to the sites of origin of

* This study was undertaken at Lankenau Hospital, Jeanes Hospital, and American Oncologic Hospital, Philadelphia, in cooperation with the Lankenau Hospital Research Institute and the Institute for Cancer Research, Philadelphia. The work was supported in part by a grant from the National Institute of Health.

these tumors revealed the inositol and folic acid levels to be significantly lower than in the tumors.

In their subsequent investigation, Lewisohn et al. repeated their experiment of fermentation L. casei factor by using instead *synthetic folic acid* or pteroyl glutamic acid. This agent was shown to have no effect upon the regression of mouse tumors.

Fermentation L. casei factor has been shown to be a di-glutamic acid conjugate of pteroyl glutamic acid, and by virtue of these additional molecules it possesses physiologic properties quite apart and distinct from folic acid when administered parenterally. It has been postulated that pteroyl-diglutamyl-glutamic acid or fermentation L. casei factor, though structurally similar to folic acid, can act as a folic acid isomer. The present concept of the mode of action of fermentation L. casei factor as an oncolytic agent is based upon a belief that it is a biochemical antagonist or competitor of pteroyl glutamic acid. It is thought to be capable of displacing pteroyl glutamic acid molecules from the tumor tissue which, in turn, is thought to require an adequate supply of this essential vitamin.

Clinical investigation of the use of teropterin* or pteroyl-diglutamyl-glutamic acid has yielded much information of interest. Preliminary reports on the use of folic acid derivatives in patients have been presented by Farber et al.,²² Klainer,²³ Lehv and Wright,²³ and Meyer.²³ Much clarification is needed in the interpretation of their findings.

For the past year we had the opportunity to investigate the use of teropterin† in 33 patients with various forms of malignancy. In this series, the dosages of teropterin were varied considerably inasmuch as the effective dose of this agent is unknown. Nearly all patients received the substance by intramuscular route. Many patients were instructed to self-administer the teropterin at home. In the early phase of our studies the patients were given two daily intramuscular injections of teropterin (doses varied from 20 mg. to 60 mg. daily). When no response was observed by the end of four weeks, the drug was discontinued. More recently, the frequency of intramuscular injections per day was increased. When teropterin administration was started, three patients expressed relief from pain, and in all of them the required amount of analgesic agents could be reduced without interfering with their comfort. Other patients obtained little or

no relief from pain, while still others admitted only a transient relief from the first few doses of teropterin. Improvement in appetite was noted in seven patients; however, only four of these subjects continued to gain weight and maintain this improvement.

No specific changes were noted in blood counts and urinalyses of the patients investigated. Toxic reaction was not encountered in the doses utilized in our studies (20 mg. to 80 mg. daily).

A significant and progressively favorable effect of teropterin on tumor was observed in one patient, while in the others only slight or no tumor reduction was observed. This single hopeful observation was noted in a 46-year-old white woman‡ who had been subjected to a left radical mastectomy for carcinoma five years prior to the time she was observed by us. Clinical and x-ray findings indicated large masses in the lung hila and osteolytic lesions in the left transverse process of the third lumbar vertebra and the right ilium. Twenty mg. of teropterin was administered daily by intramuscular injections and the dose and frequency of administration were gradually increased until the present, at which time she is receiving 80 mg. daily in four doses. At the end of six months the hilar shadows have decreased in size and density and bone regeneration has been noted in the third lumbar vertebra and the right ilium. She has received no other treatment either before or during this period and continues to use teropterin at home.

The evaluation as to the effectiveness of teropterin in such an isolated case will depend upon the examination of teropterin blood level and the elucidation of the metabolic roles of folic acid and folic acid antagonists in cancer patients.§

Inositol is believed to be capable of causing tumor regression. It has been experimentally observed that pyridoxine and para-aminobenzoic acid are potent antagonists of inositol, and yet these agents show no chemical relationship to inositol (Laszlo). Several compounds related to folic acid and possessing properties of metabolic antagonists to folic acid have been identified. Leo Meyer²³ recently reported the effect of one of these (aminopterin) in patients with acute myeloblastic leukemia.

Other agents utilizing the principle of metabolic antagonism will undoubtedly appear in the future and are awaited with keen interest.

There are other agents which will remain untouched in this discussion. To mention a few,

‡ From the medical service of Lankenau Hospital, Philadelphia.

§ Studies on teropterin blood level are now under investigation by Dr. G. Toennies and associates of the Lankenau Hospital Research Institute, Philadelphia, Pa.

* Teropterin, a proprietary name of Lederle Laboratories for pteroyl-diglutamyl-glutamic acid.

† Teropterin was generously supplied by the Lederle Laboratories Division of the American Cyanamid Company.

substances such as K.R. (protozoan endotoxin from *Trypanosoma cruzi*), stilbamidine, podophyllin, and 9, 10 dimethyl 1, 2 benzanthracene have been under scrutiny in the laboratory and under clinical trial in the case of stilbamidine.

The future of cancer chemotherapy will depend largely upon spearheading the problems of cancer by extending fundamental researches along the lines similar to those which have been discussed.

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FOR BETTER TRAINING

The appended editorial from the *Detroit Medical News* (April 4, 1949) bravely alleges and challenges correction of current incomplete specialty training programs in hospitals:

"It is to be hoped that the near future will disclose some realism in the appraisal of current training programs in our hospitals.

"Hospitals should propose to train good general practitioners and forget the pretenses of training programs in the specialties or else sink their teeth into the problem of providing effective and real training for the specialty practice of medicine. I think I am stating the proposition fairly when I suggest that the average specialty training program is geared to the mass production of an incompletely trained individual who, once he has completed the ritualistic phenomena of certification, finds himself in the outer world equipped with a diploma and the aforementioned incomplete training and thereupon dips, of economic necessity, in the broad flood of general practice.

"Now there is only so much material available for training in the average hospital and the post-war rush

for approval of specialty training programs on the part of hospitals has diluted further the prospect for sound and comprehensive training. Some of this may well have been justified as an expedient in the effort to provide opportunity for the returning medical veteran, but some of this may also have stemmed from the increasing utilization of the hospital as a workshop under the expanding hospitalization schemes. One can survey some of the specialties in certain locales and wonder how the 'approved' specialists have been able to survive within the restrictions established by their certifying boards, for the locale does not possess sufficient clinical material to engross the major part of their professional talent.

"As might be expected, Detroit doctors and hospital executives have been concerned with the problem as it is presented in this area. They are trying to reach a solution to it. An honest approach has been made and will be in operation within a few months, and this should be a good experience for the body of medical men present and future. For we know that the American citizen wants and is entitled to the best medical care available, and we propose to make it available in an unending continuous stream."

ERUPTIONS OF THE HANDS

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IT IS not the purpose of this presentation to discuss all types of diseases involving the hands even though confined only to the hands. We, therefore, will not devote any time to the numerous clinical entities seen on this part of the skin, but will confine our discussion to the diseases called eczema, dermatitis, eczematoid dermatitis, etc. The clinical picture varies greatly with causes, duration, medication, etc., but always remains within the limits of eczema or dermatitis which one finds described in any standard textbook.

At best, the picture is a rather indefinite and confusing one. Primary causes are frequently of internal origin, but the hands are subjected to more external irritants than any other part of the body. Avoidance of irritation is difficult; therefore, multiple etiologic factors are as much the rule as the exception. However, as we shall mention later, it is fortunately not always necessary to elicit all of the etiologic factors to achieve a satisfactory result. Differentiation, objectively, between cases of internal or external origin is possible in the early stage of some cases, but as the disease goes on to chronicity the clinical appearance is of little value in the evaluation of the cause in the majority of cases. Sharply defined, deeply seated groups of vesicles with a deep intense edema on either surface of the hands suggest an internal cause. Palmar lesions, particularly if deep, are apt to be of internal origin, whereas the backs of the hands are more susceptible to external irritation.

The more superficial, poorly defined vesicular plaques, fading gradually into the surrounding normal skin, suggest an external cause. In either case, complicating factors may intervene early and the picture will be changed completely. In many cases the primary cause may be removed, sometimes inadvertently, but these secondary factors have, in the meantime, become potent and may continue the process indefinitely. Cases of dermatitis involving primarily or solely the

hands constitute a large percentage of patients in both dermatologic and general practice. The exact number may vary greatly in different localities due to industry, water supply, climate, and various other, sometimes obscure, factors.

To repeat, one or a number of these factors may be present in any given case. These multiple etiologic possibilities cause both the doctor and the patient much confusion. Certain patients who have been seen by several doctors and have been given a different cause for their trouble by each one become a little antagonistic and skeptical. We try to explain to the patient that all previous consultants may be correct in their evaluation of one cause and that frequently the complete removal of one cause may effect a cure. Our explanation to the intelligent patients is that the causes of the process in which they are involved can be compared to load. Thus, with one side of the scale holding their health, resistance, or whatever they wish to call it, and the other side holding the factors which produce the disease, a balance must be struck. Therefore, if one or two weights are removed from the disease side of the scale, it may be lightened enough that health is maintained. By the same means, if weight can be added to the health side, a comparable satisfactory result may be obtained. Therefore, in resistant cases the correction of foci of infection, digestive and nervous disturbances, anemia, etc., as well as removal of some of the more common irritants, is not always futile even though for awhile only slight, if any, prolonged relief is obtained. Persistent effort will frequently balance the scale, even though in the end the prime etiologic factors may be in doubt.

In cases of widespread dermatitis and in some of the more severe incapacitating hand lesions, patients are willing to undergo various examinations and procedures to obtain relief. This, however, is not always the case with all hand lesions, particularly with those who have a not more than moderately severe, not incapacitating disease of the hands. All dermatologists know that many of these hand inflammations are such that even with complete investigation the major causes

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cannot be found, so that a favorable result cannot be assured and one is loath to urge reluctant patients into a number of expensive procedures which may prove useless from their standpoint.

Lane¹ made an exhaustive study of 475 cases and was unable to classify a large percentage etiologically. Winston,² in another series of non-specific hand eruptions, found 36 per cent not classifiable. Rowe³ believes that these and others may not have investigated the inhalant allergens sufficiently and demonstrated that pollen and dusts may cause eruptions confined to the hands. He cites a series in which 44 per cent were due to food allergy and twenty-four per cent to pollen allergy. Livengood demonstrated in this type of case, as well as others, that the accumulation of an offending substance may be at fault. We shall mention this again.

Studies such as these are done with great difficulty. As we said before, the inertia of the patient is a great stumbling block to investigations. Many wish to be classed as occupational for obvious reasons and are completely non-cooperative when confronted with dusts, pollens, blood chemistry studies, etc. Many others can get quick and sometimes prolonged relief with a little treatment and are more satisfied to have this treatment at intervals than to undergo any extensive study. Sometimes after repeated attacks the condition becomes so severe that they will cooperate when the problem has become more complex. Frequently, after repeated attacks, the area involved has become hypersensitized to a number of irritants. The natural barriers against infection break and sensitization to bacteria and their products is present. Lane has an excellent chart depicting this in the study mentioned above, in which he stresses this unbalanced host-bacteria relationship. These bacterial cases are much more common than is usually believed and many cases attributed to soap, mild occupational irritants, etc., are complicated by this factor, and if not recognized and treated, this infection may become the most important factor in prolonging the disease.

In all cases a careful history is of the utmost importance, but a reliable history is frequently most difficult to obtain. Most patients are prone to be more interested in a detailed description of the type of "blister" that occurs and the kind of "water" that exudes when they squeeze it, and other such details, than in the time of the first outbreak and the duration of the eruption and the relationship of its appearance to other events which may have a bearing on its cause. However, persistent patient questioning may some-

times elicit enough information to obviate the necessity for many tests.

We would like to cite three cases to illustrate some of the points just discussed. These cases of recurrent dermatitis of the hands occurred in young adult females. The first two presented dermatitis of the hands which appeared early in May and continued until late in July, each year for three years. Pertinent history of personal or familial allergy was negative.

Case 1 showed a vesicular dermatitis, which we considered to be external in origin, involving the distal half of the back of the right hand and the thumb and first two fingers of the left. History disclosed that she worked as a cashier in a market. She would push the various items in the customer's basket with the back of her right hand, while punching the cash register with her left. Later she would pack the items in bags using the three involved fingers of her left hand. We found that the eruption was present during the season of strawberries and home-grown radishes. She returned in one week with a positive patch to radish tops which she had avoided and the hands almost clear. In another week her hands were clear, but she said there were no berries around at the time and she couldn't be bothered anyhow but would not handle them in the future.

Case 2 we believed to be of internal origin. The lesions were the type frequently described as nummular. Careful questioning disclosed that early in May oranges increased in price and she was served tomato juice each morning for breakfast. After about one week of this her hands became troublesome. She avoided tomato juice and with soothing treatment showed rapid improvement. When we suggested a therapeutic test, she refused, stating that she didn't like tomato juice anyhow and would not drink it in the future.

Case 3, a waitress, had a rather nondescript eruption on the backs of both hands which varied in intensity but was worse in winter. Studies were begun with the common irritants, with no positive results, but in the course of questioning her diet was, we believed, low in vitamin-rich foods. She was given the clinic polyvitamin capsules and asked to take three per day. She returned in one month. The hands had cleared in seventeen days, but the disease returned one week after she discontinued the vitamin capsules. Further studies were refused and the hands have stayed clear through one winter on a maintenance dose of vitamins.

These cases would suggest allergy, dietary in-

sufficiency and sensitivity, but the only proof is cure, so they cannot be definitely classified on the evidence presented. They illustrate, however, the difficulties in obtaining a history and the non-cooperation encountered in easily controlled cases. Doctors are more interested in statistics than are patients! All three of these cases were of such severity that it is highly probable that other factors were present, but non-cooperation on the part of satisfied patients makes proof impossible.

The effect of the patient's emotional state is an important factor, but one that is extremely difficult to evaluate statistically. All other possible factors must be eliminated before neurosis can be considered as the prime cause. The chronic, itchy, papulosquamous plaques usually called neurodermites are encountered on the hands, but in the evaluation of a patient's emotional state so many other factors are involved that this diagnosis must be made with caution. We have seen many cases, however, in which the emotional state was definitely a cause for exacerbation of an eruption which began as contact dermatitis. These were more prevalent during the late war than at present.

Many cases of dermatitis of the hands were seen in young mothers which could be attributed to inferior types of soap. At that time avoidance of this and other irritants could be accomplished only with great difficulty. However, by the use of soothing, protective creams many of these cases were kept in abeyance. It frequently happened that after a considerable period of relief these patients would return with a severe exacerbation, although the régime which gave relief had been followed. Questions as to the possible cause of the exacerbation would be answered by a flood of tears and the information that either no news or bad news had been received from the war. Sedatives were of value in some of these cases and in others good news was beneficial. This is rather nebulous evidence, but it happened so frequently that we are convinced. In some cases of typical pompholyx no other cause can be elicited and in the above-mentioned cases of neurodermatitis this is also frequently so. Nummular eczema of the hands, usually of internal origin, nearly always presents a difficult problem in this regard, as the effect of the emotional state is so evident that other factors are apt to be overlooked.

Soap

Proof of the role of soap as a causative factor is sometimes difficult. In sensitive cases a patch test may be of value, but in many cases it is nec-

essary to use the soap in the usual fashion to prove its irritating faculty. Patch tests are so frequently done with a solution of soap much stronger than regularly used and left in contact for a period much longer than in ordinary use that this substance is often listed as a causative factor when it is only a faulty patch test. It is in the soap-irritated skin that the host-bacteria relationship is unbalanced and the most prominent factor finally becomes infection and with each succeeding attack becomes more severe.

The role of soap in the production of dermatitis of the hands is a subject of controversial discussion. There is no doubt that soap is an irritant or an added factor in many cases, but dermatitis due primarily to soap is not as common as many believe. Two most common examples are allergy to some component of a good soap or the prolonged use of a badly made soap preparation. Bernstein⁴ has shown that after washing the hands with soap the skin remains quite alkaline for some time. An intact, non-sensitive skin is probably not affected by this alkalinity, but damaged epithelium can be markedly affected. This is seen frequently in laundresses, janitors, etc., in whom long periods of work do not cause trouble on the hands but some slight injury is the focus around which alkalinity and later infection produce a dermatitis that can be relieved only by avoidance of soap. The use of detergents having an acid reaction to replace soap sometimes produces gratifying results, but in many cases the skin is so irritated that water cannot be used and only oils or colloidal liquids are suitable for cleansing. In the more severe cases a prolonged avoidance of soap is necessary and stronger alkaline cleansers must be avoided, probably always. In some cases this abstinence is impossible and means of neutralizing the soap and protecting the skin must be found. Household detergents and water softener are sometimes of value. In regard to water softeners, many observers are of the opinion that hard water is as much if not more at fault than soap. We are of the opinion that one must be careful not to generalize about soap and water but to view each case as an individual one and to study its idiosyncrasies.

Cases of contact dermatitis represent a small but significant portion of hand eczemas. Their significance lies mainly in the fact that they figure so largely in industrial cases as a point of differential diagnosis. Our experience has been that the incidence of contact dermatitis is lower than many reports would lead one to believe. We feel also that often when a contactant is responsible, the patient is aware of the fact and

knows full well what the offending agent is. But the opposite of this is also frequently the case. Patients often suspect materials that they encounter in their occupations, which actually have no bearing on the situation.

Frequently materials which have been applied in treatment, acting as sensitizers or primary irritants, complicate the picture. Strong, highly stimulating local applications used in the acute stages of a dermatitis of any origin may produce a superimposed contact dermatitis.

Well-known characteristics should be kept in mind in the making of a diagnosis of contact dermatitis. Its predilection for the dorsum of the hands, the frequent sharp demarcation of the border corresponding to the edge of a cuff or the limits of a glove, the diffuse distribution as against a patchy configuration, the sudden onset and the disappearance on removal of the offending agent are all indicative. Patch tests are often the proof of the pudding. It is important to remember that patch tests may not reproduce clinical conditions, and that a negative patch test does not rule out an etiologic agent nor does a positive test necessarily rule it in. Positive findings must be corroborated by history.

Fungus Infection

Most observers are in agreement that true fungus infection of the hands, proved by direct examination or culture, is not a common occurrence. We, like many others, have discontinued cultures unless there is a positive direct examination. Lane, in routine cultures in his series, found 135 consecutive negatives. Beinhauer, in routine cultures, had about the same results. It must be remembered, however, that these figures do not include chronic paronychia nor the frank cases of *erosio interdigitalis blastomycetica*. Ide reactions, both of fungus and bacterial origin, are not uncommon. This reaction is often the prime cause as well as a contributing cause. It is very confusing to patients in that it may occur after the acute phase of the infection has subsided and, in some, so much later that the patient cannot be convinced at first that the trouble on the feet has any connection with that on the hands.

Examination of the feet should be done in all cases where a cause is not obvious, and one is always amazed at the discrepancy between the patient's idea and the condition of the feet. They will admit to previous trouble, but nearly always insist that it has not been present for some time. In many cases we have obtained gratifying results by insisting on treatment of what the patient considered to be a minor or no trouble on the feet while using only a soothing protective

cream on the hands. With some patients cooperation is obtained by using the same fungicidal ointment on the hands and allowing them to believe that they really had the so-called "athlete's foot" infection on the hands as well as on the feet. It is probable that with the widespread use of penicillin, and the cross-sensitization that can occur, many more cases of phytid reactions will be seen in the future. Bacterides are a somewhat different problem, in that the infecting organism is more often present in the primary focus and later becomes implanted in the secondary focus. The same condition of an almost healed primary focus with an active Ide reaction is found, but the therapeutic approach is the same.

Management

To obtain relief in some of these cases is a very easy matter. The prime cause has been removed or can be discovered and removed quickly, and with a little soothing treatment and care the skin will quickly return to normal. Then, if the irritation has not been too severe or prolonged, further trouble need not be anticipated.

In the past few years we have had complicating attacks of erythema multiforme which usually causes great consternation to the patient. However, most of these have not been too great a problem. A little internal medication and the correction of any demonstrable defects frequently will give gratifying results.

It is the chronic and resistant cases which are difficult problems. A careful searching history is of prime importance. We have found that no routine questioning is applicable. Patients differ so greatly in their response that varied and often direct questioning is necessary. Laboratory examinations are often suggested by points brought out in the history. There are no routine laboratory procedures in these cases. Acute cases require protection and soothing. Severe oozing usually requires wet packs and we have found liquor aluminum acetate solution (N.F.) in a 1-15 to 1-30 dilution to be our most valuable remedy. Even pustular cases are usually controlled by this, although occasionally potassium permanganate 1-3000 is required. When the oozing is less, astringent pastes may be used with benefit. The addition of an antiseptic to the pastes, such as ammoniated mercury 1 to 3 per cent, zephiran $\frac{1}{4}$ per cent, etc., sometimes enhances their value greatly. Later, the addition of dernaftan 5 per cent or synthetic tar 5 per cent hastens healing. One of the advantages of pastes is that they can be applied in a thick layer and covered with dressings or cloth gloves and thus complete protection is accomplished.

Antipruritics are frequently necessary. We have found dilute hydrocyanic acid $\frac{1}{3}$ per cent very effective. We have had very few ill effects from 1 per cent benzocaine, although most observers consider this to be a frequent irritant and sensitizer. Starch and boric acid solutions are applicable in many cases in which the condition is so acute that other applications are not acceptable. Usually cold, but in some cases, heat gives more comfort. Many patients have relieved itch by immersing the hands in plain hot water, but there is no doubt that this prolongs the inflammation; however, the addition of starch, bran, or oatmeal to the hot water permits its use without prolonging the dermatitis.

In subacute or chronic cases, pastes are frequently valuable. We have found in some instances that crude coal tar is necessary, but the filth of this makes it objectionable. In most subacute cases, if infection is not a feature, liquid tar, dernaftan, or some other mild stimulant with an antipruritic in a vanishing cream or other non-greasy base is efficacious. If treatment is prolonged, it is frequently of psychic benefit to change applications from time to time. We have found that the use of either paste or cream at night and the frequent use of a buffered lactic acid cream during the day often give complete relief, particularly in cases where soap is a factor.

Chronic resistant infection is often benefited by carefully graded injections of *Staphylococcus* vatox. In some exudative plaques, the oozing may be stopped by the application of 10 per cent silver nitrate followed by a short exposure to ultraviolet ray, and this same procedure is valuable in chronic lichenoid plaques. X-ray is valuable, but must be used with the greatest caution. For rapid relief or to give the final impetus in the later stages it is unsurpassed. Small doses of x-ray can be used, but one must always resist the impulse to use it too frequently. This is difficult, as many patients realize the quick relief they get from x-ray and request it.

We have tried to present some of the difficulties which we have noted in the management of dermatitis of the hands. Our experiences and results differ not at all from the ones recorded in many excellent statistical studies found in the current literature. Many of these cases are as much of a problem as a more widespread dermatitis, and solace in discouraging cases may be had by the thought that many practitioners are harassed by these seemingly simple problems.

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IMMUNE SERUM GLOBULIN

Announcements have been made by the American Red Cross that they do not furnish immune serum globulin directly to physicians. This serum is furnished to the State Health Department, which in turn issues it to physicians in the same way that it distributes other biological products.

All requests for immune serum globulin by physicians and hospitals should be made to local health departments rather than to local Red Cross chapters.

COMPENSATION CASES

There has been and still is a lack of understanding by many physicians as to the proper handling of compensation cases—persons who receive injuries or illness caused (limited type) by their work. The laws of the State of Pennsylvania definitely define what is an injury or illness that is compensable. The law further requires the employer or his insurance carrier to provide "medical and surgical services, medicines and supplies as and when needed" with certain limitations.

But the law states that "if the employee shall refuse

reasonable surgical, medical, and hospital services, he shall forfeit all rights to compensation for disability or any increase in his disability shown to have resulted from such refusal."

In plain, simple language, if a man or woman is injured while working for a firm, company, or individual, the employer may select the doctor to treat this injury. If the injured refuses to accept this treatment, he must not only pay for his own treatment but loses all rights under the law.

To avoid misunderstandings, prevent controversies, and insure your right to collect for services rendered, do not treat patients who have been injured at work without an order for such services from the employer or his insurance company. Do not assume such cases already under the care of an authorized doctor unless you have received an order to do so.

Industry and the insurance carriers know the value of good medical care. While the law limits the responsibility of medical treatment to sixty days in time and \$150 in amount, such are not considered if further care is needed to properly treat the injury. Physicians have few complaints from industry as to their treatment. Industry should be given no opportunity to complain about the attitude of the physician.—*The Stethoscope*, Erie, Pa., April, 1949.

SULFONAMIDES IN PEDIATRICS

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THE introduction of prontosil in 1935¹ precipitated a sequence of events that has greatly changed the practice of medicine in general and of pediatrics in particular. Sulfanilamide, it was found, is the essential antibacterial agent in prontosil; and with sulfanilamide as a nucleus hundreds of derivatives have been synthesized. Of these, only a few have survived the test of clinical application. The sulfonamides that are available for general use today are sulfanilamide, sulfapyridine, sulfathiazole, sulfadiazine, sulfamerazine, sulfaguanidine, sulfasuxidine, and sulfathaladine. The last three named are poorly absorbed and are used for their local effect in the intestinal tract.

The newer, sometimes less toxic antibiotics have replaced the sulfonamides in the treatment of many diseases. Where they have not been replaced entirely, the sulfonamides are now often used in combination with one of the antibiotics. Today, however, the sulfonamides still hold an important place in pediatric therapy, and research on newer synthetics, such as phenosulfazole, holds promise for the future.

The sulfonamides now in general use are bacteriostatic. When present in sufficient concentrations, they inhibit or prevent the multiplication of susceptible organisms. They do not directly assist the phagocytic or humoral defenses of the body. They simply hold the organisms at bay while the body marshals its defenses. The degree of activity of the individual drugs varies and is fundamentally dependent upon the degree of ionization. Other factors affecting this activity are the rate and degree of absorption, dispersion in the body tissues, the amount of acetylation in the liver, which inactivates the drug, and the rate of excretion in the kidneys.

Almost all of the infections that are susceptible to sulfonamide therapy can be treated successfully with sulfadiazine or sulfamerazine. In general, these drugs are the ones least likely to produce toxic reactions when used in proper dosage.

The comparative safety of sulfathiazole is questionable. Sulfanilamide and sulfapyridine are seldom used. Sulfasuxidine and sulfathaladine are preferable to sulfaguanidine in intestinal infections.

The drugs should be given orally when possible. Parenteral administration of the sodium salts of the sulfonamides is indicated only when it is impossible to give the drugs orally or when, because of the seriousness of the case, a rapid concentration of the sulfonamide in the tissues is imperative. The exact dosage of the various sulfonamides is available in pediatric texts and in the literature supplied by the manufacturers.

Clinical Use

In general, the sulfonamides should be used only in severe infections caused by susceptible organisms. Culture and exact bacteriologic diagnosis are desirable but often not possible, and therapy need not be withheld on this account. The competent physician has a knowledge of the etiology of the majority of infections that he is called upon to treat and should be able to judge which of these may be caused by susceptible bacteria. In the severely ill patient who meets these requirements, sulfonamides should be started immediately in full therapeutic dosage and continued for forty-eight to seventy-two hours. By this time, if laboratory help is available, a bacteriologic diagnosis may have been made and decision on the continuation of treatment may be based upon it. If the etiology has not been established and the infection has shown no signs of subsiding, sulfonamide should be discontinued as it will probably do no good and may be harmful. Infections, such as pneumonia, that have responded to sulfonamide therapy should be treated for twenty-four to thirty-six hours after the temperature has subsided. In some diseases, such as meningitis and erysipelas, it may be necessary to continue therapy longer than this.

There are exceptions to these general rules. Infections of the urinary tract, for example, may not be severe in their initial stages, but frequently respond promptly to sulfonamides.

The prophylactic use of the sulfonamides is a

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From the Department of Pediatrics, University of Pittsburgh, Pittsburgh, Pa.

special problem. The drugs protect against hemolytic streptococcal infections, meningococcal infections, gonorrheal and pneumococcal infections. They have been used successfully in this way in individuals or small groups in the prevention of recurrent attacks of rheumatic fever, in epidemic meningitis, in scarlet fever, in severe measles to prevent bacterial secondary invaders, in bacterial allergies, and in intestinal tract surgery. They have also been used preoperatively and postoperatively where tonsillectomy or dental extraction has been performed on patients with cardiac or renal disease. The dangers inherent in this type of prophylaxis are obvious. The decision to use sulfonamides in this manner must be based upon the merits of the individual case. It is probable that penicillin may be used in many of these instances with less danger of side effects. Sulfonamide prophylaxis in large groups over a prolonged period of time is contraindicated because of the resultant development of sulfonamide-resistant organisms.²

Sulfonamides are of no value and may be contraindicated in the direct treatment of the common cold, acute rheumatic fever, the acute exanthemata, diphtheria, chorea, smallpox, the rickettsial diseases, malaria, and rheumatoid arthritis.

Dangers

It is claimed that infants and children tolerate the sulfonamides better than adults,³ but toxic reactions do occur.

Nausea, vomiting, dizziness, and cyanosis are relatively minor symptoms. They are most frequently associated with the use of sulfanilamide, sulfapyridine, or sulfathiazole.

Renal damage with hematuria and impairment of renal function is fairly frequent in children. The complete nature of this reaction is not known. The acetylated derivatives of the sulfonamides, with the exception of sulfanilamide, may be precipitated in the pelvis and ureters and even in the renal tubules with resultant mechanical obstruction to urinary flow. In some patients, however, temporary or even permanent impairment of renal function is seen without the presence of calculi. Rarely, tubular nephrosis has occurred as a sequel to sulfonamide therapy. Sulfathiazole is more likely to produce renal damage than sulfadiazine or sulfamerazine.

Sensitization phenomena may occur with a history of previous sulfonamide therapy or they may occur during a first course of therapy. Skin manifestations, measles-like, scarlatiniform or otherwise, usually appear after five to fifteen days of therapy. They may appear within a few

hours after the initial dose if the patient has been sensitized previously. Sensitization is particularly frequent after topical administration of the drug. Since such sensitization may be general as well as cutaneous, topical applications should be used seldom if at all. Such application is certainly contraindicated in eczematous children. Sulfathiazole is the most frequent cause of skin manifestations and sulfamerazine the least frequent.

Drug fever may be suspected in the patient whose temperature remains elevated after several days of therapy or in the patient whose temperature begins to rise despite otherwise satisfactory clinical progress. Sulfanilamide, sulfapyridine, and sulfathiazole are most frequently at fault.

Disturbances of the blood-forming elements sometimes occur in children. In some cases it may be difficult to decide whether the infection or the sulfonamide is at fault. Hypochromic anemias are usually not serious and respond to proper therapy. Hemolytic anemias are rare in children. Granulocytopenia is an alarming symptom and sulfonamides should be stopped if the total white blood count falls below 3000 per cu. mm., especially if the polymorphonuclear cells fall below 40 per cent. Agranulocytosis, one of the more frequent causes of death in these patients, is fortunately rare when either sulfadiazine or sulfamerazine is used. It usually appears after two weeks or more of sulfonamide therapy and apparently is related to the length of time the drug is administered rather than to the size of the dose.

Hepatitis is rare with the newer sulfonamides.

Toxic reactions may be avoided or recognized early if the physician follows these simple rules:

1. Obtain a history of previous sulfonamide medication with possible reaction to the drug.
2. Assess renal function. Inquire about previous urinary disturbances and obtain a preliminary urinalysis.
3. Obtain complete blood counts at frequent intervals during therapy.
4. Provide adequate fluid intake and closely observe urinary output.
5. Examine the urine at least every other day for hematuria and crystalluria.
6. Examine the patient daily for fever, rashes, pallor, or jaundice.
7. Obtain sulfonamide blood levels when there is impairment of kidney function, when the severely ill patient has not responded to therapy, or when parenteral sulfonamides have been used.
8. Administer an alkali, such as sodium bicarbonate, in equivalent doses when sulfonamides are used in therapeutic doses.

When reactions occur, the treatment is symptomatic. With severe reactions the drug should be stopped. The drug need not be stopped because of microscopic hematuria or crystalluria, but with such signs the physician should pay particular attention to fluid intake and alkali adjuvants. Gross hematuria, oliguria, or renal pain are indications for cessation of the drug. In such cases fluids should be given in adequate amounts with due respect to the presence or absence of cardiac or renal dysfunction. Alkalis orally or parenterally may be used to combat renal calculi, and in severe cases ureteral catheterization and lavage with 2.5 per cent sodium bicarbonate solution may be necessary.

The danger of crystalluria can be reduced by the use of sulfonamide mixtures.⁴ Sulfonamides dissolve independently in the urine and a saturated solution of one sulfonamide can again be saturated with a sulfonamide of a different molecular structure. The therapeutic effect of such a mixture is roughly equal to the sum of the sul-

fonamide present, but the dangers of crystalluria are equal only to the amount of each individual drug in the mixture. Therapeutic doses of sulfonamide may be given in this way with a minimum of crystalluria. It is still advisable to use a high fluid intake and the usual alkaline adjuvant.

It is possible that mixtures of sulfonamides may increase the dangers of sensitization.⁵ Since sulfathiazole is more likely to produce sensitization than sulfadiazine or sulfamerazine, it might well be omitted from such mixtures. It should be stated that the reliability and safety of such mixtures have not been definitely established.

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FEDERAL GOVERNMENT THREATENS QUALITY OF MEDICAL AND HOSPITAL CARE

The quality of medical and hospital service, on account of its effect on mortality, is of special importance in life insurance operations. The United States has an enviable record in the progress made in these areas. Mortality rates have been reduced to an unusually low level. The quality of medical and hospital service is of a very high order. There has been a rapid, widespread development of voluntary prepaid hospital service plans. A similar development is under way in the field of medical service.

We are much concerned lest these favorable conditions be endangered through the entry of the Federal Government into this field. Proposals are being made that the Government undertake to provide medical and hospital care for more than half the population, the cost of which would be defrayed by payroll taxes upon the incomes of workers included in the plan. A program of this kind, which may sound attractive in theory, would have far-reaching unsatisfactory consequences upon the quality of medical and hospital care in this country. Inevitably, in the course of time, the doctors would come under political domination. Incentives to achieve eminence in the medical profession would be weakened. Instead, the emphasis would be placed more and more upon assignment to localities where the practice of medicine would yield the doctors the maximum incomes. This attitude would be reflected in the medical schools and their standards would suffer.

The solution of the problem of better and more widespread medical and hospital care is to be found in pro-

grams which would not involve the furnishing of such care by the Federal Government. Encouragement should be given to the further development of voluntary plans by which individuals can pay in advance for medical and hospital services.

On a level of importance with the furnishing of care for those who are ill is the prevention of disease. This is the primary aim of public health services. In this field, where united action is essential, all agencies, governmental and private, must work together. Much can be done in the areas of sanitation, nutrition, housing, and merely educating people to use facilities now available. In view of the need in some localities for increased hospital buildings and equipment, governmental aid may be required.

The type of program here suggested leaves the medical profession free to continue its progress. It preserves and strengthens the incentives for doctors to improve their services and to achieve eminence in their profession. A system of this kind will give the United States what it needs to maintain its leadership in the practice of medicine.

As a life insurance company concerned with mortality rates, we feel it our duty to express our judgment in a matter of this kind. The continuance of satisfactory progress in reducing mortality rates in this country depends in large measure upon a proper solution of the problem of furnishing adequate medical and hospital care to our people. But such a solution is not to be found by setting up a system for the furnishing of such care by the Federal Government.—*Annual report of Provident Mutual Life Insurance Company of Philadelphia.*

TREATMENT OF DENDRITIC KERATITIS

JAMES H. DELANEY, M.D.

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IN 1889, Kipp,¹ in a paper before the American Ophthalmological Society, first described a form of keratitis which today we classify as dendritic keratitis. Many excellent reports have since appeared in the literature. The main purpose of this paper is to discuss and evaluate the many therapeutic methods which have been used in an attempt to cure this troublesome condition.

Etiology

It is interesting to note that in the early reports malaria was considered a most important etiologic factor, but through the years this idea was gradually discarded, only to be revived as a result of the late war. Recently, Harley and Kaiser² reported a high incidence of chronic malaria in their cases of dendritic keratitis; in fact, they reversed the process and in cases of dendritic keratitis they set out to prove the presence of chronic malaria. Out of 11 cases they reported malaria in eight, and concluded that the treatment of the malaria was of primary importance. Gundersen³ reported one case of dementia praecox undergoing malarial treatment in which dendritic keratitis developed during the course of the treatment.

Many writers give focal infection the preference as a causative agent. Schwartz⁴ recently reported 12 cases, all of which healed following the detection and removal of foci of infection. It is of note, however, that these cases all had other treatment as well, and healing was quite delayed. It is also worthy of note that this disease does have a tendency to be self-limited. Consequently, it is the practice of this writer to recommend the removal of any obvious foci of infection, but not to become too radical over the removal of tonsils and the like in the mere hope of a cure of this disease.

That there is a definite relationship between dendritic keratitis and herpes cannot be denied. The most noteworthy work on the etiology has been done by Gundersen,³ who proved that the condition is due to a filtrable virus. He re-

ported 623 inoculations into rabbits' corneas by means of linear scratches and transplanting scrapings from active human cases. A definite dendritic keratitis appeared on the corneas of the rabbits within twenty-four to seventy-two hours, depending apparently upon the virulence of the virus. He obtained positive reactions in 63 per cent of his cases, and concluded that failures were due to the death of the virus in the human cornea, its deeper penetration, or to some unknown technical fault.

There appears to be a definite association of the virus of dendritic keratitis with head colds and grippe, and various statistics show a greater preponderance in males than in females, Gundersen finding the disease two and one half times more common in the male than in the female.

As to the part played by injury in the etiology, we meet an interesting and often perplexing problem. In the literature, injury is given but a minor role (Gundersen in but 5.2 per cent of his cases), but the symptomatology is such that as the disease develops there is a sensation of scratching in the eye along with photophobia and lacrimation. A workman with this group of symptoms is apt to rub the eye and set up so much irritation that, when seen in a first-aid department, he is positive that a foreign body has entered his eye. Even though a foreign body or any history of definite injury is rarely found, it is difficult to convince him that he has not, in fact, been injured.

Any eye physician doing a considerable industrial practice is faced with this problem. Under the Workmen's Compensation Law, the usual case of dendritic keratitis would not be compensable. Since the treatment is likely to be prolonged, much work time lost and, if the ulcer be in the pupillary area, scarring and impairment of vision result, it is only natural that the patient would wish to tie it in with a compensable injury, and, in most cases, quite honestly believes that such is the case. One very graphic case of this nature was probably the cause of this writer's special interest in the problem of dendritic keratitis. In this instance (1941) the patient was

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not seen for four days after the onset of a foreign body sensation, by which time he was certain that there was sand in the eye. He had been off work with influenza and herpes. One could ascertain no definite history of injury; no foreign body was found nor was there any microscopic damage to the cornea suggestive of injury. He did have, however, a very severe dendritic ulcer in the pupillary area. Healing eventually took place, but with considerable scarring. The case was a hotly contested one before the Compensation Board, but the claim for industrial visual loss was finally denied.

One should not lose sight of the fact that trauma, by lowering the resistance of the tissue, may predispose to the disorder and, if this be the case, then it is definitely compensable. We have seen two such cases within the past few months—a definite dendritic keratitis following trauma—in one instance after removal of an embedded foreign body, and in the other after a severe blow on the eyelid by a large chip of steel. Trauma, per se, is not the cause, but by lowering the tissue resistance it probably allows the virus to gain entrance. As Gundersen states, the fact that trauma seldom results in the disease is due to the fact that the virus and susceptibility do not often coexist.

Treatment

The primary aim of this paper is, as previously stated, to discuss and evaluate the many methods of treatment which have been advocated. As is true in any other phase of medicine, when a great multiplicity of remedies are advanced, one can be quite sure that none of them is really adequate. We propose to enumerate those methods most frequently suggested and comment briefly upon each.

Heat: (a) *Moist heat.* Hot compresses do help to relieve pain and as such are an adjunct to the treatment. They probably have very little influence on the course of the disease.

(b) *Infra-red rays.* They reduce pain.

(c) *Ultraviolet rays.* Duke Elder says that this treatment is of no value. Gundersen says that the rays will not penetrate deeply enough to destroy the virus. We have used a concentrated ultraviolet lamp in a series of cases without any apparent help, and have now discarded this method of treatment.

Vaccination: (a) Gundersen tried autovaccination with virus from the patient's own ulcer. He transferred material into the mucous membrane of the lips with no vesicles developing and no improvement in the ulcers.

(b) Vaccination with cowpox vaccine. Fol-

lowing the reports of great improvement in herpes of the body by this method, it was tried in several cases. Our results coincide with those in other cases reported—the treatment was found to be worthless.

Vitamin Therapy: Supportive treatment with vitamins certainly could do no harm. In the literature, however, one finds reports of a complete cure with no other treatment than that of large doses of B₁. Unfortunately, our cases have failed to be so responsive.

Sulfa Drugs: As with each new remedy, so too with the sulfa group; great hope was aroused that here at last was the real cure. Chamberlain and Bronson⁵ used sulfadiazine powder locally in the eye and reported good results, but they also used cauterization along with the sulfadiazine. The general feeling in the literature (one which has been borne out by our own personal experience) is that sulfa drugs are of no value in the treatment.

Quinine: This is a holdover from the malarial etiology, and in cases with a true malarial background quinine is undoubtedly of value. We have failed, however, to accomplish anything in non-malarial cases, either from the systemic use of quinine sulfate or the local use of quinine ointment. For years we used quinine locally with religious fervor, but have now completely abandoned its use.

Thermophore: The thermophore has been used by some and we have tried it, too. If the branching is marked, however, too large a tip must be used. Because we believe that the involved area and the adjacent area must be cauterized so that the virus can be destroyed, we can find no fault with those who choose to use the thermophore. In our opinion, however, chemicals can do the work better.

Cauterants: Many cauterizing agents have been advocated:

(a) *Actual cautery* is apt to destroy too much healthy tissue.

(b) *Ether.* Kronenberg⁶ uses ether in the same manner as iodine (about to be described). He claims that it is less painful and gives just as good results. The idea appealed to us and we used it daily on several cases—daily, because the ulcer continued to spread. One of the disadvantages was the rapid rate of evaporation. It required many applications to cover the involved area. We could see no good in the technique and have discarded it.

(c) *Oil of wintergreen.* McKee⁷ reported good results with the use of methyl salicylate in

the treatment of serpiginous ulcers, used in the same manner as iodine. He reported on the work of Sabatzky, who claimed that methyl salicylate possesses marked germicidal effects, is deeply penetrating, and is almost a specific for corneal regeneration; that it has the capacity to clear up scar tissue and influence the newly forming lamellae so as to minimize scar formation. This seemed to us to be an excellent basis for its use in the treatment of dendritic keratitis. We tried it in five cases with no satisfactory results.

(d) *Alcohol*. Latorre and Crespi⁸ report excellent results from the local use of 90 per cent methyl alcohol used in the same manner as iodine. Gundersen also reports on the use of alcohol, but still concludes that alcoholic iodine is better.

Iodine Therapy: Iodine therapy in the treatment of dendritic keratitis is well known and has definitely stood the test of time as the best treatment to date. Cauterizing should be done early and should be extensive. The whole of the involved area as well as the surrounding tissue should be treated. In several very severe cases we have resorted to denudation of the entire cornea under sodium pentothol anesthesia.

One must use the strong solution of iodine which contains 7 per cent iodine and 5 per cent potassium iodide in alcoholic solution and which is no longer official in the *U. S. Pharmacopoeia*. With a cotton-tipped applicator the area of ulceration and well beyond is thoroughly treated. Cocaine 4 per cent is then dropped into the eye, precipitating the iodine as a cocaine iodide which is light brown in color. In twenty-four hours a smooth glistening Bowman's membrane is seen with fresh epithelial edges. The pain may be quite severe the first night after treatment and one should order a good analgesic.

Any failure with iodine treatment lies in its undertreatment. As Gundersen says, the virus invades the tissue cells and is impervious to antiseptics which do not destroy the corneal epithelium itself.

Penicillin: Of course, penicillin has been tried by everyone. Because we believe that the ulcer is a virus disease and because penicillin does not work in virus infections, we should not have been disappointed when it proved to be of no value.

Streptomycin: Alberstadt and Price⁹ reported excellent results from the use of large doses of streptomycin locally in the conjunctival sac (10,000 micrograms per cc.). Their reported cases were not of dendritic keratitis but of ulcers of various types. Because streptomycin is re-

ported to be of value in virus infections, it would seem to be a logical choice for the treatment of dendritic keratitis. Grignolo,¹⁰ however, reported a group of cases in which the local use of this drug was unsuccessful.

We have tried streptomycin without iodine cauterization and feel that it does help to inhibit the progress of the disease. However, we have found that a primary cauterization with iodine is indicated in order to destroy the virus in the corneal tissue. The subsequent use of streptomycin may possibly help to prevent reinfection. At present, we use the drug as an adjunct to iodine therapy.

Aureomycin: Of very recent date, so recent that we have been unable to use the substance in our own practice, is Braley's report on aureomycin.¹¹ He has treated 12 cases of dendritic keratitis with aureomycin with surprising results and reports some cases clearing entirely within twenty-four to forty-eight hours. He concludes that this drug is better than previous treatment, if given early. (Since the reading of this paper, aureomycin has become available and has been used in 12 cases. Results, for the most part, have been most encouraging.)

General: Atropine, of course, is used because of the associated inflammation of the deeper structures, and the patient usually feels better with a protective covering to the eye.

Conclusion

Dendritic keratitis is due to a filtrable virus, and trauma in the average case plays very little part in its etiology, and then only to lower the resistance of the tissues.

Iodine therapy continues to be the best method of treatment and failures lie in the undertreatment of cases.

Streptomycin does appear to be of some value in stopping the progress of the virus.

Aureomycin holds out hope of being a new and better treatment.

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ABSTRACT OF DISCUSSION

WILFRED E. FRY (Philadelphia): I think this paper concerning the treatment of dendritic keratitis is an interesting one. It has been estimated that one of the

most frequently diagnosed conditions encountered in office or clinic practice is a dendritic ulcer. The diagnosis is not difficult in the typical stage, in which there is the branching ulcerated area, with the nodules at the point of branching.

Apparently some cases may be somewhat atypical, and in the early stages an ulcer which later on is recognized as a dendritic ulcer may be misdiagnosed because it is seen in an atypical stage, such as in an epithelial keratitis stage.

We are particularly fortunate in having such an effective therapeutic agent as the strong tincture of iodine, so effective that most of these cases can be treated and cured with little or no resultant scarring of the cornea. In the last 11 cases which have come under my treatment, only two have required hospitalization and, of these two, one patient required hospitalization twice; this was due more to the secondary infection which ac-

companied the dendritic ulcer than to the ulcer itself.

I think that it is in these cases where secondary involvement occurs that we have to look to therapeutic agents other than the strong tincture of iodine for treatment.

Dr. Delaney has mentioned the fact that foci of infection should not be forgotten, and in these cases which do require hospitalization a thorough search for foci of infection and their proper treatment are important.

In these hospitalized cases we use all therapeutic measures in addition to tincture of iodine, including the penicillin and fever therapy. I have not used aureomycin.

The complications of a dendritic ulcer are not usually great. One does not expect a perforation of the cornea unless there is a severe secondary infection. The iritis which occurs can be annoying, and at times can be present with relatively little corneal involvement.

TRUDEAU SCHOLARSHIPS

Scholarships for the annual postgraduate course of the Trudeau School of Tuberculosis at Saranac Lake, N. Y., are again being offered by the Pennsylvania Tuberculosis Society.

This is the twelfth year in which these scholarships have been made available to physicians engaged in general practice in rural and small town communities in Pennsylvania. Up to this time 24 physicians located in as many different communities in the State have been awarded scholarships and taken the course.

The scholarships are in amounts of \$375, of which \$100 is for the tuition fee, to be paid directly to the Trudeau School by the Pennsylvania Tuberculosis Society.

This year's course, the thirty-fifth, will open on Monday, September 12, and close October 7. The course has become so highly regarded and popular among physicians wishing to do postgraduate study in tuberculosis that it is impossible for the school to accept all applicants. However, four places are being held for Pennsylvania physicians who may be awarded scholarships by the Pennsylvania Society.

The program aims to present the essentials of history, etiology, epidemiology, pathology, diagnosis, prognosis, and treatment. Emphasis is placed on bedside teaching and the clinical study and treatment of patients, combined with x-ray and pathologic conferences. Students participate actively in the study and presentation of cases. The class will be divided into groups of four for bedside conferences and observation of surgical procedures. The teaching staff is composed of outstanding specialists in all aspects of tuberculosis.

Scholarship awards will be determined by a committee of competent tuberculosis specialists practicing in Pennsylvania.

Interested physicians should write promptly to the Pennsylvania Tuberculosis Society, 311 S. Juniper St.,

Philadelphia 7, Pa., for application forms and, if desired, further information. While four places are being held open by the Trudeau School for Pennsylvania physicians, this cannot be done indefinitely in fairness to those applicants who have not been accepted because of necessary limitations.

SULFONAMIDE TOXICITY

Generalized hypersensitive manifestations usually occur after six or more days of therapy unless the patient has been sensitized previously by a course of sulfonamide treatment. Drug fever is one of the frequently encountered hypersensitive manifestations, and the differential diagnosis between a drug fever and a fever due to exacerbation of the infectious process being treated may at times be difficult.

Keefer and co-workers have offered these points which might aid the physician in diagnosing febrile reactions to sulfa: (1) The onset is usually abrupt and unexplained. (2) The fever is high and intermittent. (3) It usually occurs after one or more days of afebrility when the disease is in a quiescent state. (4) The patient may not appear as ill as the height of the fever suggests him to be. (5) The febrile episode is usually not accompanied by symptoms of the original illness, but by other signs of a hypersensitive state. (6) Onset is most commonly about the seventh day of sulfonamide therapy, but may occur as early as the fourth day. (7) Accompanying chills are usually present. (8) There is usually a relative bradycardia. (9) There is rapid defervescence upon discontinuance of the drug. The leukocyte count may be high, low, or normal and is of little value as a diagnostic sign.—*California Medicine*, January, 1949.

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EDITORIALS

EDUCATIONAL INFORMATION NOT ADVERTISING

Twenty or more years ago, the criticism which followed use of the radio by physicians to broadcast information about preventive medicine was added to the age-old controversy about practitioners whose names occasionally appeared in the newspapers in connection with professional activities. Within a short time, however, county medical societies having access to local broadcasting facilities recognized the potentialities for imparting information and instruction throughout wide areas, and authorized duly selected officers and committee members to be introduced in person over the air, but as speaking in the name of the organized medical profession. That step forward has been followed by approval of similarly representative communication through the public press and by speaking appearances before lay groups and organizations.

The state medical associations and the American Medical Association have expanded this type of public service until today thousands of publications and hundreds of radio stations are accepting news and educational messages for the millions who are interested in the facts of medical progress and improved health.

In the wake of this more practical expansion of earlier interpretations of the Principles of Medical Ethics, the Judicial Council of the

American Medical Association is currently *proposing* an innovation which, if adopted by the 1949 A.M.A. House of Delegates, may disarm the most conservative critic of advancing medical public relations.

The Council under its Proposed Principles of Medical Ethics (principles not laws to govern, but principles to guide) *submits* the following under "Educational Information Not Advertising":

"SECTION 5.—Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

"The medical profession considers it ethical for a physician to meet the request of a medical society to write, act, or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by publishers, motion picture producers, or radio announcers. These may offer to the physician opportunity to release to the public some article, exhibit, or drawing. Refusal to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self-seeking or solicitation. In such circumstances the physician should be guided by the decision of official agencies established through constituent and component medical organizations.

"A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society. . . ."

THE PREVENTION OF POSTOPERATIVE THROMBO-EMBOLISM

The recent widespread usage of heparin and dicumarol in the prophylaxis and therapy of thrombo-embolic phenomena has resulted in a significant reduction in morbidity and mortality from these postoperative complications. In the administration of dicumarol it is imperative to have accurate, daily prothrombin-time determinations if the anticoagulant effect of this drug is to be controlled and disastrous hemorrhagic episodes avoided. As such laboratory service is not available in many hospitals throughout the State, it is well to recognize that the anticoagulants are not the sole method of effectively preventing postoperative thrombo-embolism.

Stasis of blood is an essential prerequisite for the development of intravascular clotting. There are several procedures of value in preventing stasis. If the surgeon gives meticulous attention to measures tending to prevent stasis of venous blood flow, intravascular clotting is unlikely to occur. Ankle to groin elastic wraps to compress superficial varicose veins should be applied before surgery and kept snugly adjusted during and after operation. Delicate handling of tissues during surgery and the avoidance of unnecessary trauma to major vessels will minimize vasospasm and the attendant stasis. Postoperatively, the surgeon should insist upon such measures as passive exercise of the legs at frequent intervals until the patient is able to actively cooperate in performing bicycle exercises. Such exercise should be carried out at hourly intervals while the patient is awake. Frequent deep breathing exercises assist in aerating all parts of the lungs, thereby preventing atelectasis, and each deep inspiration aspirates blood from the lower half of the body and prevents stasis in the larger veins.

Strict adherence to these measures, and especially the frequent bicycle and deep breathing exercises, will effectively prevent stasis in the larger veins of the lower half of the body and will prevent the occurrence of intravascular clotting. However, it should be emphasized that half-hearted, intermittent attention to these measures is of little value. To effectively prevent thrombosis, both the deep breathing and the bicycle exercises must be carried out frequently and vigorously. If so prosecuted, a significant reduction in the occurrence of thrombo-embolic complications may be achieved without the use of anticoagulants. These simple measures are particularly of value to surgeons who do not have readily available the laboratory facilities for the controlled administration of the anticoagulant drugs.

C. M.

PHYSICAL STIGMATA OF SYPHILIS

(EDITOR'S NOTE: This is the third of a series of guest editorials prepared by members of the Pittsburgh Syphilis and Venereal Disease Control Program and the Department of Dermatology and Syphilology, University of Pittsburgh School of Medicine. They should refresh the minds of practicing physicians on the procedures necessary to establish a diagnosis of syphilis, the modern therapy, the follow-up of treated cases, and certain public health aspects.)

Neurosyphilis

Late neurosyphilis is divided into preponderantly vascular, diffuse meningovascular, and preponderantly parenchymatous (tabes dorsalis, paresis, and taboparesis). In general, the subjective symptoms of late neurosyphilis include gastric symptoms, lightning pains, headache and head pain, diplopia and failing vision, malaise, weakness, "rheumatism," bladder symptoms, loss of consciousness, girdle pain, ataxia, and dizziness. Objective signs include abnormal knee reflexes; abnormal Achilles tendon reflexes; abnormal spinal fluid; abnormal ocular signs, including Argyll Robertson pupils, "slow" reflexes, irregular pupils, unequal pupils, fundus changes, and muscular paralysis; sensory disturbances; positive Romberg sign; mental symptoms; ataxia and speech defect.

Purely vascular involvement is characterized by vascular accidents, which may be sudden due to hemorrhage, or more often insidious due to thrombosis. Paralysis may be partial or total, mono-, hemi-, or triplegic. Prodromal symptoms include headache, dizziness, insomnia, and psychic disturbances, but are not distinctive. Death is rare.

Predominantly, meningal neurosyphilis can present a variety of symptoms. The cranial nerves are commonly involved, producing ocular palsies, facial palsies, and deafness. Headache, dizziness, vomiting, and convulsions may occur, and if the convexity is involved, psychic disturbances result, plus headache, dizziness, and vomiting.

The outstanding symptoms of paresis are mental changes. These vary from simple dementia in most cases to agitation and expansiveness, depression, and more rarely other types of psychoses. The onset is usually insidious, with personality changes, lack of neatness, loss of memory, irritability, and errors of judgment, most grandiose in type. The patient deteriorates slowly and declines into silliness, dementia, and finally amentia. Tremor of the lips is an important sign, and pupillary changes are likely to be present.

Tabes dorsalis results from involvement of the posterior columns. Its onset is insidious, with a marked variation in the number and severity of symptoms. Important symptoms include light-

ning pains; visceral crises with pain, vomiting, or both; diminution of sexual desire; ataxia; bladder disturbances leading to the cord bladder; optic atrophy; malum perforanspedis; and tabetic arthropathy (Charcot joint). The signs include Argyll Robertson pupils, absent knee jerks, and a positive Romberg.

Congenital Syphilis

Early prenatal syphilis is a severe, often overwhelming infection, not infrequently resulting in death. The syphilitic infant is often marasmic, its skin looks withered and cafe au lait in color ("old man facies"), and coryza and snuffles may be present. The skin lesions are similar to those of acquired syphilis, with the following exceptions: bullae may appear, particularly on the palms and soles; lesions of the gummatous type may be present; there may be a diffuse infiltration of the skin, especially of the palms, soles, anogenital and circumoral regions, with the production in the latter region of deep fissures (rhagades), which may leave permanent scars. The spleen is almost always palpable, the liver less often so. Pulmonary involvement is common, which may prevent the lungs from expanding at birth. The osseous system is more frequently involved than in the acquired type, with all the osseous syphilids seen in the latter occurring. In addition, a high percentage of syphilitic babies have osteochondritis and chondro-epiphysitis, revealed by x-ray studies of the long bones. Tenderness of the ends of the long bones is present, but often the first symptomatic warning may be a flaccid paralysis of the upper extremities (Parrot's pseudoparalysis) or a spastic paralysis of the lower extremities. Central nervous system involvement, if found, is usually meningitic and not distinctive.

Late signs and symptoms of prenatal syphilis appear between five and forty years of age, but rarely after thirty. They consist of developmental stigmata plus manifestations produced by the *Treponema pallidum* in loco. Various disturbances of the age-development ratio represent the non-specific developmental stigmata, which are in no way distinctive. Hutchinsonian upper central incisors and mulberry molars involving the second dentition are, however, distinctive. In addition, stigmata are found in the older syphilitic child which have resulted from former active lesions. These include saber shins, thickening of the clavicles at the sternoclavicular junction, evidence of former eye lesions, especially corneal opacities, and saddle nose. Of the active lesions, the cutaneous and mucosal appear usual-

ly after the eighth year and are similar to those of acquired syphilis.

Internally, involvement of the eye, osseous and nervous systems is of the greatest importance; the heart and blood vessels are rarely involved. Interstitial keratitis is seen in approximately one-third of all late congenital syphilitics seen in clinics, being manifested by ciliary congestion and grayish infiltration of the cornea with development of capillaries. Periostitis of the tibia, fibula, radius, or ulna is the most common osseous involvement. Osteomyelitis may develop, and gummas, while rare, involve primarily the nasal septum and hard palate. Paresis is the most frequent manifestation of central nervous system involvement, appearing as simple dementia because the child has not developed sufficiently to show delusions of grandeur, confabulation, etc. It is usually advanced when first recognized. Tabes dorsalis is rare, but in those who do develop it optic atrophy and cord bladder are the most common findings. Eighth nerve involvement is very common, often occurring in conjunction with interstitial keratitis. The deafness is rarely complete.

HARRY W. WOOLHANDLER, M.D.

STANDING MEDICAL ORDERS FOR INDUSTRIAL NURSES

Origin and Finish

Medical orders involve basic principles which hold an obstinate need of repetition, a need common to all principles defining right and wrong, justice and injustice. These principles of justice were enunciated by the Pennsylvania Legislature in the Medical Practice Act of 1911, Pamphlet Law 639, amended in 1913 by Pamphlet Law 1220. In the preamble of this law, it is declared, "Whereas, The safety of the citizens of this Commonwealth is endangered by incompetent physicians and surgeons, and a due regard for public health and the preservation of human life demands that none but competent and properly qualified physicians and surgeons shall be permitted to practice their profession. . . ."

The intent of this law was expressed in 1911 as follows: ". . . it being intended that this act shall furnish a complete and exclusive system in itself so far as relates to the right to practice medicine and surgery in the Commonwealth of Pennsylvania."

The term "medicine and surgery" was defined in a 1941 amendment, Pamphlet Law 903, to

mean "the art and science having for their object the cure of diseases of, and the preservation of the health of, man, including all practice of the healing art with or without drugs, except healing by spiritual means or prayer." Prohibition of this act in 1941 stated: "It shall not be lawful for any person in the State of Pennsylvania to engage in the practice of medicine and surgery, . . . or to diagnose diseases, or to treat diseases by the use of medicines and surgery as defined in section 1 (c) of this act or by any other means . . . , unless he or she has first fulfilled the requirements of this act and has received a certificate of licensure from the board. . . ."

This 1941 amendment further states: "On first offense any person willfully violating the provisions of this section of this act shall, upon conviction, be deemed guilty of a misdemeanor and shall be subject to a fine of not more than five hundred dollars or imprisonment for not more than six months in the county prison, or both or either, at the discretion of the court; on second offense shall be subject to a fine of not less than five hundred nor more than one thousand dollars and imprisonment of not less than six months nor more than one year, at the discretion of the court."

Such is the Medical Practice Act—designating those qualified to practice medicine and surgery, excluding all others from such practice, and fining and imprisoning all convicted offenders.

In 1909, by Pamphlet Law 321, the State Legislature defined the "Nurses Act" which states: "Every graduate nurse who shall receive a certificate of registration under the provisions of this act shall be entitled to be styled and known as a Registered Nurse, and it shall be unlawful for any other person to use said title, or any equivalent thereof." This act amended in 1919 by Pamphlet Law 545 construes the following meaning: "Nor shall anything herein contained be considered as conferring any authority to practice medicine, or to undertake the treatment and cure of disease, in violation of the laws of the Commonwealth."

This construction was emphatically reasserted in 1923 by Pamphlet Law 683 which states: "Nothing contained in this act shall be construed as conferring any authority to practice medicine, or to undertake the treatment or cure of disease, in violation of the laws of the Commonwealth."

Amendments to the Nurses Act in 1943, Pamphlet Law 514, and 1947, Pamphlet Law 194, empower the Registration Board to "suspend or revoke any certificate of registration in any case where the Board shall find: . . . (c) That said registrant has willfully or repeatedly

violated any of the provisions of this act, or of the by-laws and regulations of the Board."

In 1923 Pamphlet Law 683 added the additional penalty of fines by stating, "Any person who violates any of the provisions of this act shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay a fine of not less than fifty (\$50.00) dollars nor more than two hundred (\$200.00) dollars for each offense."

Such is the Nurses Act—designating those qualified to function as registered nurses, specifically excluding them from diagnosing and treating diseases, and punishing convicted offenders by loss of registration and fine.

All employers are involved by the general principle of criminal law which states that any person who willfully and intentionally engages another to commit a criminal offense is as guilty as the person who commits the offense.

It is apparent that the Medical Practice Act defines by law the hands in which have been placed the "public health and preservation of human life"—the hands of licensed physicians and surgeons. By the Nurses Act registered nurses and all others are explicitly defined as being excluded from the practice of medicine and surgery. Criminal law indicts the employer. Loss of registration, fine and imprisonment may follow conviction under these laws.

These laws are the foundation of medical orders. Here they start that they may finish with the greatest possible benefit "to the public health and the preservation of life." In medical orders alone can the nurse in industry perform her invaluable service to medicine and the workers. Herein are designated her responsibilities and rights of action. Conforming to explicit medical orders she stands above criticism. She acts as the instructed agent of a licensed physician on whose shoulders lie justly the legal responsibilities and penalties of the law. A grievous injustice is done to a nurse on whose shoulders are placed illegal functions by the dictates of a misinformed or law-evading employer. Stupid and deserving of reprehension would be the nurse who willfully assumes such responsibilities and penalties. Whatever the circumstances, equally culpable of practicing medicine without a license are the nurse and the employer for whom the nurse is an agent.

There is but one course within the law. It is this. No nurse can lawfully function under any circumstance without the explicit direction and supervision of one or more licensed physicians. In industry that physician must be associated with the management in such a way that he is

free to exercise his responsibilities by personal supervision of all nursing functions.

All employers should take heed. Legal consciousness of workers concerning welfare rights is a searching eye, growing in keenness. Time is running short when employer and nurse offenses against the Medical Practice Act, the Nurses Act, and Criminal Law will stand in the full glare of legal judgment.

These facts are urged on all employers who maintain a medical service without a specific physician responsible. All nurses involved in such illegal procedures should hasten the adjustment. May none have to bear the stigma and the shame of having besmirched their splendid profession.

F. BENEDICT LANAHAN, M.D.

MATERNAL MORTALITY

Maternal mortality decreased to a new low in the United States during 1947, according to figures released March 20 by the national Office of Vital Statistics of the Public Health Service, Federal Security Agency. The maternal mortality rate was 1.3 per 1000 live births in 1947 as compared with 1.6 in 1946. The number of maternal deaths also decreased from 5153 deaths in 1946 to 4978 in 1947, despite the tremendous increase in the number of births.

For the individual states the maternal mortality rates in 1947 ranged from 0.6 deaths per 1000 live births for residents of Minnesota to 2.6 for residents of Alabama, Mississippi, and South Carolina. The rate for residents of Pennsylvania was 1.3 in 1947 compared with a rate of 1.5 in 1946, and 3.2 in 1940.

Through the cooperation of the Bureau of Vital Statistics, Pennsylvania Department of Health, the JOURNAL has published monthly for a number of years a table of mortality statistics in each county.

On page 894, this issue, will be found a listing of "Deaths from Selected Causes in Pennsylvania, December, 1948." The column "Maternal Deaths" totals 12, divided by counties as follows: Philadelphia, 4; Allegheny and Fayette, 2 each; Beaver, Berks, Bradford, and Dauphin, 1 each. It is hoped that the causes for these deaths were determined and discussed by members of the medical societies in the counties where such deaths occurred.

MEDICAL X-RAY PROTECTION UP TO TWO MILLION VOLTS

The increasing use of high-energy x-rays in medical diagnosis and treatment has presented new problems in all phases of radiation protection and shielding. Recommended standards of safety for the installation and use of high-voltage x-ray equipment are concisely set forth in a new handbook, *Medical X-ray Protection up to Two Million Volts*, published by the National Bureau of Standards.

This handbook was written by a subcommittee of the National Committee on Radiation Protection composed of representatives of radiological societies, electrical societies, and the National Bureau of Standards. It contains instructions for meeting presently accepted stand-

ards as well as advisory recommendations that should be applied where possible. Rules are given for working conditions, survey and inspection of installations, planning an x-ray installation, structural details of protective barriers, and specific types of installations. A chapter on electrical protection treats such topics as high-voltage circuits, grounding inspection and maintenance, warnings and instructions, and first-aid and fire-extinguishing devices. Also included are tables and graphs for determining the requirements of protective barriers and distance protection in specific cases.

National Bureau of Standards Handbook 41, *Medical X-ray Protection up to Two Million Volts* (49 pages, 6 line cuts, 9 tables, 15 cents), is obtainable from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.

DEMOCRATIC NATIONAL COMMITTEE CHAIRMAN ATTACKS STATE MEDICAL SOCIETIES

Mr. J. Howard McGrath, Senator from Rhode Island, who is also National Chairman of the Democratic Party, very recently gave a dramatic and significant demonstration of how the party's national leadership proposes to apply political pressure and interference should a national system of compulsory sickness insurance become the law of the land.

Democratic Chairman McGrath has, according to press association reports of March 21, declared state medical societies and the American Medical Association "a medical dictatorship."

The Democratic National Committeeman for the State of Arkansas subsequently wired Chairman McGrath as follows:

"The medical profession is threatened with a government dictatorship, not a medical dictatorship, as you well know, and your action affords eloquent evidence of why we don't want political medicine in this country.

"There are thousands of doctors who, like myself, are Democrats in good standing, and who will resent your use of Democratic Party facilities to undermine public confidence in the medical profession.

"If you insist on playing politics with the health needs of the American people, you will bring discredit on both yourself and our party."—*Pittsburgh Medical Bulletin*.

MAKE YOUR HOTEL RESERVATIONS EARLY

99th ANNUAL SESSION

THE MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA

September 25, 26, 27, 28 and 29, 1949, Pittsburgh

Hotel rooms are still at a premium, but the Pittsburgh hotels, in cooperation with the Pittsburgh Convention Bureau, have assured us that there will be available ample rooms for those attending our annual meeting if the reservations are made now. Make your plans now to attend the whole session and write directly to the hotel of your choice for reservations today.

HOTEL WILLIAM PENN—General Headquarters

William Penn Way

Single rooms	\$4.50	\$5.00	\$6.00	\$7.50
Double beds	6.75	7.50	9.00	10.00
Twin beds	7.75	9.00	12.00	13.00
Suites	15.00	18.00	22.00	27.00

ROOSEVELT HOTEL—Woman's Auxiliary Headquarters

607 Penn Avenue

Single rooms	\$4.00	\$4.50	\$5.00	\$5.25
Double beds	6.50	7.50	8.00	8.50
Twin beds	8.50	9.00	9.50	10.00
Suites	14.00	17.50	18.00	23.00

PITTSBURGHER HOTEL

428 Diamond Street

Single rooms	\$4.00	\$4.50	\$5.00	\$5.50
Double beds	6.00	6.50	7.00	7.50
Twin beds	8.00			
Suites	18.50			

FORT PITT HOTEL

Tenth Street and Penn Avenue

Single rooms	\$3.50	\$4.00	\$4.50	\$5.00
Double beds	5.00	5.50	6.00	7.00
Twin beds	6.00	6.50	7.00	8.00

SHERATON HOTEL

212 Wood Street

Single rooms	\$4.00	\$4.50	\$4.85	\$5.00
Double beds	5.00	5.50	5.75	6.00
Twin beds	7.00	7.50	8.00	
Suites	9.85	11.85		

WEBSTER HALL HOTEL

4415 Fifth Avenue

Single rooms	\$4.50	\$6.00	\$8.50	
Double beds	7.00	8.50	11.00	
Twin beds	7.00	8.50	11.00	

SCHENLEY HOTEL

Bigelow Boulevard and Fifth Avenue

Single rooms	\$4.50	\$5.50	\$7.00	\$9.00
Twin beds	7.00	8.00	9.00	11.00
Suites	15.00	16.00		

PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division, American Cancer Society, in cooperation with the Pennsylvania Department of Health, Philadelphia Division, American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

Pennsylvania Division, A.C.S.

Testosterone Propionate.—Evidence has been cited to indicate the palliative value of testosterone propionate in the treatment of advanced cancer of the breast in females. Until recently, distribution of this medication was limited to physicians engaged in clinical investigation work directly responsible to the Therapeutic Trials Committee of the Council on Pharmacy and Chemistry of the American Medical Association.

The American Cancer Society now has received the approval of the Committee to make testosterone propionate available to those physicians not taking part directly in the specific investigative program.

Arrangements have been made with Schering Corporation of Bloomfield, N. J., and Rare Chemicals of Harrison, N. J., to supply the chartered divisions of the American Cancer Society, including the Pennsylvania Division, with testosterone propionate at \$6.00 a vial provided three or more vials are ordered. Orders for testosterone must be made directly to the desired concern using the official letterhead of the Division. It is urged that repeated small orders be avoided, and whenever possible orders should be placed on the basis of estimated requirements for six or twelve months. Testosterone obtained in this manner must be made available only to the medically indigent.

Courses in Exfoliative Cytology.—A course in cytologic diagnosis of cancer for physicians will be held from May 16 to 28 at Cornell University Medical College in New York. The course will be under the direction of Dr. George N. Papanicolaou with the cooperation of his clinical associates and will include lectures, discussions, demonstrations of slides, and study of representative smears from various fluids. The tuition is \$100 and inquiries may be directed to Dr. Papanicolaou, Cornell University Medical College, 1300 York Ave., New York 21, N. Y.

Yale University School of Medicine also has announced a course for training laboratory technicians in exfoliative cytology. This training program is under the direction of Dr. Samuel C. Harvey, professor of surgery (oncology). Inquiries should be directed to him at the Yale University School of Medicine, 789 Howard Ave., New Haven 4, Conn.

Medical Brochures.—As a service to practicing physicians, the American Cancer Society is distributing without charge a series of monographs written by distinguished physicians designed to emphasize some of the more important and useful measures that can be used by the doctor in detecting early cancer. The Pennsylvania Division is cooperating in this project and already has mailed two of the brochures to physicians. The second one, "Cancer of the Head and Neck," by Dr. Hayes Martin, attending surgeon at Memorial Hospital, New York City, was just distributed.

Also included in this series of brochures will be pamphlets on "Skin Cancer," "Esophagus and Stomach," "Large Intestine and Rectum," "Larynx-Pharynx," "Thyroid," "Lung," "Breast," "Female Pelvic Organs," "Genito-urinary Diseases," "Soft Part Tumors," and "Lymphomatous Diseases."

Film Loan Library.—A Professional Film Loan Library has been set up by the American Cancer Society as part of its program of professional education. This lending system was started because of the large number of requests from numerous professional organizations for films on cancer for showings before professional groups including county and state medical societies, hospital staff conferences, and medical schools.

The list of available films may be obtained from the American Cancer Society, or the Pennsylvania Division, Hall Building, Harrisburg.

CANCER REPORTABLE IN PENNSYLVANIA

Cooperation of Physicians Earnestly Requested

Published Through the Cooperation of the Pennsylvania
Department of Health and The Medical Society
of the State of Pennsylvania

Several years ago, the Advisory Health Board of the Pennsylvania Department of Health passed a regulation adding cancer to the list of reportable or notifiable diseases. The laws of Pennsylvania give authority to the Advisory Health Board to pass such regulations. This required reporting of cancer apparently has not been observed by practicing physicians or enforced by health authorities, partly due to ignorance of the legal requirement and partly due to the fact that no well-rounded cancer control program had been developed by the Department of Health to which such reporting might serve a useful purpose.

The Division of Cancer Control of the Pennsylvania Department of Health is now carrying on a modern program aimed at prevention, early diagnosis, and prompt and adequate treatment of this disease, which ranks second only to heart disease as a cause of death in the Commonwealth. This program is being carried on in cooperation with the Cancer Commission of The Medical Society of the State of Pennsylvania and the state and local units of the American Cancer Society through a recently created State Cancer Coordinating Committee. In this coordinated program, the chief function allocated to the Division of Cancer Control of the Pennsylvania Department of Health is that of gathering and analyzing statistics on cancer. This must be based (1) on complete and adequate reporting of cancer by practicing physicians in compliance with the legal requirement, and (2) on the voluntary system of a central Tumor Registry whereby copies of tumor records are received by the Division of Cancer Control from the various hospitals of the State.

Steps are now being taken to prepare a new, separate report form for physicians to report their cases of malignant neoplasm under seal direct to the State Department of Health. This will take the place of the postal card formerly used for reporting cancer. The active cooperation of all private practitioners of medicine is earnestly requested in compliance with the legal requirement. In addition to their fundamentally important professional services on the early diagnosis and prompt and adequate treatment of cancer, practicing physicians have a great opportunity to contribute to the total cancer control program in Pennsylvania through more prompt and complete reporting of cancer as a notifiable disease.

NORRIS W. VAUX, M.D.,
Secretary of Health,
Commonwealth of Pennsylvania.

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*

8104 Jenkins Arcade

Pittsburgh 22, Pa.

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

AMENDMENTS TO CONSTITUTION AND BY-LAWS

In the interim between annual sessions, proposals for amendments or alterations to the Constitution and By-laws of our Society must be sent to the secretary-treasurer of the Society at least four months before the next annual session, and must be published in the JOURNAL at least three months in advance.

The Official Call for the 1949 Session will be published in the June JOURNAL. It should include all proposals for amendments or alterations, and they should be received by the secretary-treasurer not later than June 1.

1949 SCIENTIFIC PROGRAM PLANNED BY SURGERY AND ITS ALLIED SPECIALTIES

The action taken by the House of Delegates of The Medical Society of the State of Pennsylvania, Oct. 6, 1948, terminated the sectional meetings which were previously held, and divided the program into two main phases—medical and surgical. However, the officers of the several previous specialty sections have been retained as an advisory board to the general program committee, and sectional programs are classified appropriately under the two main headings—Medicine and Surgery.

The officers of the Sections on Medicine and Surgery have collaborated in arranging a combined program which will be held Monday, Sept. 26, 1949, from 1:00 to 5:00 p.m. in the Urban Room of the Hotel William Penn, Pittsburgh. In keeping with the trend of the times, the tempo of the program has been accelerated, with member speakers being limited to ten to fifteen minute addresses and guest speakers allotted thirty minutes.

The subject material has been chosen to be of

greatest interest to the general practitioners, although including material of such diverse and detailed value that members of the specialist group will find the meetings worthy of their consideration.

By careful arrangement, symposia or panel discussions have been arranged to alternate with the period presentations arranged by the various specialty representatives. The Tuesday, Wednesday, and Thursday programs provide that while a panel discussion is in progress in the Urban Room on a medical subject, an advisory board period will be scheduled on a surgical subject in the Monongahela Room and vice versa. It will be possible for any physician who is interested mainly in panel discussions to progress alternately from one room to the other on the same floor, should he prefer this type of discussion to the more highly specialized program.

Monday, September 26

The first phase of the combined meeting on Monday afternoon will be a symposium on The Present Status of the Silicosis Problem. Later, a second symposium on The Newer Aspects of Cardiovascular Disease will be presented with Charles P. Bailey, Philadelphia, describing The Surgery of Mitral Stenosis, and Julian Johnson, Philadelphia, discussing The Surgical Aspects of Congenital Heart Disease. These two surgical papers have been appropriately placed between medical papers which will form a well-rounded program on this subject.

Tuesday, September 27

On Tuesday morning, at 9:00 a.m., the Eye, Ear, Nose and Throat Advisory Board will present a program which will include Systemic Aspects of Ocular Disease by Jay G. Linn, Pittsburgh; Acute Pharyngeal Obstruction in Children by Francis W. Davison, Danville; and Fletcher D. Woodward, Charlottesville, Va., guest speaker, Medical Criticism of Modern Automotive Engineering.

For the second period, beginning at 10:40 a.m., a symposium on Advances in Surgery has been prepared. John H. Gibbon, Jr., Philadelphia, will be the moderator, and the subjects will include Surgical Aspects of Portal Hypertension by John D. Stewart, Buffalo, N. Y.; The Use of Tantalum Gauze Mesh in Repair of Fascia-Deficient Hernias by James Vickers Scott, Pittsburgh; The Modern Treatment of Actinomyces by Walter S. Nettrour, Pittsburgh; and Recent Advances in Surgery of the Esophagus by Frank F. Allbritten, Jr., Philadelphia.

On Tuesday afternoon, Samuel P. Harbison, Pittsburgh, will be moderator of a discussion on Surgery of Trauma, including The Emergency Treatment of Fractures by George V. Foster, Pittsburgh; Soft Tissue Injuries by S. Milton Dupertuis, Pittsburgh; Tendon Injuries by William Erb, Philadelphia; Thoracic Injuries by George P. Rosemond, Philadelphia; Cerebral Trauma by Stuart N. Rowe, Pittsburgh; and Rehabilitation by Howard A. Rusk, New York.

Following a recess, the Obstetrics and Gynecology Advisory Board will present Indications and Contraindications for Hysterectomy by Elvin J. Bateman, Pittsburgh; Toxemia of Pregnancy by Joseph J. Kocyan, Wilkes-Barre; Local Carcinoma of the Pelvis—Causes of Delay in Diagnosis of Carcinoma in Women by John Y. Howson, Philadelphia; and Obstetric Hemorrhage—Cesarean Section by Charles A. Gordon, Long Island, N. Y.

Wednesday, September 28

The Wednesday morning surgical program will begin with a period devoted to pediatric surgery under the chairmanship of Joseph A. Soffel, Pittsburgh. The following papers are scheduled to be presented. The Acute Abdomen in Infants by Elmer S. A. King, Pittsburgh; Malignant Tumors in Childhood by Charles E. Wolf, Philadelphia; Urologic Complications in Infancy by Samuel H. Johnson, III, Pittsburgh; Imperforate Anus in the Newborn by C. Everett Koop, Philadelphia; and Tracheo-esophageal Fistula in the Newborn by Orvar Swenson, Boston.

The second period of the morning program, under the direction of Julian Johnson, Philadelphia, secretary of the Surgical Section, will include Plastic Operations on the Breast by Hans May, Philadelphia; Reconstruction of the Hip Joint by Leonard F. Bush, Danville; Reconstruction of the Common Duct by Isidor S. Ravdin, Philadelphia; and Electrolyte Balance in the Surgical Patient by Fred Collier, of Ann Arbor, Mich.

The afternoon program will open with a Clinicopathologic Conference arranged by Allen Graham, of Pittsburgh. The discussion on each of two interesting cases will be opened by a surgeon. Advance publication of both cases in the PENNSYLVANIA MEDICAL JOURNAL will permit all to study the clinical history and arrive at their own conclusions in advance.

The Urology Advisory Board has prepared the following appealing program to be presented at 3:20 p.m.: Testicular Tumors by Lloyd Lewis, Washington, D. C.; Care of the Patient with Advanced Carcinoma of the Prostate by Axel Olsen, Sayre; Evaluation of Prostatic Surgery by Elmer Hess, Erie; Lower Urinary Tract Infection in the Female by Harold E. Brown, Danville; and Chemotherapy and Antibiotics in Urology by Stanford W. Mulholland, Philadelphia.

Thursday, September 29

A Symposium on Anesthesia will open the morning surgical program. Henry S. Ruth has prepared a program covering the newer methods of anesthesia which should be of interest to all members of our society.

In the second period of the morning Edwin P. Buchanan, Pittsburgh, will be moderator during a discussion of surgery of malignancy. The following subjects will be discussed: Lesions of the Lip, Mouth, and Jaw by Henry P. Royster, Philadelphia; Carcinoma of the Esophagus by Herbert R. Hawthorne, Philadelphia; Carcinoma of the Breast by Donald Guthrie, Sayre; Carcinoma of the Colon by John W. Stinson, Pittsburgh; and Carcinoma of the Stomach by George Pack of New York City.

The Thursday afternoon session will convey to general practitioner and specialist alike the selections of the Advisory Boards on Pathology and Radiology. The first period, devoted to pathology, will include the following papers: Newer Techniques in Diagnosis of Cancer by Robert C. Horn, Jr., Philadelphia; Tuberculosis in Infants by John C. Henthorne and William C. McCarthy, Pittsburgh; and the Place of the Liver Biopsy in the Diagnosis of Liver Disease by Regis A. Wolff and Samuel R. Haythorn, Pittsburgh.

The second period will be devoted to radiology. The three papers to be presented are: Syphilis of the Aorta by James Jackman, Erie; Modern Radiologic Diagnostic Procedures by Lloyd E. Wurster, Williamsport; and New Developments in Superficial Radiation Techniques by Richard H. Chamberlain, Philadelphia.

BASIC TO EVERY COMPONENT SOCIETY

The secretary of The Medical Society of the State of Pennsylvania herewith requests the secretary and other officers of each county medical society to carefully file away this issue of the PENNSYLVANIA MEDICAL JOURNAL.

The object is to preserve for future guidance of officers and members alike the article by Secretary Charles V. Hogan of the Schuylkill County Society on "Responsibility of County Medical Society in Disciplining Members" appearing on page 861 this issue.

DUE RECOGNITION

At the January, 1949 meeting of the Bradford County Medical Society, Stanley D. Conklin, M.D., was presented with a gold watch and chain, properly inscribed, in appreciation of twenty-five years as secretary of the Bradford County Society. Only those who have been intimately in contact with Dr. Conklin over these twenty-five years can appreciate the tremendous amount of work and the deep interest which he has shown in carrying out the secretarial duties of this society. Frequently, over these years, he not only filled the office of secretary but was delegated many of the duties which in larger societies are carried out by various committees.

The Bradford County Medical Society was unanimous in this expression of appreciation and concluded the presentation with the expressed hope that Dr. Conklin may serve another twenty-five years in this capacity.

For the above occasion the president of the county society conveyed the following message from the secretary of the State Medical Society:

"The Medical Society of the State of Pennsylvania, greatly indebted to Dr. Stanley D. Conklin for a quarter century of faithful service as secretary of a component society, gladly extends congratulations and best wishes to him on this occasion of well-earned recognition by those who know him best."

BULLETIN 233B LAUDED

To Officers of The Medical Society of the State of Pennsylvania.

GENTLEMEN:

On April 11 I attended the conference held in Room 321, Education Building, Harrisburg, Pa., at 1:30 p.m., representing The Medical Society of the State of Pennsylvania in a discussion with regard to the "Elementary

Course of Study," better known as Bulletin 233B. This bulletin is quite an extensive piece of work and contains a marvelous section on health. Part of the material was furnished by me and I had the opportunity of proofreading a great deal of it. Needless to say, the section on health is the best thing of its kind that has ever been produced by the Department of Public Instruction. The section on health covers sixty-one pages.

In the course of my remarks at the meeting, I stated that it took a long time for the educators of this state to recognize the importance of health activities endorsed by the Pennsylvania State Medical Society. I informed the group that organized medicine was solidly behind Bulletin 233B. I also delivered this volume to the State Medical Society library at 230 State Street. I think that those who examine this bulletin will be surprised at the extensive amount of health material contained therein.

If I can be of further service in this matter, kindly call upon me.

LAMONIER SMITH, M.D., *Director,*
Pittsburgh Public School Health Service.

April 12, 1949

CANCER CONTROL IN PENNSYLVANIA

The component participating agencies of the Pennsylvania State Cancer Coordinating Committee, 230 State Street, Harrisburg, are: Commission on Cancer of The Medical Society of the State of Pennsylvania; Division of Cancer Control, State Department of Health; American Cancer Society, Pennsylvania and Philadelphia Divisions.

Brief History

In January, 1948, the Pennsylvania State Cancer Coordinating Committee, representing the above participating agencies, reviewed the problems of cancer control in Pennsylvania and the facilities available in the State in the fight against cancer. The several particular problems were stated and the spheres of activities for the several agencies were outlined. There has been a substantial measure of cooperation on the part of each of these agencies and this coordinating effort has seemed worth while.

The committee in its 1948 progress report segregated the *seven problems of cancer control in Pennsylvania* as follows:

1. Lay education.
2. Professional education.
3. Diagnosis and treatment of cancer.
4. Statistical program.
5. Research program.
6. Organization.
7. Campaign for funds.

The committee's plans for 1949 are appended and criticism is invited.

1949 Plans

Commission on Cancer—1949 Prospectus

1. It shall be the purpose of this commission to continue the professional and lay education on cancer, particularly in the precancerous or early formative stage—but in the future, at a more rapid pace.

(Note: This is being promulgated by the Committee on Professional Education and its Subcommittee on Periodicals, etc., very well, thanks to the committees headed by Drs. Wesley D. Richards and James Bloom).

2. To urge every recognized, approved A.M.A. hospital in the State of Pennsylvania to have a tumor clinic.
3. To urge the establishment of Health Maintenance-Cancer Detection Centers in large towns or cities in the State of Pennsylvania. If necessary, and where sufficient interest is present, a group of doctors who do not have the immediate advantages of hospital facilities, could band together and establish such a group or center. We further recommend the examination in the physicians' offices.
4. To continue the harmonious cooperation established by the Commission on Cancer of The Medical Society of the State of Pennsylvania, the American Cancer Society, Pennsylvania Division (under Dr. John H. Harris), the State Department of Health (under Drs. Norris W. Vaux and Leverett D. Bristol), and the American Cancer Society, Philadelphia Division (under Dr. Catharine Macfarlane).
5. To urge more unified and orderly research work on cancer in the State of Pennsylvania under one head, such as Dr. Stanley P. Reimann, to prevent reduplication of effort and to bring eventually better results from same.
6. To interchange ideas and methods on cancer studies with other state-established commissions in order to better our own efforts.

Pennsylvania Division, American Cancer Society

1. Extend the American Cancer Society lay education program to the now unorganized counties of the State.
2. Formulate a systematic and regular lay education program for industrial workers.
3. Establish a cancer information center in all counties of the State.
4. Recruit 5000 additional volunteers to carry out the local lay education and service programs.

Philadelphia Division, American Cancer Society

LAY EDUCATION

1. An expanded lay education program is being carried on in relation to magazines, newspapers, radio, television, posters, car cards, and other educational media.
2. Five information centers will be functioning during 1948-1949.
3. Essentially the same program of in-service teacher training with expansion of student education.
4. An expanded program is being conducted and the same fine cooperation is being received from the physicians. Additional media are being explored and developed. Exhibits are being more widely utilized.

PROFESSIONAL EDUCATION

Factual material in the form of a handbook for dentists and a cancer manual for physicians is being distributed in Philadelphia and Montgomery counties.

DIAGNOSIS AND TREATMENT OF CANCER

1. Six cancer detection centers are planned for 1948-1949. Five are now in operation and the sixth will be activated shortly.
2. Home nursing care and transportation for medically indigent cancer patients is being provided in keeping with the need. The budget for both has been expanded.

RESEARCH

1. Clinical Research—increased subsidy for pelvic cancer study.
2. Early cancer clinic for women subsidized.
3. Five fellowships for promising young physicians allocated.
4. \$132,000 of Division's funds sent to national society for research; \$213,000 returned to Philadelphia in form of national grants.

CAMPAIGN FOR FUNDS

The campaign goal for the Philadelphia Division in 1949-1950 will be \$500,000.

Division of Cancer Control, Pennsylvania Department of Health

LAY EDUCATION

An expanding program is planned for participation in lay education, through the further supply of basic statistical material and occasional addresses and published articles for public groups by Division personnel.

PROFESSIONAL EDUCATION

Financial assistance will be continued during the coming year to provide:

1. Postgraduate courses at the University of Pennsylvania Medical School for physicians on the prevention, diagnosis, and treatment of cancer.
2. Postgraduate courses at the University of Pittsburgh Medical and Dental School for dentists.
3. Out-of-state fellowships for Pennsylvania physicians for short observation refresher courses on cancer.
4. Honoraria to medical speakers for talks to professional audiences.

Consideration will be given to possible financial assistance in the development of plans of cancer education for graduate pharmacists and senior pharmacy students and for nurses and social workers.

A series of sound motion picture films on cancer, particularly on the problem of early diagnosis, will be made available for the use of professional groups. The first of these films on gastric cancer is now in the Division office and may be borrowed on application to the Chief of the Division.

DIAGNOSIS AND TREATMENT OF CANCER

Financial assistance will be provided in 1949 to assist hospitals in the continuation and further development of tumor clinics for the diagnosis and treatment of cancer. This will include salaries for tumor clinic secretaries and a reasonable amount of needed supplies and equipment.

STATISTICAL PROGRAM

Every effort will be made in 1949 to further expand the facilities for a complete tumor registry and record system through the voluntary cooperation of the hospitals of the Commonwealth.

It is planned to employ an additional person as research statistician who will be responsible for the detailed analysis of all records collected by the Division, and to assist in the preparation of material for special studies and reports.

A statistical survey and report on so-called occupational or industrial cancer will be made by the Pennsylvania Department of Health's Divisions of Industrial Hygiene, Cancer Control, and Vital Statistics, in cooperation with the Cancer Control Branch of the National Cancer Institute.

RESEARCH

While no authorization is given to the Division to carry on scientific research as one of its direct activities, the Division will continue to make available financial grants to a few selected educational institutions and hospitals for special projects in the field of cancer research.

ORGANIZATION

The present staff of the Division consists of a chief, who is a physician trained in public health and preventive medicine in general and cancer control in particular; a biometrician in charge of the tumor registry in the state office and who assists in training and advising tumor clinic secretaries; an office supervisor and 12 clerks and office assistants. Necessarily, the work of these individuals is confined more or less to activities in the state office. In order to carry the Division's program into various parts of the State, and particularly to assist hospitals in the further promotion and maintenance of tumor clinics, it is planned to employ a special field representative or public relations consultant as an assistant to the chief of the Division.

FUNDS

While no final approval and authorization are as yet forthcoming as to Federal and State budgets for cancer control during the coming year, it is believed that at least the same amount of funds will be available as for the past year.

HORACE B. ANDERSON, M.D.

JOHN V. BLADY, M.D.

LEVERETT D. BRISTOL, M.D.

LEO F. GERBER

JOHN H. HARRIS, M.D.

HAROLD J. HARRIS, M.D.

MARTIN S. KLECKNER, M.D.

CATHARINE MACFARLANE, M.D.

E. C. NICODEMUS

ROSS M. VICKERS

RALPH D. BACON, M.D., *Chairman*,
117 W. Eighth St., Erie, Pa.

ROBERT L. RICHARDS, *Acting Secretary*,
230 State St., Harrisburg, Pa.

RESPONSIBILITY OF A LOCAL SOCIETY IN DISCIPLINING MEMBERS

CHARLES V. HOGAN, M.D.

POTTSVILLE, PA.

The first five years of my administration as trustee and councilor of the Fourth District were comparatively quiet and serene. However, during this first year of my second term in office several ethical problems have confronted me, which is doubtless the reason this subject has been assigned to me.

Reduced to more general terms, the subject would seem to deal with things that concern the physician himself, his responsibility and his success, and in introducing my subject I feel that I cannot do better than to quote liberally from *The Physician Himself*, written by the late Dr. D. W. Cathell, of Baltimore, in 1890, which went through nine editions.

Dr. Cathell emphasized the following advice to his readers:

"Observe and strictly practice every acknowledged rule of professional etiquette. For this purpose it is your duty to familiarize yourself at the very threshold of your professional career with the Code of Ethics of the American Medical Association, and never to violate either its letter or its spirit.

"Absence of a code would make it possible for Dr. G to pounce on the patients of Drs. A, B, C, D, E, and F like a wolf on sheep, and to carry on a regular cold-blooded system of infringements, self-advertising, certificate-giving, and wrong-doing in general regardless of their rights, and still claim to be as honorable as Socrates, while those aggrieved would have no visible standard of appeal by which to prove the contrary.

"In view of these and many other facts, it has been found necessary to have a code of written ethics for regulating the conduct of physicians toward each other and toward the public generally.

"Dr. Thomas Percival, an English physician, in a small book published in London in 1807, proposed an admirable code of ethics, which, excepting a few alterations made necessary by the lapse of time and the advance of medical science, is the identical code adopted by the American Medical Association in 1847, and which from then until now has instructed and governed nine-tenths of our profession throughout this broad land.

"Professional morals are an important part of medical education universally required, and it is as much the duty of every medical college in America to acquaint its students with the precepts of this code and to furnish to each of its alumni a copy of it with his diploma as it is for a mother to familiarize her children with the Ten Commandments.

"In our land this code is the balance-wheel that regulates all professional action, and neither Professor Bigbee nor Dr. Littlefish can openly ignore it without

Read at the thirty-seventh annual Conference of Secretaries and Editors, Harrisburg, March 3, 1949.

overthrowing that which is vital to his standing among medical men.

"Medical society membership is a guarantee of your good standing and that you pursue legitimate practice.

"Medical societies give a sound and healthy tone to the entire profession and stimulate the healthy growth of the profession at large, and also generate and keep alive a genuine professional and social spirit that constantly tends to minimize all that is unprofessional.

"Never oppose the admission of any clean-handed, honorable, and competent one into society membership for private or personal reasons, or for any cause other than ineligibility or unfitness to receive the honors and benefits that membership confers.

"It would be unjust to mix private feelings with professional duties, and interpose an objection or to cast a black ball against anyone on purely personal grounds."

From the writings of Dr. William Osler, internationally famous physician, teacher and writer, who was a member of our own state medical society during the short period (1886-1889) that he was in Philadelphia before going to Baltimore, we quote from his advices:

"The quarrels of doctors make a pretty chapter in the history of medicine. Each generation seems to have had its own. But these quarrels are becoming less and less intense, and it is safe to predict that in the present century, when science has fully leavened the dough of homeopathy, the great breach of our day will be healed.

"So far as my observation goes, the fault lies with the older men. The young fellow, if handled aright and made to feel that he is welcome, not an intruder to be shunned, is only too ready to hold out the hand of fellowship.

"The medical society comes in here as professional cement. The meeting in a friendly, social way, with a free and open discussion of affairs, fosters a spirit that refuses to recognize in differences of opinion on the non-essentials of life a cause of personal animosity or ill-feeling.

"An aptitude of mind habitually friendly, more particularly to the young man, even though you feel him to be the David to whom your kingdom may fall; a little of the old-fashioned courtesy which makes a man shrink from wounding the feelings of a brother practitioner, in honour preferring another—with such a spirit abroad in the society and among its older men, there is no room for envy, hatred, malice, or any uncharitableness.

"Envy, that pain of the soul, as Plato calls it, should never for a moment afflict a man of generous instincts who has a sane outlook in life.

"If you hear that a young fellow just starting has made mistakes or is a little 'off colour,' go out of your way to say a good word to him, or for him. It is the only cure; any other treatment only aggravates the malady."

Consultation with Secretary-Treasurer Donaldson of our state society brings out the information that infractions of the Principles of Ethics have been few and far between throughout Pennsylvania in the last decade if one may judge from the records in his office.

Dr. Donaldson has further pointed out that the report of the Judicial Council of the Amer-

ican Medical Association to the 1943 House of Delegates, quoted herewith, indicates that disciplinary action on such charges must have been rare throughout all state medical associations. Excerpts from the report read as follows:

"The activities of the Judicial Council during the past two or three years have been confined largely to acting on applications for Fellowship and to the consideration of inquiries submitted by individuals or groups. There have been almost no appeals from disciplinary actions of constituent associations for the Council to adjudicate.

"This is quite different from the situation five to ten years ago, when component county medical societies and constituent state medical associations were sensitive to infractions of their by-laws and the Principles of Medical Ethics and were active in bringing offenders to account. During that period the Council was seldom without an appeal to be heard from a decision by a constituent association. The question naturally arises as to the causes underlying such a condition. Are our organized societies more actively governing the ethics of the practice of their membership or has the stress of the times resulted in indifference to our ethical principles?"

From this report one may surmise that appeals from county and state medical society disciplinary action on charges of unethical conduct had been very infrequent. On the other hand, during the same period many evidences of individual infractions evidently did not come to the attention of the censors of component county medical societies.

Again quoting, "It might be inferred from the number and the nature of problems which have come up for decision by the Council in the last two or three years with respect to Fellowship that in many instances a more or less complete disregard for the principles of ethics has been exhibited by individual members and that component societies having original jurisdiction have failed to take proper action."

Can it be true that throughout Pennsylvania this state of affairs exists, and for lack of initiative or courage, or a finer sense of responsibility, the membership of county societies may be deliberately overlooking infringements upon our code of ethics, which from the time of Hippocrates have been freely at hand to govern the members of our profession in the principles of ethical ideals, and obligations higher than those of any other occupation or profession? The basic principle of our code of medical ethics is, always has been, and should remain, the duty of the doctor of medicine to make the welfare of his patient his first consideration.

If we have been careless in maintaining ethical standards, we may have at hand the explanation for loss of favor in public opinion which many claim has come to our profession in the past decade.

What are the provisions in the Constitution and By-laws of our state medical society or of our individual component county society by-laws for the enforcement of disciplinary action?

In principle they provide that members of a component county medical society accused of criminal offense involving moral turpitude or gross misconduct as a physician, or a violation of the constitution and by-laws of his component society, or of his state society, or the principles of medical ethics of the American Medical Association, shall be subject to censure, suspension, or expulsion by his county society. Each county society shall maintain a board of censors whose duty shall be to conduct trials based on formal charges.

Principles of justice shall guide all disciplinary actions such as: (1) the accused is presumed to be innocent until he has been proved guilty; (2) after charges have been preferred there shall be no evasion of the fact that the respondent is to be tried; that the board of censors of the component society before which he is cited to appear is a trial body and that he will be on trial when he appears; (3) he must be notified by registered mail of the specific charges which are made against him at least two weeks before the day set for his trial; (4) he may not be found guilty of anything not included in the charges preferred against him and presented to him; (5) all evidence not pertinent to the charges as made shall be considered irrelevant and immaterial; it shall be wholly disregarded in the decision; (6) testimony not bearing on the charges shall be objected to, and if sustained by the trial body, stricken from the records; (7) the respondent shall be advised of his rights by the trial body, namely, that (a) he may be represented by any member of the Society as counsel, (b) he or his counsel may cross-examine witnesses, (c) he may offer in evidence any records or documents that he deems fit, (d) he may enter objections as to testimony or to material offered in evidence, (e) he may address the trial body in his own behalf, and (f) he has the right of appeal to the Judicial Council of the State Medical Society; (8) a comprehensive stenographic record of the proceedings must be kept for reference; (9) this committee, sitting as a trial body, shall find the accused either guilty or not guilty. If the verdict is guilty, the trial body shall recommend censure, suspension, or expulsion. The findings of the trial body must be presented to the component county society for approval or rejection. The accused must be notified by registered mail at least ten days before the date set for the meeting at which this action will be taken. If the findings

of the trial body are against the accused, the secretary of the component society shall acquaint the accused by registered mail with his right to appeal to the Judicial Council of the State Medical Society within thirty days.

What are the provisions for an accused member to appeal from the decision of his county trial board to an appellate division of his state medical society, or finally to the Judicial Council of the American Medical Association?

It should be understood that the appeal shall consist only of a review and hearing as to the regularity of the procedure followed during the former trial. The first avenue of appeal set forth in the Constitution and By-laws of our own state medical society is described in Chapter 4 of Section 2 as follows:

"Each councilor district shall have a separate board of censors. The board shall be formed by the House of Delegates of this Society electing one censor from each component county medical society in the councilor district. Each component county medical society is requested to present to the House of Delegates for its consideration the name of a suitable member for district censor."

This is followed by Section 3, and that in turn by paragraphs B and A respectively:

"The district censors of each councilor district shall sit under the chairmanship of the councilor of the district who shall not have the right to vote. They shall consider every case of appeal from the decision of a component county medical society by a member who has been censured, suspended, or expelled, provided that the appeal is made within three months after the censure, suspension, or expulsion. They shall report in writing their decision thereon to the county medical society, and also to the trustees and councilors of this Society. They shall consider and dispose of all questions affecting the principles of medical ethics that may be referred to them, either by a component county medical society or by this Society. The decision of the censors in every case must be signed by a majority of the board. Any appeal or judicial question arising in a district comprised of less than three county societies shall be referred directly to the judicial council of this Society."

"B. In hearing appeals the district censors may admit oral or written evidence as in their judgment will best and most fairly present and record the facts.

"After giving at least thirty days' notice to the appealing member and his component county society, the Board of Trustees and Councilors sitting as a Judicial Council shall hold a hearing on the appeal. The Board shall review the record of the original proceedings and may obtain additional evidence. Its decision shall be final except that within the next ninety days a further appeal may be made to the Judicial Council of the American Medical Association."

"A. In instances wherein the censors or judicial board of a component society suppress without a proper hearing, or deny appeal from board decision on charges of unethical conduct formally brought against a member of this Society, the complainant may bring such alleged conduct or such decision, through the Board of Trustees and Councilors of this Society, to the consideration of a

grievance committee composed of the district censors of the complainant's councilor district. The findings of the grievance committee shall be reported to the Board of Trustees and Councilors, seated as a Judicial Council, for disposition."

There is one remaining situation in which an appeal proviso may be found in the By-laws of our state society—Chapter VIII, Section 3:

"Any Doctor of Medicine who may feel aggrieved by the action of a component county medical society in refusing him membership shall have the right to appeal to the censors of the councilor district for their decision."

The reading of this section brings us back to the opening paragraphs of this paper and the wise words of Dr. Cathell, quoted as follows:

"Never oppose the admission of any clean-handed, honorable, and competent one into society membership for private or personal reasons, or for any cause other than ineligibility or unfitness to receive the honors and benefits that membership confers."

And those of Dr. Osler:

"If you hear that a young fellow just starting has made mistakes or is a little 'off colour,' go out of your way to say a good word to him, or for him. It is the only cure; any other treatment only aggravates the malady."

In conclusion, and for future guidance in striving to bring about proper observance of the principles of medical ethics, I quote from the words of the late Dr. George E. Follansbee, for many years chairman of the Judicial Council of the American Medical Association:

"The medical profession has gained its position of favor in public opinion through the exercise of the principles of right action throughout hundreds of years of growth since the days of Hippocrates. Let us not, as individuals or as organizations, by either willfulness, carelessness, or indifference, jeopardize the fair reputation our profession has built."

EXCERPTS FROM MINUTES OF BOARD OF TRUSTEES' MEETINGS

Dec. 16, 1948

A regular meeting of the Board of Trustees and Councilors of The Medical Society of the State of Pennsylvania was held Thursday evening, Dec. 16, 1948, in Parlor C of the Penn-Harris Hotel, Harrisburg, Pa.

Members in attendance were: Drs. Hugh M. Miller (1st), Francis J. Conahan (3d), Charles V. Hogan (4th), James Z. Appel (5th), Joseph S. Brown (6th), George S. Klump (7th), Herman H. Walker (8th), Frank A. Lorenzo (9th), James L. Whitehill (10th), Leard R. Altemus (11th), and Thomas R. Gagon (12th). John F. Sweeney (2d) was absent due to arrival December 15 of son's remains for reburial. He was killed in action during World War II.

Officers present were: Drs. Gilson Colby Engel,

president; Walter F. Donaldson, secretary-treasurer; E. Roger Samuel, president-elect; and Harold B. Gardner, first vice-president.

Others present were: Drs. Elmer Hess, former president; C. L. Palmer, chairman of Committee on Public Health Legislation; Howard K. Petry, chairman of Committee on Public Relations; Louis W. Jones, chairman of Committee on Medical Economics; Charles L. Shafer, chairman of State Board of Medical Education and Licensure; and Mr. Lester H. Perry, executive secretary of the MSSP.

Chairman Lorenzo called the meeting to order at 7:50 p.m.

Before approval of the minutes, Secretary Donaldson reported corrections to the October minutes in detail.

Reports of Board Committees

Finance Committee

Chairman Whitehill presented the report of the Finance Committee, including the results of the committee's conference with Mr. T. Rowe Price, of Baltimore (recommended by President Engel), for advice on reinvestment of funds.

It was moved (Dr. Miller), seconded (Dr. Altemus), and unanimously carried that money in the Building Fund account (\$56,164.86) be invested in short-term (90-day to one year) government securities.

It was moved (Dr. Hogan), seconded (Dr. Altemus), and unanimously carried that the cash balances in the Medical Defense, Medical Benevolence, and Endowment Funds be withdrawn from savings accounts as soon as possible and invested in long-term U. S. Savings Bonds, Series "G," at 2½ per cent.

It was moved (Dr. Gagon), seconded (Dr. Conahan), and unanimously carried that the report of the Finance Committee be accepted.

Building Maintenance Committee

Chairman Conahan announced that the architects had completed preliminary surveys looking to the remodeling of the 226 State Street building. They reported, in addition to the fact that Dr. Laverty may occupy the first floor for five years, that the plumbing in both buildings is bad and should be renewed, and the lighting in both buildings should be modernized.

It was moved (Dr. Whitehill), seconded (Dr. Altemus), and unanimously carried that the architects be authorized to prepare preliminary drawings for the March board meetings.

Report of President

President Engel reported on a number of items involving considerable correspondence which was largely informative. He called attention to the appeal of a physician who had been denied membership in a component society. The appeal was referred through the trustee and councilor to the district censors of the councilor district.

Dr. Engel next advised that state medical society representatives should plan to meet with the key men of organized labor in Pennsylvania to show willingness to cooperate with them on a voluntary health insurance program.

After free discussion, it was moved (Dr. Klump), seconded (Dr. Whitehill), and unanimously carried that in line with President Engel's recommendations the chairmen of the Industrial Health and Hygiene, Medical Economics, and Public Relations Committees, respectively, and the President constitute a committee to

approach labor in the manner outlined and that Dr. Engel act as chairman of the group.

DR. ENGEL: It is time that somebody starts criticizing Mr. Oscar Ewing of the Social Security Administration to the public. He has been making statements right and left, many of which are easy to refute. I have written him a letter which I will show to Dr. Petry. This society, through the Public Relations Committee, should start on a definite program to discredit many of Mr. Ewing's public statements.

DR. CHARLES L. SHAFER, chairman of the State Board of Medical Education and Licensure: By an act of legislature, Pennsylvania has an osteopathic surgeons' board consisting of two members of The Medical Society of the State of Pennsylvania and two from the Osteopathic Association. At present the osteopaths have two members and the State Medical Society has but one. George Hawk, M.D., of Sayre, has been serving alone for a number of years. Recommendations to the Governor come from the State Board of Medical Education and Licensure. Such have been made, but thus far no appointment has been made. If the trustees of the State Medical Society will suggest two or three names to submit to Governor Duff, I feel sure that the State Board of Medical Education and Licensure will be glad to recommend them.

Following the report of the convention manager, it was moved (Dr. Whitehill), seconded (Dr. Gagion), and unanimously carried that the 1950 meeting be held in Philadelphia on Oct. 16, 17, 18 and 19, 1950, in accordance with the recommendation of the convention manager on Dec. 10, 1948.

SECRETARY DONALDSON: In Pittsburgh, with a convention coming up next September, we have been making preliminary plans on the basis of a religious hour on Sunday afternoon; the installation meeting on Tuesday night to be more elaborate than it has been in Pittsburgh before; and the president's reception to be on a more elaborate scale. Will this Board of Trustees approve of reasonable expenditures to cover such plans?

DR. KLUMP: Did you mention the state dinner?

SECRETARY DONALDSON: I didn't mention that because it is a subscription affair. We have already planned a Local Committee on Arrangements.

It was agreed that the plans be approved as outlined.

Report of Committee on Public Health Legislation

Chairman Palmer, in discussing legislation on the question of rebates, stated that his committee deemed it advisable, in case some very radical bill was introduced, to be prepared to suggest to the State Board of Medical Education and Licensure clarification of the Medical Practice Act as it provides for the revocation of a license to be along lines similar to those in the Iowa act, which realistically includes rebating as unprofessional conduct. (Dr. Palmer read that section of the Iowa law pertaining to rebates.)

On the question of legislation to license practical nurses, the Committee on Public Health Legislation and the Commission on Preventive Medicine and Public Health jointly agreed to approve the bill as written except for its provision regarding tuberculosis and mental institutions.

It was moved (Dr. Klump) and seconded (Dr. Miller) that this portion of Dr. Palmer's report be accepted.

After debate on the rebate item, the motion carried unanimously.

Report of Committee on Medical Economics

Chairman Jones, referring to the report as mailed to Board members and touching on that portion in regard to the relationship of the general practitioner to hospitals, advised that the Society now has a permanent Committee on Hospital Relations (see Section 12, Chapter VII, of the By-laws). He said that this new committee was no doubt created by the House to make such studies.

It was moved (Dr. Gagion), seconded (Dr. Walker), and unanimously carried that the report of the Committee on Medical Economics be accepted and approved.

Report of Committee on Public Relations

Chairman Petry's report dealing with news association messages about the A.M.A. and Mr. Oscar Ewing's public report on the 1948 National Health Assembly, and the attendance at board meetings of paid lay representatives of the Public Relations Committee, was read and discussed.

It was the consensus of the Board that Dr. Petry's request in behalf of Public Relations Committee lay representatives be approved.

Dr. Petry then reported his committee's recommendation that all rejected nominees for the Benjamin Rush Award who are locally considered persons or organizations of merit, be presented a miniature Benjamin Rush medallion.

It was moved (Dr. Miller), seconded (Dr. Altemus), and unanimously carried that the report be accepted and approved.

Following Dr. Petry's comments on the subject of educating new employees or Society members in insurance problems, it was moved (Dr. Gagion), seconded (Dr. Whitehill), and unanimously carried that the Board of Trustees at this meeting suggest to the American Medical Association that it establish a workshop for the indoctrination of employees and medical personnel in contrasting forms of sickness insurance.

Dr. Klump, as a member of the Society's Commission on Preventive Medicine and Public Health, of which Dr. Lucchesi is chairman, reported informally on the Pennsylvania public health survey which was made at the suggestion of the commission. The report will consist of 26 chapters, 200 pages 8 x 10. One thousand copies of this report will be delivered to Secretary Vaux. There will be a 48-page digest published in the *Commonwealth Magazine* and 15,000 copies of that particular issue will be available.

It was moved (Dr. Miller), seconded (Dr. Conahan), and unanimously carried that the meeting be adjourned to reconvene at 230 State Street at 9:30 a.m., Dec. 17, 1948.

The meeting was adjourned at 11:30 p.m.

FRANK A. LORENZO, *Chairman*,

WALTER F. DONALDSON, *Secretary-Treasurer*.

Dec. 17, 1948

A regular meeting of the Board of Trustees and Councilors of The Medical Society of the State of Pennsylvania was held Friday morning, Dec. 17, 1948, in the board room of the headquarters building, 230 State St., Harrisburg, Pa.

Members in attendance were: Drs. Hugh M. Miller (1st), Francis J. Conahan (3d), Charles V. Hogan (4th), James Z. Appel (5th), Joseph S. Brown (6th), George S. Klump (7th), Herman H. Walker (8th), Frank A. Lorenzo (9th), James L. Whitehill (10th),

Leard R. Altemus (11th), and Thomas R. Gagion (12th).

Officers present were: Drs. Gilson Colby Engel, president; Walter F. Donaldson, secretary-treasurer; E. Roger Samuel, president-elect; Harold B. Gardner, first vice-president; and Park Berkheimer, assistant secretary-treasurer.

Others present were: Drs. C. L. Palmer, Chairman, Committee on Public Health Legislation; Howard K. Petry, Chairman, Committee on Public Relations; Louis W. Jones, Chairman, Committee on Medical Economics; Park A. Deckard, Vice-Chairman, Committee on Public Health Legislation; and Mr. Lester H. Perry, Executive Secretary.

Chairman Lorenzo called the meeting to order at 9:30 a.m.

Discussion on Amendment of the Enabling Act of the Medical Service Association to Include MSAP Payment of Osteopaths

DR. PALMER: This is a very controversial question.

DR. GAGION: If the act was amended to say "service delivered through a doctor of medicine or an osteopath," what about chiropractors?

Secretary Donaldson quoted the following:

"Scope of Osteopathy.—Court decisions by the supreme courts of three states have within recent months determined the scope within which osteopaths may legally function. A Pennsylvania case involved the right of an osteopath to issue certificates of commitment to state institutions under the mental health act. The court held that an osteopath has no such right because he is not a 'qualified physician' licensed to practice medicine in the State within the meaning of the mental health act.

"In a North Carolina case the Supreme Court declared that osteopaths could not use drugs and that the phraseology used in the act under which they are licensed, authorizing them to practice 'as taught by the various colleges of osteopathy recognized by the North Carolina Osteopathic Society' did not confer on them any right other than to practice osteopathy. The court said that the osteopathic colleges could not change the law of North Carolina nor widen the scope of the osteopath's certificate so as to permit him to practice other systems of healing by the simple expedient of varying their curricula."

DR. GAGION: Has the governing board of MSAP made up its mind as to what it wants to do?

DR. PALMER: At your last meeting they appeared and asked you to open their enabling act.

After a half-hour's discussion of this question it was moved (Dr. Whitehill), seconded (Dr. Klump), and unanimously carried that this question of proposed Legislation be left in the hands of the Committee on Public Health Legislation.

Discussion on Report of Committee on Rural Medical Care Regarding General Health Council

DR. PALMER: For several years the A.M.A. Council on Rural Medical Care and the Council on Medical Service have been urging state medical societies to form general health councils for the purpose of discussing improvements in public health services, sanitation, etc.

A number of states have done so. In consultation with Drs. Donaldson, Engel, and Borzell, it was decided that now may be the time for our state medical society to take the lead in organizing a General Health Council. We wrote to a number of organizations asking them to submit the name of one individual to represent them at a meeting early in the winter for the purpose of organizing such a General Health Council. The Public Charities Association submitted a rather large list. The Committee on Rural Medical Care would like the blessing of this Board before it goes ahead and takes the lead in this endeavor.

After free discussion, pro and con, it was moved (Dr. Klump), seconded (Dr. Altemus), and unanimously carried that the Board of Trustees approve organization by the Committee on Rural Medical Care of the proposed state General Health Council.

There was a fifteen-minute recess while a group photograph was taken of the Board members.

The report of the Commission on Graduate Education, previously distributed, resulted in the following motion:

It was moved (Dr. Miller), seconded (Dr. Walker), and unanimously carried that the report of the Commission on Graduate Education be accepted, and that the recommendation that Drs. Smith and Brown be delegates to the national Conference on Medical Service to be held in Chicago on Feb. 6, 1949, be approved.

Dr. Petry reported that the Advisory Committee to the Woman's Auxiliary had raised a question as to whether the State Society considered it obligatory that they hold their councilor district meetings at the same time and place that the Medical Society held theirs. They are rather unhappy over it and wonder what the attitude of the Board would be toward their holding separate councilor district meetings.

DR. ENGEL: Shouldn't this be a problem for each councilor district to settle on its own basis?

It was moved (Dr. Walker), seconded (Dr. Conahan), and unanimously carried that plans for Woman's Auxiliary meetings be left to the discretion of each district councilor.

Columbia County Resolution

SECRETARY DONALDSON: This is the item referred to the Board of Trustees by the 1948 House of Delegates on which the Board reported back to the House of Delegates that they would report to the next meeting of the House in 1949. Each trustee received a copy of every action taken by the A.M.A. House of Delegates in the last thirty-three years on this subject (the practice of medicine by hospitals). I would suggest that at some meeting before next July the Board take a position on this problem.

It was moved (Dr. Whitehill), seconded (Dr. Hogan), and unanimously carried that further consideration of the practice of medicine by hospitals be taken up at the March meeting after the proposal has been studied. (SECRETARY'S NOTE: At its March meeting the Board of Trustees instructed the society's Committee on Hospital Relations, Dr. Hess, chairman, to bring in a report at the May meeting of the Board of Trustees.)

Selection of Committee on Educational Fund

Secretary Donaldson stated that the Constitution provides that this committee shall consist of the secretary-treasurer and three members, one of whom shall be a member of the Board of Trustees.

It was moved (Dr. Miller), seconded (Dr. Klump), and unanimously carried that the Committee on Educational Fund be comprised of Drs. James L. Whitehill, Elmer Hess, Louise Gloeckner, and Walter F. Donaldson.

It was moved (Dr. Altemus), seconded (Dr. Hogan), and unanimously carried that the 1948 personnel be reappointed to the 1949 Disaster Emergency Medical Service Committee with a new member being appointed to take the place of Dr. William Sunderman.

It was moved (Dr. Altemus), seconded (Dr. Gagion), and unanimously carried that Dr. Irwin M. Pochapin be given the opportunity to go to Bethesda for a period to acquire knowledge on atomic defense.

Dr. Engel then announced that he wished to appoint Dr. Donald W. Gressley, Rochester, Pa., to take Dr. Sunderman's place on the Disaster Emergency Medical Service Committee. The appointment was approved by Board action.

Correspondence

Secretary Donaldson read a communication from the Medical Bureau of Harrisburg, which the State Medical Society underwrote ten years ago for the sum of \$3,500 to begin the development in Harrisburg of a service that has now become an outstanding service bureau for the physicians and dentists and the people of Dauphin County and vicinity. They have now repaid in full, without interest, the last and final balance—the sum of \$400.

Statement of Dr. James J. Monahan Referred to Board of Trustees

Secretary Donaldson explained agenda item 7(b) on rebates, saying that the House of Delegates referred this problem to the Board of Trustees, seated as a Judicial Council.

It was moved (Dr. Gagion), seconded (Dr. Altemus), and unanimously carried that the matter of item 7(b) be deferred until the report of the A.M.A. committee on this particular question has been received to serve as a guide and source of information.

(SECRETARY'S NOTE: Rebate statement referred to appeared in Dec. 18, 1948 issue of *Journal A.M.A.*, pages 1176-7.)

Reports of Medical Defense Cases

In the First District, Case No. 375, approval has been completed. In the Sixth District, Case No. 372 has not been called in court. There were no reports from other districts.

Dr. Engel reported a communication from the Pediatric Society which he had received before the Scientific Work Committee met yesterday. He said this should be taken into consideration in developing the scientific program for the 1949 convention.

Secretary Donaldson announced that the 1949 Scientific Work Committee is developing a program in every period of which one former scientific section will be featured with topics devoted to medicine and to surgery for the general practitioner. It will be so scheduled that if a general practitioner doesn't want to stay during a specialty period he may move over to the other room where a general practitioner's period is under way.

Dr. Gagion announced that Drs. Shafer, Hess, and Richards of the State Board of Medical Education and Licensure had decided that rather than have the State Board give the names of two or three surgeons to Governor Duff, it would be better if this board would ad-

dress a letter to the Governor urging him to appoint as promptly as possible another doctor of medicine as a surgeon to the vacancy on the Osteopathic Surgeons' Board.

Dr. Palmer read a few paragraphs of law on this question from Section 417 of the Administrative Code, pointing out that it is the duty of the State Board to make such recommendations.

It was moved (Dr. Gagion), seconded (Dr. Miller), and unanimously carried that a letter be sent to Governor Duff urging that the existing vacancy on the examining board for osteopathic surgeons be filled by appointment of a nominee from among those recommended to him by the State Board of Medical Education and Licensure.

Secretary Donaldson advised the appointment of an additional member to the Committee on Medical Economics and to the Committee on Public Health Legislation.

Dr. Appel nominated Dr. Edgar W. Meiser, of Lancaster, to the Committee on Medical Economics. (Nomination approved by the Board of Trustees.)

Dr. Klump nominated Dr. Herman C. Mosch, of Coudersport, to the Committee on Public Health Legislation. (Nomination approved by the Board of Trustees.)

DR. APPEL: The Lebanon County Medical Society has asked for informal advice as to what attitude it should take toward admitting members of the medical staff of the Veterans Administration Hospital now being developed in Lebanon—whether they should be considered as new members or transfers from other Pennsylvania county societies.

SECRETARY DONALDSON: Those not licensed in Pennsylvania may be elected to affiliate membership at one-half the usual county and state society dues, and if recommended by the county society, they may be elected affiliate members of the State Society by the Board of Trustees.

DR. APPEL: Another problem is this. A few of the members of the staff of the VA Hospital have requested information from the Lebanon County Society as to the advisability of their opening up private offices in Lebanon County for consultation work in their respective specialties.

Dr. Jones said that he obtained information to the effect that a doctor engaged full time with the VA is not allowed to have a private office or to engage in private practice except in an emergency or on a consultative basis when a civilian consultant is not available.

Secretary Donaldson stated the next item for consideration was the collection of the A.M.A. \$25 membership assessment, and he referred to a plan that he had mailed to Board members for consideration. He also read an A.M.A. opinion from Attorney Holloway regarding this question.

It was moved (Dr. Gagion), seconded (Dr. Altemus), and unanimously carried that an effort be made to collect the A.M.A. assessment and that Dr. Donaldson employ a secretary whose sole duty it will be to handle the solicitation and collection, with all essential expense to be charged to the A.M.A.

SECRETARY DONALDSON: To simplify the process, make checks payable to "American Medical Association—Assessment" and send through our Pittsburgh office.

DR. GAGION: That is important. We should get a ruling from the Internal Revenue Department as to whether this is a deductible item.

Election of Associate Members

SECRETARY DONALDSON: Under the newly revised Constitution and By-laws, associate members who were formerly known as affiliate members are to be elected by the Board of Trustees. I have a list of five men who have been duly elected to associate membership in their respective county medical societies: *Allegheny County*—Dr. Henry T. Price; *Crawford*—Dr. William E. Hyskell; *Delaware*—Drs. George C. Webster, Sr., and Joseph R. T. Gray; *Schuylkill*—Dr. Joseph G. Kramer. All named were duly elected.

Representation to American Cancer Society (Seventh Councilor District)

DR. KLUMP: The present incumbent, Dr. Merle Colvin, has resigned. Dr. Louis L. Hobbs, Jr., of Ridgway, Elk County, has been agreed upon as successor to Dr. Colvin.

It was moved (Dr. Whitehill), seconded (Dr. Miller), and unanimously carried that the nomination of Dr. Louis L. Hobbs, Jr., be approved.

Resolution from Pennsylvania State Dental Society

Secretary Donaldson presented a resolution from the Pennsylvania State Dental Society congratulating our society on its one hundredth anniversary, and said that a letter of appreciation will be directed to that society.

Miscellaneous

Dr. Donaldson presented the 1949 copy of the project of the American Cancer Society, Pennsylvania Division, in which is set forth their budget to be expended in Pennsylvania during the year beginning September, 1948 and ending Aug. 31, 1949. It is similar to that submitted last year and is signed, first, by Dr. John H. Harris, of Harrisburg, who is president of the Pennsylvania Division. It provides a space for an authorized representative of the MSSP to sign approval of their budget.

It was moved (Dr. Altemus), seconded (Dr. Miller), and unanimously carried that President Engel approve the current budget of the Pennsylvania Division of the American Cancer Society.

Dr. Donaldson then introduced to the Board of Trustees the new assistant secretary-treasurer of the State Society, Dr. Park Berkheimer of Hummelstown, Dauphin County.

Special Order of Business

It was moved (Dr. Gagon), seconded (Dr. Whitehill), and unanimously carried that the question of the protest against telephone rates be referred to the Committee on Medical Economics.

Setting Date of Next Meeting

SECRETARY DONALDSON: The thirty-seventh annual Secretaries and Editors Conference convenes March 3 and 4, 1949, with the Board of Trustees meeting here Thursday morning, March 3, and again Friday afternoon, March 4, 1949.

The meeting adjourned at 12:30 p.m.

FRANK A. LORENZO, *Chairman*,
WALTER F. DONALDSON, *Secretary-Treasurer*.

CHANGES IN MEMBERSHIP OF COUNTY SOCIETIES

New (84) and Reinstated (2) Members

ALLEGHENY: Albert J. Bruecken, Jr., Hugh J. Burns, Grace K. Martin, and Robert J. Shoemaker, Pittsburgh; Bernard H. Cobetto, Pitcairn; Adolph F. Reiter and Howard S. Reiter, McKeesport; Raymond L. Rau, Berwyn, Ill.

ARMSTRONG: John E. Gallagher, Apollo.

BEDFORD: (Reinstated) Victor Maffucci, Bedford.

BLAIR: Edward R. Bowser, Jr., Altoona.

BUCKS: Alvin Thuma, Souderton.

CAMBRIA: Barbara Ann Horner and Robert M. Mattson, Johnstown.

CARBON: Louis A. Erskine, Palmerton.

CHESTER: J. Clifford Scott, West Chester.

CUMBERLAND: James G. Dickson, Carlisle; Bradford R. Strock, Mechanicsburg.

DAUPHIN: Leverett D. Bristol, Harrisburg.

DELAWARE: Lewis H. Kirchhofer, Springfield; Leonard Rosen, Chester; Albert G. Schran, Drexel Hill; Theodore D. Stevenson, Media.

ERIE: Robert L. Lasher, Edwin M. Mszanowski, John M. Willis, and Edward J. Zimm, Erie; F. Robert Walch, Edinboro. (R) Joseph M. Faso, Jr., Snyder, N. Y.

FAYETTE: Don G. Soxman, Connellsville.

FRANKLIN: Ann T. Gibson, Chambersburg.

GREENE: Robert W. Leibold, Waynesburg.

HUNTINGDON: William W. Schock, Huntingdon; Harold W. Stewart, Alexandria.

LACKAWANNA: William V. McDonnell, Scranton.

LYCOMING: Robert J. Hitchens, Watertown.

MONTGOMERY: George W. Henry, Villanova; Frank J. Tornetta, Norristown.

PHILADELPHIA: Mary Lou Buckley, Camillo T. DeBerardinis, Margaret VanM. Deming, John M. A. DiSilvestro, Jr., Herbert S. Doroshov, Henry J. Dudnick, Elizabeth B. Eken, J. Russell Elkinton, Abraham Fremer, Charles A. Furey, Jr., Janet A. Hampton, Carl J. Hoffman, John P. Hubbard, Henry R. Jenkins, Samuel H. John, Thomas C. Jones, Patricia M. Kamsler, Henry S. Kinloch, John J. Laskas, Vincent T. Lathbury, Jr., Norbert N. Linder, Herbert Lipshutz, Bernard Margolis, Edward S. McCabe, Edward L. McConnell, Jr., William R. O'Brien, H. M. Panzer, William R. Penman, Arnold J. Rawson, William J. Rhinehart, S. E. Robertson, John T. Ross, Jr., Barbara McMullen Sachs, George N. Stein, John A. Sterner, Helen F. Stochen, Joseph J. Szal, Wilbur C. Thomas, and Allan D. Wallis, Philadelphia; Sidney S. Lerner, Jenkintown; Hurley L. Motley, Wynnewood; W. P. Stelmach, Reading.

SCHUYLKILL: Frederick W. Herman, Pottsville.

TIOGA: Robert S. Sanford, Mansfield.

WASHINGTON: Eugene E. Costa, Charleroi; Michael Vaccaro, Monongahela.

WESTMORELAND: Milton H. Graditor, N. Belle Vernon; Warren T. O'Hara, New Kensington.

Resignations (35), Transfers (11), Deaths (10)

ALLEGHENY COUNTY: *Transfer*—Joseph L. Moretto, New Castle, to Lawrence County Society. *Deaths*—Frank R. Bailey, Pittsburgh (Univ. Pa. '13), March 7, aged 62; Charles M. Watson, Pittsburgh (Univ. Pgh. '00), March 12, aged 74.

BUTLER COUNTY: *Death*—Albert A. Huba, Butler (Loyola Univ. '32), Nov. 12, 1948, aged 43.

CAMBRIA COUNTY: *Resignation*—Bernard J. McCloskey, Jacksonville, Fla. *Transfer*—Thaddeus A. Nigborowicz, Altoona, to Blair County Society. *Death*—George C. Berkheimer, Windber (Coll. Phys. & Surg., Baltimore '05), March 4, aged 76.

CRAWFORD COUNTY: *Transfers*—Richard K. Frawley and Albert J. Ingham, Titusville, to Venango County Society.

DAUPHIN COUNTY: *Resignation*—A. J. Mogavero, San Diego, Calif. *Transfer*—Howard B. Hamilton, Narberth, to Philadelphia County Society.

DELAWARE COUNTY: *Resignation*—Clarence S. Martin, Kensal, N. D.

ERIE COUNTY: *Resignation* — Roman J. Shubert, Dunkirk, N. Y.

FRANKLIN COUNTY: *Resignation*—Lysle W. Sherwin, Baltimore, Md.

HUNTINGDON COUNTY: *Resignation* — William A. Doebele, Ocean City, N. J.

INDIANA COUNTY: *Death*—Anthony B. Danisawich, South Mountain (Jeff. Med. Coll. '22), February 18, aged 52.

JUNIATA COUNTY: *Transfer* — George G. Dawe, Lewistown, to Mifflin County Society.

LANCASTER COUNTY: *Resignation*—George I. Uhde, Louisville, Ky.

LYCOMING COUNTY: *Resignation* — Dorothy B. Davies, Northampton, Mass.

MONTGOMERY COUNTY: *Death* — Walter E. Fine, Ambler (Hahn. Med. Coll. '04), February 28, aged 71.

NORTHUMBERLAND COUNTY: *Death* — James G. Strickland, Shamokin (Jeff. Med. Coll. '13), February 28, aged 61.

PHILADELPHIA COUNTY: *Transfers* — Thomas W. English, Lucerne Mines, to Indiana County Society; George E. Fissell, Williamsport, to Lycoming County Society. *Deaths*—John Diven, Philadelphia (Univ. Pa. '12), Dec. 16, 1948, aged 66; Samuel B. Scholz, Jr., Philadelphia (Univ. Denver '05), March 4, aged 71. *Resignations*—Abraham Cantarow, Martin C. Sampson, John P. Repetto, Edgar M. Hall, Jr., Herbert S. Greenspan, Charles J. Zinn, Philadelphia; Frances C. Frank, Strafford; John W. Eiman, Bala-Cynwyd; Felix E. Karpinski, Cleveland, O.; Althea D. Kessler, Washington, D. C.; Richard P. Thompson, St. Augustine, Fla.; Thomas M. Scotti, Richmond, Va.; Wm. T. O'Brien, Paramount, Calif.; George Wada and Albert H. Domm, Los Angeles, Calif.; Cyril V. Gross, New York City; Wm. H. Kneidler, Charlotte, N. C.; Robert F. Welty and Elizabeth McN. Main, Spokane, Wash.; Herman Trager, Tacoma, Wash.; Wm. W. L. Glenn, New Haven, Conn.; Charles R. Perryman,

Baton Rouge, La.; Frederic B. Faust, Littlefield, Tex.; Eleanor H. Valentine, Wheat Ridge, Colo.

SOMERSET COUNTY: *Transfer*—Norman B. Ream, Tyrone, to Blair County Society.

WARREN COUNTY: *Death* — Gail K. Riddelsperger, Warren (Univ. Buffalo '33), March 12, aged 44.

WASHINGTON COUNTY: *Transfers*—Robert T. Gray, Nemacolin, to Greene County Society; James O. Ferguson, Dixmont, to Allegheny County Society.

WESTMORELAND COUNTY: *Resignation* — Joseph H. Watson, Jeannette.

YORK COUNTY: *Resignations*—Charles K. Wainger, Allston, Mass.; Harold G. O'Donnell, Indianapolis, Ind.

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since February 28. Figures in first column indicate county society numbers; second column, State Society numbers.

Mar. 1	McKean	42-48	7644-7650	\$105.00
	Crawford	1-44	7651-7654	60.00
	Perry	1-13	7655-7667	195.00
	Montgomery	264,		
		292-309	7668-7686	285.00
	Lycoming	133-134	7687-7688	30.00
	Clinton	23	7689	15.00
	Blair	109-114	7690-7695	90.00
	Bucks	77-82	7696-7701	90.00
	Washington	131-132	7702-7703	30.00
4	Allegheny	1426-1572	7704-7850	2,205.00
	Luzerne	171-258	7851-7938	1,320.00
	Lackawanna	206-252	7939-7985	705.00
	Dauphin	147-150	7986-8005	300.00
	Bucks	83-86	8006-8009	60.00
	Greene	1-18	8010-8027	270.00
	Erie	157-186	8028-8057	442.50
	Westmoreland	180,		
		185-190,		
		192-195,		
		197-200	8058-8072	225.00
	Berks	223, 234-245	8073-8085	195.00
	Bradford	34-48	8086-8100	225.00
	Franklin	72-73	8101-8102	30.00
	Delaware	255-275	8103-8123	315.00
	Lebanon	57-60	8124-8127	60.00
	Warren	43-45	8128-8130	45.00
	Cambria	3-4	8131-8132	30.00
	Blair	115-119	8133-8137	75.00
	Butler	68	8138	15.00
	Armstrong	37-38	8139-8140	30.00
	Somerset	26-27	8141-8142	30.00
	Indiana	35-37	8143-8145	45.00
	York	159-163	8146-8150	75.00
	Lycoming	135	8151	15.00
	Montour	34-35	8152-8153	30.00
	Lawrence	62-77	8154-8169	240.00
	Clearfield	45-48	8170-8173	60.00
	Potter	1-6	8174-8179	90.00
	Wayne-Pike	1-19	8180-8198	285.00
	Columbia	50	8199	15.00
	Venango	6-9	8200-8203	60.00
	Beaver	120-133	8204-8217	210.00

Mar. 4	Fayette	99-103	8218-8222	\$75.00
	Chester	87-109	8223-8245	345.00
	Washington	133-138	8246-8251	90.00
	Lancaster	191-220	8252-8281	450.00
	Mercer	82-89	8282-8289	120.00
	Northampton	187-197	8290-8300	165.00
	Cumberland	39-43	8301-8305	75.00
	McKean	49-52	8306-8309	60.00
8	Butler	69	8310	15.00
	Jefferson	41-51	8311-8321	165.00
	Crawford	45-48	8322-8325	60.00
	Beaver	134	8326	150.00
9	Warren	46	8327	15.00
10	Cambria	123-139,		
		141-153	8328-8356	435.00
	Venango	10-17	8357-8364	120.00
	Perry	14	8365	15.00
	Carbon	29-31	8366-8368	45.00
	Centre	31	8369	15.00
	Clinton	24	8370	15.00
	Fayette	104-106	8371-8373	45.00
11	Mifflin	24-35	8374-8385	180.00
	Bedford	11-14	8386-8389	60.00
	Elk	19-25	8390-8396	105.00
	Montgomery	310-323	8397-8410	210.00
14	Luzerne	259-302	8411-8454	660.00
	Warren	47	8455	15.00
	Beaver	119, 135	8456-8457	30.00
	Delaware	276-285	8458-8467	150.00
	Potter	7	8468	15.00
	Bucks	87-88	8469-8470	30.00
	Blair	120-125	8471-8476	90.00
	Northampton	198-199	8477-8478	30.00
15	Schuylkill	115-117,		
		119-133	8479-8496	270.00
	Northumberland	67-74	8497-8504	120.00
	Montgomery	324-327	8505-8508	60.00
	Montgomery	328	8509	7.50
	Luzerne	303-311	8510-8518	135.00
	Huntingdon	1-26	8519-8544	390.00
	Philadelphia	1619-2653	8545-9579	15,517.50
	Bradford	49	9580	15.00
	Carbon	32-33	9581-9582	30.00
16	Indiana	38	9583	15.00
17	Franklin	74-76	9584-9586	45.00
	Dauphin	230-239	9587-9596	150.00
	Westmoreland	191	9597	15.00
18	Lycoming	136-138	9598-9600	45.00
21	Cambria	154-155	9601-9602	30.00
	Luzerne	312-318	9603-9609	105.00
	Lackawanna	253-256	9610-9613	60.00
	Lancaster	221-222	9614-9615	30.00
	Westmoreland	201-205	9616-9620	75.00
	Fayette	108-111	9621-9624	60.00
22	Delaware	286-287	9625-9626	30.00
	Cumberland	44-45	9627-9628	30.00
	Greene	19-23	9629-9633	75.00
23	Washington	139-142	9634-9637	60.00
	Lycoming	139	9638	15.00
	Tioga	26	9639	15.00
	Lackawanna	257-258	9640-9641	30.00
	Potter	8	9642	15.00
	Armstrong	39-40	9643-9644	30.00
	Erie	187-204	9645-9662	270.00
	Venango	18-21	9663-9666	60.00
24	Warren	48	9667	15.00
25	Potter	9-10	9668-9669	30.00
	Lebanon	61-63	9670-9672	45.00
28	Blair	126	9673	15.00
	Carbon	34	9674	15.00

Mar. 28	York	164	9675	\$15.00
	Fayette	112-113	9676-9677	30.00
	Crawford	49-51	9678-9680	45.00
	Berks	246-253	9681-9688	120.00
29	Cambria	156-161	9689-9694	90.00
30	Somerset	28	9695	15.00
	Allegheny	1573-1610	9696-9734	570.00
31	Clinton	25	9735	15.00
	Dauphin	240-252	9736-9748	195.00

CONTRIBUTIONS TO MEDICAL BENEVOLENCE FUND

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One hundred and twenty-four requests were filled from March 1 to March 31 covering the following subjects:

Mortality statistics	Bacitracin therapy
Medical aptitude tests	Lead poisoning
Rice diet (4)	Medical records
Viruses	Cancer
Use of hyaluronidase	Amblyopia
Tumors of the heart	Acute head injuries
Treatment of migraine	Aortic aneurysm
Phenylpyruvic acid	Blood banks
Headache	Ophthalmology
Abdominal tumors	Arachnoiditis
Mental telepathy	Painful shoulder
Posture	Diagnosis of diabetes
Rh factor (2)	Electroshock therapy
Streptomycin	Nutrition
Myasthenia gravis	Study of cancer
Sarcoma	Lipoid pneumonia
Hodgkin's disease	Fibrositis
Senile psychosis	Blood proteins
Alcoholic psychosis	Anuria
Scleroderma	Barbiturate poisoning
Elastic tissue	Diabetes mellitus
Hypertrophy of breast	Contact dermatitis
Carcinoma of uterus	Euthanasia
Tropical medicine	Geriatrics
Sprue	Psychiatry
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Beriberi	Von Gierke's disease
Pellagra	Cor triloculare
Hay fever	Scurvy
Heart diseases	Wound healing
Herpes zoster	State medicine
Collagen disease	Diseases of the eye
Tuberculosis mortality	Shaver's disease
Cerebral palsy	Thyroid
Rickets	Federalized medicine

Bladder cysts	Pathology
History of anesthesia	Bone grafts
Splenectomy	Treatment of epilepsy
Use of tyrothricin	Rheumatoid arthritis
Socialized medicine (2)	
Technique of basal metabolism	
Effect of testicular extract	
Lesions of small intestine	
Acute and chronic pancreatitis	
Trichomonas vaginalis vaginitis	
Congenital disease of the hip	
Atelectasis of the newborn	
Infectious mononucleosis	
Treatment of hypertension	
Infectious diarrhea of the newborn	
Rheumatic heart disease (2)	
Vitamin E in heart disease (3)	
Lupus erythematosus (2)	
Gas cysts of the intestine	
Suction technique for cataract extraction	
Biography of Oliver Wendell Holmes	
Ambulatory treatment of hypertension	
Peptic ulcer and calculous cholecystitis	
Effect of electrical shock	
Reactions from contact with TNT and other explosives	
Ultraviolet ray sterilization	
Voluntary health insurance plans	
Treatment of dermatoses	
Occupational dermatitis	
Diverticulitis of the colon	
Carcinoma of the sigmoid	
Surgery of the pancreas	
Chronic non-specific granuloma	
Ruptured intervertebral disk	
William Osler—the physician	
Aluminum therapy in silicosis	
Surgical treatment of hypertension	
World Medical Association	

VANISHING RIGHTS OF THE STATE OF OHIO

Recently, the Richmond, Va., *News-Leader* published an editorial entitled "Locking the Stable on States' Rights," commenting on the current row over civil rights.

The following paragraph is taken from that piece: "In 1926 James M. Beck published his 'Vanishing Rights of the States' and thereby opened a nation-wide argument. The contention of this newspaper then was that the rights of the states were 'vanishing' because in many matters of rightful public demand, the states failed to act and thereby shifted the demand from state capitals to Washington. States were losing their rights because of their neglect and not because of Federal usurpation."

Truer words were never written. Take Ohio, for example, and the way it has treated its own public health setup. Well-to-do Ohio has been short-changing its state health department. In order to give even minimal services and retain competent personnel it has had to look to Washington for a substantial portion of

its operating funds. Many local health departments have had to stick out a hand to Washington repeatedly simply because the community has failed to raise sufficient money to finance services which the people require and demand.

Sure, Ohio has been losing its rights in this and other fields of public service through its own neglect and don't care attitude. At the same time there are probably lots of folks in Ohio who would like to lock the stable before more of Ohio's rights vanish. These same people probably would like to see Ohio have a stronger, better public health system. If that's true, then it would be well for them to get busy and let their public officials and legislators know how they feel. Also, they will have to show more indication than in the past that they are willing to foot the bill.

Until this happens, the "vanishing" process will continue, but Ohioans will still be footing the bill indirectly, plus the neat cut which Washington takes before it returns part of the "take" in the form of so-called subsidies or grants-in-aid. Ohioans ought to be smart enough to see that the present setup is neither good government nor good business.—*Ohio State Medical Journal*.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the co-operation of the Pennsylvania Tuberculosis Society
and The Medical Society of the State of Pennsylvania

Medicine and its associated sciences can take great pride in the report which follows—it gives the progress to date of a large-scale cooperative endeavor in which many individuals and diverse agencies pooled skills and resources in testing a new therapeutic agent—streptomycin, against an old disease—tuberculosis.

STREPTOMYCIN IN THE TREATMENT OF TUBERCULOSIS

Pulmonary Tuberculosis. Streptomycin has a limited but important place in the therapy of pulmonary tuberculosis, but should be withheld if other treatment is available and likely to be satisfactory. Streptomycin therapy is not advisable in: (a) chronic fibroid or fibrocaseous pulmonary tuberculosis; (b) acute destructive and apparently terminal tuberculosis, except for symptomatic relief; (c) minimal pulmonary tuberculosis with a good prognosis.

Streptomycin appears to be most effective in recent, acute, fairly extensive, and progressing pulmonary tuberculosis and is particularly recommended for tuberculous pneumonia. Streptomycin therapy is regarded as especially suitable for: (a) acute tuberculous bronchopneumonia; (b) acute bronchogenic spread, particularly if the acute process prevents much needed collapse therapy; and (c) chronic disseminated finely nodular tuberculosis without large confluent areas of destructive disease.

As streptomycin can be used for only a few months in the therapy of this disease because of the emergence of resistant organisms, it is imperative that streptomycin be used during the course of the disease when the greatest benefit can be expected. *Streptomycin is best used as an adjunct and should be worked into an over-all plan of treatment which will often include collapse therapy and generally includes institutional care. The committee looks with disfavor on the practice of utilizing streptomycin prior to institutional care or as an alternative to collapse therapy.*

Ulcerating Tuberculous Lesions of Mucous Membranes. Streptomycin, preferably adminis-

tered by the parenteral route, is recommended for laryngeal, tracheal, bronchial, oropharyngeal, and enteral ulcerations, and tuberculous otitis media. It is less effective in granulomatous lesions in this area, still less so in diffuse inflammatory lesions, and ineffective in cicatricial lesions.

Tuberculous Sinuses and Fistulas. Streptomycin is recommended in the treatment of draining tuberculous sinuses and fistulas. Usually, however, superior results are obtained only with streptomycin and suitable surgery.

Genito-urinary Tract. Streptomycin is recommended in the treatment of tuberculosis of the genito-urinary tract usually as an adjunct to other therapy.

Tuberculosis of Bone, Joint, and Cartilage. Streptomycin is advised in the treatment of tuberculosis of bone, joint, and cartilage with other therapy. Timing in the use of the drug is important.

Tuberculous Meningitis. Intensive therapy with streptomycin, administered both parenterally and intrathecally, is imperative for the treatment of tuberculous meningitis. Two grams a day should be given intramuscularly for four to six months. It is recommended that not more than 50 mg. of streptomycin be administered intrathecally every second or third day during treatment. This may be given daily for the first week. Frequent and serious neurologic complications may arise as a result of this regimen, yet complete clinical remission is observed in an appreciable number of cases. The response is best when treatment is early, so it need not await bacteriologic confirmation of the diagnosis.

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RESEARCH IN THE SERVICE OF MEDICINE

1. Howarth, S.; McMichael, J., and Sharpey-Schafer, E. P.: The Circulatory Action of Theophylline Ethylene Diamine, Clin. Sc. 6:125 (July 17) 1947.

However, to avoid treating a non-tuberculous meningitis, streptomycin should be used only when an active tuberculous focus is present, or, the cerebrospinal fluid in culture is negative for ordinary pathogens but is characteristic of tuberculous meningitis.

Miliary Tuberculosis. Streptomycin therapy is indicated in the treatment of acute hematogenous (miliary) tuberculosis and chronic hematogenous disseminated tuberculosis. Good clinical judgment is needed to differentiate these from non-tuberculous pulmonary infiltrations, especially in the early stages. Early treatment is desirable and in some cases should be started before bacteriologic confirmation. Bone marrow biopsy and culture may aid early diagnosis. Treatment should continue for at least four months. One to two grams a day is adequate dosage. In acute miliary tuberculosis, development of tuberculous meningitis is common. After the diagnosis is established, routine lumbar punctures are recommended. Intrathecal therapy should be added whenever the cerebrospinal fluid is abnormal.

Tuberculous Lymphadenitis. Streptomycin may be employed in the treatment of tuberculous lymphadenitis, especially in the acute stage. The attendant toxicity and the emergence of resistant bacteria are factors limiting its use.

Tuberculous Peritonitis and Pericarditis. Streptomycin is recommended in the treatment of tuberculous peritonitis. Clinical remission is common and relapse relatively infrequent following adequate therapy. Streptomycin may not be expected to alter the sequelae of tuberculous pericarditis, but appears to have a beneficial effect on the acute process itself.

Dosage and Duration of Streptomycin Therapy. Probably no single streptomycin regimen is suitable for all forms of tuberculosis. Except in miliary tuberculosis and tuberculous meningitis, it is advised that streptomycin be administered in

one-half gram doses, i.e., one gram daily, at twelve-hour intervals in courses of forty-two days. Until further study, it cannot be recommended that injections be made less frequently or for shorter periods of time than here indicated.

Toxic Manifestations of Streptomycin Therapy. Toxic manifestations are relatively infrequent on the dose recommended above, i.e., one gram a day. Nevertheless, the following reactions do occur and the dangers should be weighed against the disease hazards: (a) a disturbance of vestibular function; (b) deafness, in very rare instances; (c) serious renal damage appears rarely without pre-existing renal disease; (d) cutaneous rashes occasionally—serious exfoliative dermatitis rarely.

Emergence to Predominance of Drug-Resistant Tubercle Bacilli. The disappearance of drug-sensitive strains of tubercle bacilli and their replacement with drug-resistant strains handicap prolonged effective therapy with streptomycin. This is usually avoided by confining duration of therapy to forty-two days.

Dihydrostreptomycin. The committee has reviewed limited experimental and clinical evidence concerning dihydrostreptomycin, a hydrogenated derivative of streptomycin. The pharmacologic and biologic properties of dihydrostreptomycin and streptomycin are quite similar. Dihydrostreptomycin is less toxic than streptomycin in its action on the vestibular apparatus, although other toxic reactions sometimes occur. It appears to be tolerated by some patients who are hypersensitive to streptomycin. These advantages warrant extensive clinical trials.

Report of Clinical Subcommittee of Committee on Medical Research and Therapy, Chairman, John D. Steele, M.D., American Trudeau Society, American Review of Tuberculosis, January, 1949.

The Pennsylvania Department of Health desires the services of 25 young physicians from July 15 to 31, inclusive, at the newly created Camp for Underprivileged Boys at Indiantown Gap, Pa. Remuneration will be \$10 per day plus expenses and transportation. For further information, communicate with Norris W. Vaux, M.D., Secretary of Health, Commonwealth of Pennsylvania, Harrisburg, Pa.

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PRESIDENT'S MID-YEAR REPORT



Since the work of the counties has been summarized for you by the state chairmen, I shall confine this report to my own activities. I want to express sincere appreciation to all members of the state executive board for their willing service, enthusiasm, and

insight, without which no statewide auxiliary program could be carried on, and to say to the county officers, please take back to your members the grateful thanks of your state officers for the fine program results which have been accomplished this year.

These last six months have been the busiest, but I think the most interesting of my life. It has been a truly rewarding experience to serve as your president. I shall cherish the friendship of the auxiliary members I have met all over the State as we have worked together.

First, I want to introduce to you Miss Suzanne Treadwell, a new member of the public relations staff of the State Medical Society, assigned to work with the Auxiliary. We believe that she is the first woman to have such a position. We look forward to working with her and to doing a pioneer job by showing that this confidence of the Medical Society in us will pay enormous dividends in our enlarged public relations program.

The cooperation of the State Medical Society this year has been most helpful. At each step of the way, Dr. Howard K. Petry, chairman of the advisory committee, has been ready with kind and reasonable advice and unmeasured time and interest to help us. There have been several conferences with him, and with members of the staff at the Harrisburg office, as well as frequent telephone calls. The State Medical Society, through the Public Relations Department, has paid for and mimeographed the issues of our *Auxiliary News*, forwarded each time to over seven hundred of our county officers and committee chairmen. Two or three more issues will be forthcoming before the year is over.

Our long-awaited pamphlet, "Your Family's Future Health," is ready for distribution. Each county president and state board member has received a sample copy and can order a supply in sufficient quantity to give one to every doctor and auxiliary member in every county, and to distribute at public meetings where we present speakers. The pamphlet is readily readable and most informative.

The Auxiliary pages of the PENNSYLVANIA MEDICAL JOURNAL have been revamped. It is our aim, which has the approval of the editor, to provide socio-economic articles which will interest and inform every member, and physicians, too. Routine reports of the counties have been omitted, and we are experimenting with selective summaries. Suggestions regarding these pages will be welcomed.

As your representative, I was asked to speak before the Conference of Secretaries and Editors of the State Medical Society in March on "What the Auxiliary Expects from the County Medical Society." Believing that what I said should reflect the thinking of the members throughout the State, letters were addressed to county presidents and board members. Fifty replies were received; from the ideas submitted, the talk was prepared on working relationships with the medical societies. A summary of this talk was given to those in attendance and is available for our own membership. It is my hope that the county presidents will discuss with their own medical society officers the fields of future cooperation and will evaluate their county activities on the basis of the points given in the summary.

The chairmen of our legislative and public relations committees, the president, and president-elect have met with the public relations and public health legislation committees of the State Medical Society at their regularly scheduled meetings. This is the first year that we have been invited to attend. These meetings give us a fine opportunity to gain insight into the workings of the State Society. We are then better equipped to interpret the aims of the medical profession and to fit our own program to their needs. We have recommended that this same

type of cooperation soon become the custom in each county.

Since part of our program suggests that auxiliary members speak before lay groups, I thought I personally should know how to meet such situations and become aware of the problems involved. So far I have accepted fourteen dates to appear before PTA's, churches, Federation of Women's Clubs, dentists' wives, Council of Social Agencies, and a class of high school seniors. In addition, I have attended several meetings of other organizations, either to gain background information for myself or to present the medical viewpoint to them.

I once thought that the visits of the state president to the counties were unnecessary, but I am now convinced that these personal contacts are exceedingly worth while. They are helpful to the president and to the county group. But with our growth in numbers and in activity, we will have to share the visiting. This will give other board members a chance to know the county groups, and the county members the opportunity to know more of their state board members. I have visited thirty-eight county auxiliaries; all others will be visited before the middle of May. Where possible, members of the county medical society are also contacted; we discuss our program and ask their cooperation with the women.

The newspaper coverage of my visits has been most unusual. Attempting to bring the facts of

socialized medicine before the public, we have sent out prepared statements to the papers in advance of county meetings. The public is interested and the papers are therefore willing to give us space. This is a technique which might well be used for all kinds of county meetings when the speakers' points are news-worthy.

Radio broadcasts were arranged in three towns on the subject of the auxiliary program or on socialized medicine. Three newspaper interviews were given. It is a tribute to the Auxiliary that we have been told to speak for ourselves, so long as we present facts and admit that, while willing to find them, we don't know the answers to all the questions.

We have made great strides this year, but some changes need to be considered.

1. The president cannot continue to do an executive's job and visit all the counties. Some rearrangement using other members of the board must be developed.

2. The preparation of reports is an oppressive task to many counties. The committee appointed to work on this problem offered some helpful suggestions for annual convention reports, but how to collect essential information accurately and painlessly remains a problem.

3. On these points we would like your opinion: (a) What kind of a convention program do you want? (b) What do you want to read in the JOURNAL? (c) Shall Auxiliary News be ex-

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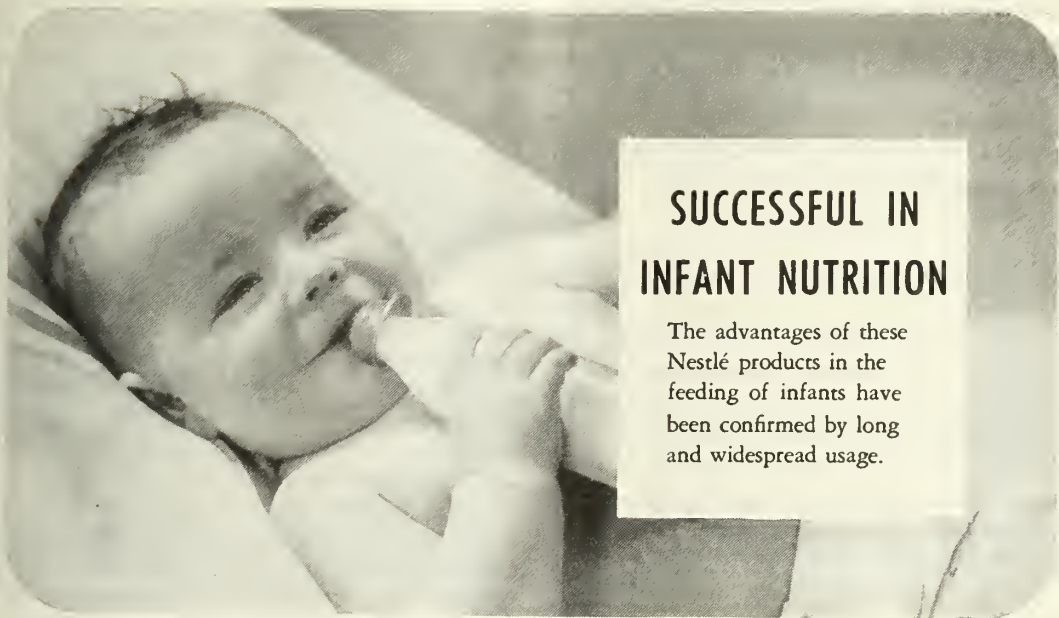
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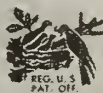
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panded to go to every member? (d) Would you like running commentary and explanatory material on state and national legislation? (e) Could we get better attendance at councilor district meetings if they became neighborhood conference workshops on county problems?

The whole program of the Auxiliary and its relationship with the Medical Society has been so different this year from previous years that it is difficult to operate within the budget outlined for us. Some expenses will be in excess, others diminished. Committee chairmen have had mimeographing service by the Harrisburg office. With the pressure of health legislation and public relations activities there have been many telephone calls. This year the Auxiliary has indeed been in a changing order.

With the national education campaign of the American Medical Association developing in the counties, many activities requiring correlation with the medical society and lay groups will be starting. Our usefulness increases as we work on these practical plans under the supervision of the Medical Society.

It is fortunate that we have had over twenty-four years of working together, so that as an organization we are prepared to carry on effectively the enlarged field of service in these crucial times.

My deep appreciation to you all, at this half-way mark, for the privilege of serving you. Your comments and criticisms for the benefit of the Auxiliary will be welcomed. Do let me hear from you.

(MRS. PAUL C.) CATHARINE PALMER CRAIG,
President.

A.M.A. ANNUAL SESSION

LAST CALL for reservations for the twenty-sixth annual convention of the Woman's Auxiliary to the American Medical Association, which will be held at Haddon Hall, Atlantic City, N. J., June 6 to 10.

COUNTY NEWS

Fifteen counties reported news in February and March. Is your auxiliary telling other auxiliaries of its activities?

The *Hygeia* contest closed January 31. Congratulations to CARBON County and to Mrs. Marvin Evans, *Hygeia* chairman, for placing first in Group I and receiving a check for forty dollars. CARBON, with a membership of sixteen, had a credit rating of 456 per cent for the contest. DAUPHIN reported forty-two subscriptions and INDIANA forty-four, with seventy-one credits.

Health legislation is uppermost in auxiliary member minds. Mrs. Gilbert L. Dailey brought DAUPHIN up to date in March. Mrs. Samuel Shriner spoke at the January meeting of ALLEGHENY. She urged all doctors' wives to make themselves familiar with all phases of socialized medicine, so that they can intelligently explain to laymen why the political form of medical service would not give them what they truly seek. At the Uniontown Hospital in February, Mrs. Francis L. Larkin read a comprehensive summary of Oscar Ewing's report to the FAYETTE Auxiliary. Mrs. Donald W. Haff was the discussion leader at a meeting of LEHIGH'S study group. "Private Enterprise or Government in Medicine" by Louis H. Bauer and "The Issue of Compulsory Health Insurance" (Brookings Institution report) were used as the text. In WARREN, Mrs. William L. Ball read the Ewing report and Mrs. Julius A. Fino, the Brookings report, as summarized by the MSSP.

In the March PENNSYLVANIA MEDICAL JOURNAL (page 640) were listed the auxiliaries who were cooperating with Dr. Palmer, chairman of the Committee on Public Health Legislation, MSSP, in the signing of petitions concerning approved animal experimentation legislation. ALLEGHENY, CAMBRIA, CARBON, and INDIANA are added. (One state senator replied, in part: "I am at a loss to understand what such persons as button-sewers, housewives, miners, electricians, and clerks, etc., know about vivisection—a rather technical subject.") Mrs. Elmer H. Bausch, Second District councilor, gave a highly informative talk on "Animal Experimentation" to LEHIGH.

ALLEGHENY had a birthday party in January honoring all its past presidents and marking its twenty-fourth year as an auxiliary. Past presidents were introduced by Mrs. Noss D. Brant, social chairman. Mrs. Harvey L. Steele, music chairman, presented Mr. Roy Shoemaker, violinist, and his wife, accompanist. Mrs. Paul C. Craig, state president, and Miss Suzanne Treadwell, newly appointed member of the public relations staff of MSSP, visited DAUPHIN in March. James D. Weaver, M.D., spoke on Korea and showed many interesting slides for ERIE. Motion pictures of a medical society picnic were shown in FAYETTE. INDIANA met with the medical society in March to hear C. L. Palmer, M.D., and Mr. Thomas J. Lawry, both of Pittsburgh, discuss MSAP (Blue Shield). LACKAWANNA met at the Scranton Club in February. Guests included Mrs. Paul C. Craig, Mrs. Edward Huber, president of the pharmaceutical auxiliary, and Mrs. N. M. Pecuch, president of the dental auxiliary. Mrs. Carl L. Hosier, program chairman, presented Mrs. Clare Ginty Edwards, who sang, accompanied by Miss Ruth White. The invocation was given by Mrs. Harry M. Mittleman. President Craig spoke to the seventy in attendance.

LEHIGH had varied programs. Mrs. H. Newsham Bentz reviewed *Wild Country* by Louis Bromfield. Marian G. Raber, an exchange teacher last year to the British Isles, described "Christmas in England." Martha S. Rambo sang, accompanied by Mrs. Carl Newhart. In January they joined with the doctors at the annual dinner-dance in Allentown. Mrs. Craig also visited LUZERNE in February. MERCER had Dr. Jane Dunaway, assistant to the medical director of the Mercer Sanitarium, review *Magic in a Bottle*. Dick Broscoe played two piano solos.

In MONTGOMERY, each month, Mrs. Paul G. Atkinson, president, has presented some medical feature.

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Elwyn, Pa.

Mr. Raymond Middleton gave an illustrated lecture on "Bird Life." Mrs. Craig and several officers of surrounding county auxiliaries attended the Christmas meeting. Mrs. Herbert B. Shearer gave Christmas readings. Two travelogues were given, one by Mrs. Isaac Shelly on England and one by Miss Harriet Styer who spent last year in India and China. Mrs. Russell Wonstall gave a talk on nutrition.

PHILADELPHIA had an educational, amusing, and entertaining talk by Mrs. Katharine Miller Balm on "Dolls of All Nations." A "birthday tea" honoring past presidents and the post-graduate wives was held in March. Mary VanDoren gave a piano recital.

Mrs. George Hohman spoke to SCHUYLKILL at Pottsville in March. Auxiliary members should be encouraged to join hospital auxiliaries in their respective communities and the medical auxiliary as a whole should make visitations to these hospitals. At WARREN, Mrs. Hugh R. Robertson gave an enjoyable reading. At the March meeting, Mrs. Francis S. Ericsson sang and Miss Eleanor Swanson played the piano. During the dinner the Every-Niters quartette sang.

DAUPHIN held a dessert-bridge and fashion show in Harrisburg in February. Two hundred and sixty-five members and guests attended. Mrs. Ross K. Childerhose, president, spoke on the opening of the American Heart Association drive. Mrs. John J. Snyder, hospital-ity chairman, and Mrs. A. Harvey Simmons, program chairman, made the arrangements. Proceeds were for the establishment of a nurses' scholarship at the Harrisburg and Polyclinic Hospitals, each to be given to a student nurse at the end of the first year's training. The directress of nurses is to select a worthy student who is unable to continue her training course for financial

reasons. The scholarship is to be used for educational purposes only. This should fill a real need.

In September the ERIE auxiliary, with the approval of the county medical society, allocated five hundred dollars to inaugurate permanent displays of health education subjects for the general public. The exhibit will be housed in the Erie Public Museum, under the direction of Mr. John V. Alexick, curator. Writes Mrs. Usher H. Meyers, president, "We hope to start in a modest way, perhaps one or two good exhibits, and gradually add periodically to the established units. Our auxiliary is the first organization to help start a permanent health education exhibit in Erie. With the cooperation of every member of the society, we hope to help make 'health visible' in our community."

LEHIGH held a fashion show, bridge, and coffee hour at the Woman's Club, Allentown, in February, for the benefit of the Benevolence Fund. PHILADELPHIA'S annual bridge and fashion show held in Wanamaker's on Valentine's Day made over \$200 for the Benevolence Fund.

MERCER heard letters from the wife of an obstetrician in Budapest, to whom they have been sending boxes of clothing and supplies for over a year. She expressed sincerest appreciation. The doctor's monthly income is enough to buy one pair of shoes. They have three children who were destitute for warm clothing.

NORTH-OF-THE-MOUNTAIN BRANCH Auxiliary is sponsoring a health poster contest in conjunction with the Schuylkill County Medical Society.

ALLEGHENY reported five new members in January, bringing to thirty-two their total for this year. DAUPHIN announced three new members; their total membership is now 185. Seven new members were ad-



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mitted to ERIE; total membership is now 136 active members and 28 honorary members. FAYETTE welcomed three new members and three joined SCHUYLKILL.

Mrs. J. Newton Hunsberger, a former president of the Auxiliaries of the State Medical Society and of the A.M.A. and an active member of MONTGOMERY for twenty-four years, was made an honorary member and presented with a white orchid.

In WARREN, Mrs. Jacob F. Crane read an "in memoriam" on Mrs. Charles H. VerMilyea, a charter and very faithful member, who passed away in February.

N.P.C. TO DISBAND

The following is an official statement of the board of trustees of the National Physicians Committee for the Extension of Medical Service dated April 14 and signed by the chairman, Edward H. Cary, M.D., and addressed to officers and members of cooperating organizations, also contributors to the National Physicians Committee:

Ten years ago, a group of officers and Fellows of the American Medical Association realized that the Association was not as active in certain functions as was deemed necessary, some of which seemed at that time inappropriate for the American Medical Association to perform. As a result, the National Physicians Committee for the Extension of Medical Service was created and has worked during these intervening years within the policies established by the House of Delegates of the American Medical Association.

Several times during those years, the House of Delegates has expressed confidence in the work of this organization.

Two years ago, a committee of the House of Delegates reported that "the American Medical Association should and must do its own public relations work."

In December, 1948, the House of Delegates took action to create a new agency to carry on public relations activities and to further the extension of medical care. This new agency has been created and is functioning. The program as planned and now being carried on by the American Medical Association represents the fulfillment of the objectives for which the National Physicians Committee was created and toward which it has been working.

Its aims having been accomplished, the board of trustees of the National Physicians Committee met in Chicago on April 10, 1949 and voted (1) to approve the action of its management committee in authorizing cessation of all activities as of April 1, 1949, and (2) to liquidate the affairs of the National Physicians Committee in an orderly manner.

It planned further to hold its next meeting in Atlantic City in June, 1949, and at that time to consider further action looking toward dissolution of the organization.

During its ten years of activity, the National Physicians Committee has brought about the formation of forty-seven state committees of physicians and forty-six state committees of dentists, in addition to other local organizations, that have functioned vigorously and well. The board of trustees now suggests to the physicians making up the personnel of these state committees that they offer their services to the new American Medical Association agency.

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technique, two weeks, starting June 20, July 25, August 22. Surgical Technique, Surgical Anatomy and Clinical Surgery, four weeks, starting June 6, July 11, August 8. Surgical Anatomy and Clinical Surgery, two weeks, starting May 16, June 20, July 25. Surgery of Colon and Rectum, one week, starting June 13, September 12. Esophageal Surgery, one week, starting June 13. Thoracic Surgery, one week, starting June 20. Breast and Thyroid Surgery, one week, starting June 27. Fractures and Traumatic Surgery, two weeks, starting June 13, October 3.

GYNECOLOGY—Intensive Course, two weeks, starting June 20, September 26. Vaginal Approach to Pelvic Surgery, one week, starting May 16, June 13, September 19.

OBSTETRICS—Intensive Course, two weeks, starting May 16, September 12.

MEDICINE—Intensive General Course, two weeks, starting June 13, October 3. Electrocardiography and Heart Disease, two weeks, starting July 18. Gastroenterology, two weeks, starting June 27. Personal Course in Gastroscopy, two weeks, starting May 16, June 13.

PEDIATRICS—Diagnosis and Treatment of Congenital Malformations of Heart, two weeks, starting June 13. Personal Course in Cerebral Palsy, two weeks, starting August 1.

DERMATOLOGY Formal Course, two weeks, starting June 13. Informal Clinical Course every two weeks.

CYSTOSCOPY Ten-Day Practical Course every two weeks.

UROLOGY—Intensive Course, two weeks, starting September 26.

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References: 1. Dodd, K. and Minot, A. S.: *J. Pediat.*, 8:442, 1936.
2. Dodd, K. and Minot, A. S.: *J. Pediat.*, 8:452, 1936.
3. Sahyun, M.: *Am. J. Dig. Dis.*, 13:59, 1946.

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MEDICAL NEWS

Future Meeting Calendar

AMERICAN MEDICAL ASSOCIATION—Atlantic City, N. J., June 6-10, 1949.

PENNSYLVANIA TUBERCULOSIS SOCIETY — Pittsburgh, May 25-27, 1949.

INTERNATIONAL CONGRESS ON RHEUMATIC DISEASES—New York City, May 30-June 3, 1949.

AMERICAN COLLEGE OF CHEST PHYSICIANS—Atlantic City, N. J., June 2-5, 1949.

AMERICAN OTORHINOLOGIC SOCIETY FOR THE ADVANCEMENT OF PLASTIC AND RECONSTRUCTIVE SURGERY—Atlantic City, N. J., June 6, 1949.

INTERNATIONAL ACADEMY OF PROCTOLOGY — Atlantic City, N. J., June 10, 1949.

AMERICAN ASSOCIATION OF RAILWAY SURGEONS—Chicago, Ill., June 30 to July 2, 1949.

Births

TO DR. AND MRS. MICHAEL M. ETZL, of Philadelphia, a son, William James Etzl, March 29.

TO DR. AND MRS. GEORGE E. BURDEN, of Bala-Cynwyd, a son, David Andrew Burden, March 29.

Engagements

MISS MARY KALISH, of Philadelphia, to Jacob L. Gluchoff, M.D., of Bloomsburg.

MISS MARY KROUSE WURST to Mr. Edward Hervey Weiss, Jr., son of Dr. and Mrs. Edward H. Weiss, all of Philadelphia.

MISS CARLYN ANN LAGERMAN, of Bryn Mawr, to Mr. Chevalier J. Tucker, son of Dr. and Mrs. Gabriel Tucker, of Cynwyd.

MISS NANCY CLARK HUMPHREYS, of Chestertown, Md., to Mr. Robert Austin Hauslohner, son of Dr. and Mrs. Austin L. Hauslohner, of Wilkes-Barre.

MISS MARY JANE MILLER, daughter of Dr. and Mrs. Hugh McCauley Miller, of Wyncote, to Mr. Herman Frederick Schaurer, Jr., of Baerdwood.

MRS. BETTY TYLER LUCK LAYNE, of Richmond, Va., to Mr. John William Urquhart Fewell, son of Dr. and Mrs. Alexander G. Fewell, of Philadelphia.

MISS WINIFRED JEAN ANGENENT, daughter of Dr. and Mrs. Pieter Hendrik Angenent, of Java, Netherlands East Indies, to Mr. Edward McCollin Arnett, son of Dr. and Mrs. John H. Arnett, of Philadelphia.

Marriages

MARY AMES, M.D., to Edward C. Raffensperger, M.D., both of Harrisburg, April 9.

MISS CAROLINE KLOSS ROBINSON, of Port Royal, to W. North Sterrett, M.D., of Arendtsville, April 9.

MRS. VIRGINIA SHAEFFER THOMAS, of Bronxville, N. Y., to David Pryse Thomas, M.D., of Scranton, March 26.

MISS LOUVAIN ROBERTS, daughter of Dr. and Mrs. Silvia J. Roberts, to Mr. Carl H. Daugherty, all of Harrisburg, April 23.

MISS DOROTHY C. WEEDER, daughter of Dr. and Mrs. S. Dana Weeder, of Philadelphia, to Dr. Zachary A. Simpson, of Charlotte, N. C., April 20.

MISS ELEANOR E. GROH, daughter of Dr. and Mrs. John L. Groh, to Mr. Philip Smyser Davis, all of Lebanon, March 26.

anon, March 26. Mrs. Davis, a graduate nurse, is superintendent of the Lebanon Sanatorium.

MISS HELEN KING KLEBERG, of Kingsville, Texas, to John Deaver Alexander, M.D., son of Mrs. Emory G. Alexander, of Philadelphia, and the late Dr. Alexander, and grandson of the late John B. Deaver, M.D., April 16.

Deaths

⊙ Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

⊙ James G. Strickland, Shamokin; Jefferson Medical College of Philadelphia, 1913; aged 62; died March 7, 1949, following several heart attacks. Dr. Strickland enlisted in World War I and served as a field surgeon with the 114th Infantry Battalion and was decorated for gallantry at Verdun. He later studied in Vienna. During World War II, he was secretary of the Shamokin Draft Board. He had been in private practice in Shamokin for more than thirty years. Surviving are his mother, nearly 90 years of age, his wife, and one daughter.

⊙ Frank R. Bailey, Pittsburgh; University of Pennsylvania School of Medicine, 1913; aged 61; died suddenly from coronary occlusion Feb. 25, 1949. He was a Fellow of the American College of Surgeons and chief of the surgical staff of Western Pennsylvania Hospital, where he had also served his internship and a residency upon graduation from medical school. He served overseas in World Wars I and II, and retired from the Army with the rank of colonel. He is survived by his widow and two sons.

⊙ Harry F. Leibert, Bethlehem; Medico-Chirurgical College of Philadelphia, 1904; aged 65; died of a heart condition April 12, 1949. Dr. Leibert was roentgenologist and radiologist at St. Luke's Hospital since 1913, as well as chief surgeon of the Lehigh and New England Railroad Company, and a member of the Bethlehem Civil Service Commission. He was a member of the Radiological Society of North America and the American College of Radiology. His widow and a son survive.

⊙ Shaul George, Pittsburgh; Northwestern University Medical School, Chicago, 1904; aged 75; died April 14, 1949. A Fellow of the American College of Physicians, Dr. George had been on the staff of Pittsburgh Hospital since 1904, where he had also served his internship. He did postgraduate work in Vienna and Berlin. He served in World War I. Surviving are his widow and a son, Robert S. George, M.D.

⊙ David L. McCarrell, Hickory; University of Pittsburgh School of Medicine, 1899; aged 77; died March 31, 1949. Dr. McCarrell was on the staff of Washington Hospital, and served twenty-seven years as a member of the Mt. Pleasant School Board. He is survived by his widow, one daughter, and three sons, one of whom (John K. McCarrell) is a practicing physician in Morrisville.

⊙ Philip S. Pile, Latrobe; Baltimore (Md.) Medical College, 1905; aged 78; died April 11, 1949. Dr. Pile took a keen interest in civic and fraternal affairs. He served as a member of the Latrobe Board of Education for twelve years, and was a still active member of the Latrobe Board of Health. He is survived by his widow, a foster daughter, one brother, and three sisters.

⊙ C. Carter Hamilton, Philadelphia; University of Iowa College of Medicine, 1923; aged 51; died March

28, 1949. Dr. Hamilton was radiologist at Chestnut Hill Hospital, and was a member of the New England Roentgen Ray Society. He is survived by his widow, a former member of the New Hampshire legislature, and a son.

○ **Samuel B. Scholz, Jr.**, Jenkintown; Denver and Gross College of Medicine, Colorado, 1905; aged 70; died March 4, 1949. Dr. Scholz was medical director of the Penn Mutual Life Insurance Company in Philadelphia, and was a Fellow of the American College of Physicians.

○ **Herbert E. Woelfel**, Bellevue; University of Pennsylvania School of Medicine, 1908; aged 67; died Feb. 13, 1949. Throughout his professional career Dr. Woelfel showed a special interest in pediatrics. He is survived by his widow, a son, and a daughter.

○ **Paul Staman**, Uniontown; St. Louis (Mo.) University School of Medicine, 1933; aged 41; was killed in Canton, Ohio, April 18, 1949, when his automobile collided head-on with a tractor-trailer. His wife was also killed in the crash.

○ **Charles H. Sanderson**, Lansdowne; University of Pennsylvania School of Medicine, 1909; aged 64; died April 12, 1949. He maintained offices in Philadelphia and at his home. He is survived by his mother, a sister, and a brother.

○ **Anthony B. Danisawich**, South Mountain; Jefferson Medical College of Philadelphia, 1922; aged 51; died Feb. 18, 1949. He was associated with Mt. Alto Sanitarium, and was a member of the American College of Chest Physicians.

○ **Edward Horgan**, Philadelphia; University of Pennsylvania School of Medicine, 1893; aged 80; died April 10, 1949. Dr. Horgan, who had been an ear, nose, and throat specialist, was retired.

○ **Frank M. Coyne**, Philadelphia; Maryland Medical College, Baltimore, 1907; aged 66; died April 11, 1949. He is survived by his widow, a brother, and three sisters.

○ **James R. Gerhard**, Reading; University of Pennsylvania School of Medicine, 1901; aged 75; died March 30, 1949, following a long illness. Two daughters survive.

Michael Gradess, Philadelphia; Temple University School of Medicine, 1906; aged 73; died April 2, 1949. His widow, a son, and two daughters survive.

○ **John Diven**, Philadelphia; University of Pennsylvania School of Medicine, 1912; aged 65; died Dec. 16, 1948. He specialized in pediatrics.

○ **Gail K. Ridelsperger**, Warren; University of Buffalo (N. Y.) School of Medicine, 1933; aged 43; died March 12, 1949.

○ **Walter E. Fine**, Ambler; Hahnemann Medical College and Hospital, Philadelphia, 1904; aged 70; died Feb. 28, 1949.

○ **Albert A. Huba**, Butler; Loyola University School of Medicine, Chicago, 1932; aged 44; died Nov. 12, 1948.

George H. Jordy, Hanover; Baltimore (Md.) University School of Medicine, 1898; aged 75; died April 18, 1949.

Miscellaneous

THE ANNUAL ALUMNI POSTGRADUATE SEMINAR OF THE HAHNEMANN MEDICAL COLLEGE of Philadelphia will be held June 22 and 23.

THE AMERICAN ASSOCIATION OF ANATOMISTS held its sixty-second session at the Temple University School of Medicine, Philadelphia, on April 13, 14, and 15. Six hundred anatomists were in attendance.

THE HAHNEMANN MEDICAL ALUMNI ASSOCIATION REUNION will be held June 8, at 6 p.m., in Chalfonte-Haddon Hall, Atlantic City. Tickets for alumni and ladies may be purchased in advance from the alumni office.

THE PENNSYLVANIA RADIOLOGICAL SOCIETY held its thirty-fourth annual meeting at the Bedford Springs Hotel, Bedford, May 20-21. Harold S. Callen, M.D., Lebanon, is president, and James M. Converse, M.D., Williamsport, is secretary-treasurer of the organization.

THE AMERICAN OTORHINOLOGIC SOCIETY FOR THE ADVANCEMENT OF PLASTIC AND RECONSTRUCTIVE SURGERY will meet during the coming session of the American Medical Association at Atlantic City on Monday, June 6, at Chalfonte-Haddon Hall. The program will begin at 5 p.m.

BY THE WILL OF THE LATE A. ATWATER KENT, philanthropist and retired radio manufacturer, the Medical School of the University of Pennsylvania and Jefferson Medical College of Philadelphia will each receive \$250,000 for medical research. The gifts, to be held in trust, are to be paid each institution annually until the funds are exhausted.

CARROLL R. MULLEN, M.D., has been named executive surgeon of the Wills Eye Hospital, Philadelphia, succeeding the late Dr. J. Milton Griscom. P. Robb McDonald, M.D., has been appointed attending surgeon at the same institution succeeding Frank C. Parker, M.D., who has retired after forty-nine years of continuous service.

W. EMORY BURNETT, M.D., professor and head of the Department of Surgery, Temple University School of Medicine, spoke in North Wileysboro, Salisbury, and Raleigh, N. C., April 26, 27, and 28 respectively, on "Methods for Decreasing the Risk of Surgery in Older Patients" under the Extension Division of the School of Medicine, University of North Carolina.

THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND celebrated its sesquicentennial (1799-1949) at the Lyric Theater in Baltimore on Monday, April 25. The Medical Society of the State of Pennsylvania was officially represented at the commemorative exercises by Harold B. Gardner, M.D., of Pittsburgh, first vice-president.

WILLIAM N. PARKINSON, M.D., dean of Temple University School of Medicine, recently announced the following staff appointments: Dr. George D. Vaughan, instructor in proctology; Dr. George W. Russell, assistant instructor in psychiatry; Dr. Sydney Ellis, associate professor of pharmacology. Gifts of \$1,388 to the Psychiatric Department Research Fund and \$5,100 for research in ophthalmology were also announced by Dr. Parkinson.

A BIOLOGICAL PHOTOGRAPHIC AND PHOTOMICROGRAPHIC SERVICE has been established at the School of Medicine of the University of Pennsylvania operated in conjunction with the Department of Anatomy. This service is available to physicians of the Philadelphia area. Anyone interested can obtain particulars by writing to the Department of Anatomy, School of Medicine, University of Pennsylvania, Philadelphia 4.

THE FIRST MEETING OF THE NEWLY FORMED INTERNATIONAL ACADEMY OF PROCTOLOGY will be held at the Marlborough-Blenheim in Atlantic City, N. J., on Fri-

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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60;
Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.



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day, June 10, 1949. The scientific portion of the program will consist of the presentation of papers and motion picture films of interest to all physicians as well as those specializing in proctology. Further information and a copy of the program may be obtained by writing to Alfred J. Cantor, M.D., International Academy of Proctology, 43-55 Kissena Blvd., Flushing, N. Y.

THE COOK COUNTY GRADUATE SCHOOL OF MEDICINE, Chicago, has arranged two courses of special interest. A two weeks' intensive personal course in "Diagnosis and Treatment of Congenital Malformations of the Heart" will be offered by Benjamin M. Gasul, M.D., starting Monday, June 13. A two weeks' intensive personal course in "Cerebral Palsy" will be offered by Meyer A. Perlstein, M.D., starting Monday, August 1. These physicians are members of the attending staff of the Cook County Hospital.

CATHARINE MACFARLANE, M.D., research professor of gynecology at the Woman's Medical College, Philadelphia, received the twenty-fifth annual Strittmatter Award at a special meeting of the Philadelphia County Medical Society on the evening of April 13. In accepting the gold medal and scroll for her "contributions to Philadelphia medicine as gynecologist, teacher, civic leader, and for pioneer research in the early detection of cancer," Dr. Macfarlane raised the point that medical students are not being taught the beginnings of cancer but the "more spectacular" later phases.

CERTIFICATES ARE NOW READY FOR MAILING TO FORMER MEDICAL OFFICERS who served during the war with the designation of Flight Surgeons. The certificates, which are suitable for framing, indicate that the officers concerned were graduated from the Aviation Medical Examiner's Course given at the U. S. Air Force School of Aviation Medicine, Randolph Air Force Base, Texas.

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THE GRADUATE SCHOOL OF MEDICINE OF THE UNIVERSITY OF PENNSYLVANIA will offer a special eight-month course in anesthesiology beginning next October. It is not intended to compete with or replace a required and supervised residency in anesthesiology in an accredited hospital, but is offered as a supplement, or preliminary, to such resident training. It has been arranged with the advice of the American Board of Anesthesiology. The chairman of the newly created department is Robert D. Dripps, M.D., professor of anesthesiology at the graduate school and director of anesthesiology at the University Hospital. Members of the faculty and anesthesiologists throughout the Philadelphia metropolitan area will join in the teaching.

THE SPRING MEETING OF THE PENNSYLVANIA ASSOCIATION OF CLINICAL PATHOLOGISTS was held April 29 to May 1 at Pocono Manor. The following scientific papers were presented: Liver Function Tests, Frank

W. Konzelmann, M.D., Atlantic City; Lower Nephron Nephrosis, John E. Kurtz, M.D., Harrisburg; Demonstration of Apparatus for Making Twenty-four Urine Albumin Tests at One Time, George R. Moffitt, M.D., Harrisburg; Use of Lecithin to Detect Pseudo-agglutination, William P. Belk, M.D., Philadelphia; Estimation of Serum Total Base and Sodium by Means of Conductivity Measurements and of Serum Protein by Refractive Index, F. William Sunderman, M.D., Cleveland; Present Status of State Laws in Relation to Training of Clinical Laboratory Personnel, Claude P. Brown, M.D., Philadelphia; Medical Education and the Photographic Library, Elwyn L. Heller, M.D., Pittsburgh.

A GRATEFUL PATIENT, UPON WHOM AN UNUSUAL SURGICAL OPERATION was performed successfully under the auspices of the University of Pennsylvania's Graduate School of Medicine, has made a gift to the university which is intended to contribute to the physical welfare of others similarly stricken. The gift, of approximately \$200,000, is for establishment of an endowment in the Graduate School of Medicine, the proceeds of which are to be devoted solely to the advancement of medical science in the fields of bronchology, esophagology, and



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laryngeal surgery. The name of the donor remains anonymous by request. The deed of gift by which the university acquires the endowment specifies that it shall be known as "The Gabriel Tucker Fund for the Department of Bronchology, Esophagology, and Laryngeal Surgery."

THE MELLON INSTITUTE AND THE UNIVERSITY OF PITTSBURGH SCHOOL OF MEDICINE have announced that the second annual Symposium on Orthopedic Appliances will be held at the Institute during the week of Sept. 19, 1949. The first symposium, which was fully successful in every respect, has been cited as "a dynamic example of cooperation among scientists, physicians, engineers, and technicians." This second symposium will be open to invited orthopedic physicians and surgeons as well as to selected orthopedic technologists skilled in brace design, fitting, and construction. The symposium's lecture staff will include a number of nationally recognized authorities in orthopedics as well as scientists of Mellon Institute. They will give detailed attention to bracing problems in cerebral palsy, paraplegia, and hemiplegia resulting from poliomyelitis and other disabling diseases, to scoliosis and related spinal conditions, and to other specialized orthopedic problems. Inquiries concerning attendance and program details should be addressed to the Orthopedic Appliance Fellowship, Mellon Institute, 4400 Fifth Ave., Pittsburgh 13, Pa.

"They are as sick that surfeit with too much as they that starve with nothing," wrote Shakespeare.

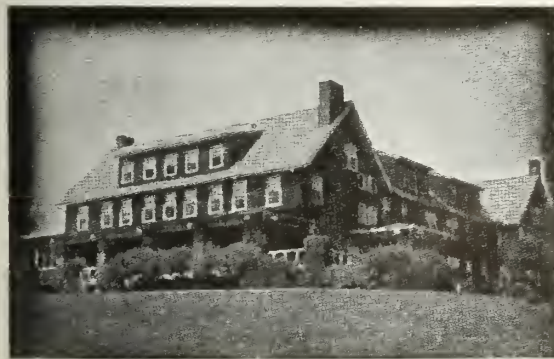
IMPROVED OUT-PATIENT SERVICES

Recently the chief of one of the staffs in one of our larger hospitals unburdened his mind to us. The following is given in an attempt to summarize his ideas:

Of recent years the service given in our hospitals has been enormously improved, especially in the hospitals that have a good supply of interns and residents. The treatment of the patient in the ward is far better than it was ten years ago. There are many factors that account for this improvement, but of great importance have been the desire of the staff to give these men good training and the enthusiasm of the younger men themselves.

Unfortunately, this great improvement has not extended in an equal manner to the out-patient departments and accident rooms. Here the work has been done by the younger men with, we believe, almost no supervision by their seniors. Really, the most important work is done in the accident rooms and the out-patient departments. When a patient has reached the wards, it is almost certain that his case is an important and difficult one. It is the important and difficult work of the youngster to recognize these cases among the flood of the run-of-the-mill stuff.

A matter that has always seemed ridiculous to us is the handling of fractures. In the case of a fracture of a leg, the patient gets into the ward and probably a senior surgeon takes care of him. If he breaks his forearm, the best he can hope for is that a resident rather than the inexperienced intern will take care of his break. There are mighty few positions in this world that a man with a limping leg cannot take care of, but if he has a poorly functioning wrist, he is pretty well finished



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in any of the mechanical positions. Good hands raise men above the brutes. The great proportion of hand injuries are left to the young men.

Dr. William Osler years ago made the point that it might be well worth while for the out-patient work to be done by the more experienced physicians. He was undoubtedly thinking that in most diseases the important thing is early recognition. Once the importance of the disease is recognized and the patient sent to the wards, investigation is largely a routine matter.

There is another aspect of out-patient work that should be stressed. Our interns and residents prepare themselves for practice by handling the most spectacular of our diseases. These diseases are often spectacular because they are few in number. It must be a rare young man who starts in practice handling largely this type of case. It is the mature consultant who gets them.

The trainee should care for the colds, the coughs, the indigestions, and the aches and pains that bring people to our waiting rooms. He should learn how to soothe the middle-aged patient whose indigestion is probably due to recent overindulgence and yet have a serious eye

open to spot the primary anemia or the beginning of cancer.

Although the staffs have made every effort to treat the out-patient well, it is not usually considered the ideal arrangement for the older and the younger men to work side by side and consult together. My chief of staff believes that the quality of treatment does not compare with that which is given when the older men are teaching the younger men and the younger men are trying eagerly to acquire as much knowledge as they can during their relatively short period of training.

It is not often that the young man starting in practice has the opportunity that some of us had in the surgical out-patient department years ago when we worked with Dr. M. P. Mahoney. For twenty-five years he had a large practice and yet continued to take his service each year in the surgical out-patient department. Probably a good proportion of the budding physicians who worked under him had as good an understanding as he had of the so-called major problems of surgery, but Dr. Mahoney knew innumerable helpful little things. In those days it was rare for the non-Jewish boy baby to be cir-



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The above studies should be supplemented, when possible, with courses in mathematics, qualitative analysis, physical chemistry, foreign languages (Spanish, French, or German), and sociology.

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cumcised in the Lying-In Hospital. These operations were the chief operative procedure in the out-patient department. Dr. Mahoney used to tell his assistants that there was no single procedure that had gotten physicians in bad with families so much as had circumcisions.

We will close by quoting our staff consultant: "The younger doctor sees the patient just as he does in private practice and has to make his diagnosis as efficiently and as accurately as he can. This experience is fully as valuable as any experience he can get in the ward in treating very sick people. It would be of great benefit to the public and to the young doctors if our out-patient services could be organized with the same efficiency and along the same lines that our ward services function."—Editorial, *Rhode Island Medical Journal*.

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GRASS ROOTS CONFERENCE JUNE 5

Discussion of compulsory health plans for medical care and for disability compensation will highlight the fifth annual meeting of the Conference of Presidents and Other Officers of State Medical Associations to be held at Atlantic City on Sunday afternoon, June 5. The meeting will be held in the Rose Room of the Traymore Hotel, the day preceding the opening of the A.M.A. general sessions, and it will be open to all physicians.

Cecil Palmer, English publisher, author, and journalist, will tell of the impact of socialized medicine on the British doctor and his patients. Palmer, now completing a tour of America, has been a brilliant spokesman for the British Society for Individual Freedom. An American viewpoint of the British health system will be given by W. Alan Richardson, editor of *Medical Economics*, now in England for a firsthand study of all phases of the program.

With compulsory disability compensation programs operating in three states, and Washington and New York the latest to pass such laws, the conference will present two speakers on this vital question. Edward H. O'Connor, managing director of the Insurance Economics Society of America, will discuss the legislation, and Dr. Bert S. Thomas, medical director of the California program, will tell of the medical implications of cash sickness compensation acts.

The A.M.A. relationship to the state societies will be reviewed by Dr. George F. Lull, secretary of the A.M.A., and the problems facing the state association at the crossroads will be the subject of a talk by Dr. Clarence Northcutt, president of the Oklahoma State Medical Association. Plans are also pending for the presentation of views on national health legislation by a member of Congress.

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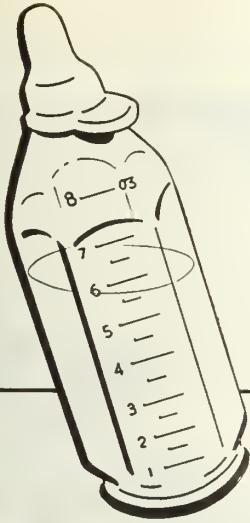
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Deaths from Selected Causes in Pennsylvania, December, 1948

County	All Causes, Excluding Stillbirths	Still- births	Infant Deaths	Maternal Deaths	Cancer	Heart Disease	Intra- cranial Lesions of Vascular Origin	Nephritis	Pneu- monia	Tuber- culosis
Adams	28	0	0	0	5	4	4	4	1	0
Allegheny *	1343	62	72	2	178	526	105	50	60	30
Armstrong	57	7	4	0	9	17	3	3	3	1
Beaver	128	8	12	1	11	45	8	5	8	5
Bedford	26	0	3	0	1	11	0	3	1	1
Berks *	229	7	11	1	30	80	19	8	7	3
Blair *	142	9	14	0	8	57	8	9	2	1
Bradford	54	3	4	1	8	21	4	1	1	3
Bucks	81	1	3	0	11	29	7	7	3	1
Butler *	61	4	4	0	2	19	9	4	3	1
Cambria *	160	12	11	0	18	53	14	12	6	4
Cameron	2	1	0	0	0	1	0	0	0	0
Carbon	37	2	3	0	1	15	4	5	0	1
Centre	58	2	5	0	8	23	3	1	2	0
Chester *	132	7	9	0	16	52	16	9	4	0
Clarion	36	1	1	0	0	16	5	2	1	1
Clearfield	53	2	5	0	5	24	7	2	1	1
Clinton	33	2	2	0	5	13	3	1	2	0
Columbia	61	3	3	0	6	25	8	3	0	0
Crawford	73	2	9	0	6	29	10	1	3	0
Cumberland *	77	1	2	0	10	27	11	5	1	1
Dauphin *	199	3	10	1	25	69	15	18	4	1
Delaware	300	11	22	0	37	114	26	16	9	6
Elk	28	1	2	0	6	13	2	0	3	1
Erie *	202	13	15	0	30	67	20	5	5	3
Fayette	167	11	16	2	34	46	14	14	2	4
Forest	6	0	2	0	0	1	0	0	0	0
Franklin *	66	2	4	0	7	30	3	13	2	1
Fulton	7	0	0	0	0	2	3	0	0	1
Greene	36	4	5	0	6	11	3	5	2	1
Huntingdon	28	3	2	0	5	13	1	2	0	0
Indiana	58	3	5	0	4	22	5	6	3	0
Jefferson	37	3	4	0	3	13	5	2	2	0
Juniata	7	0	0	0	2	2	0	0	0	0
Lackawanna	300	12	16	0	49	100	26	13	16	8
Lancaster	194	5	11	0	23	66	21	10	3	5
Lawrence	75	4	2	0	10	32	10	2	3	3
Lebanon *	69	4	3	0	8	26	9	6	1	1
Lehigh *	221	12	12	0	23	90	24	9	7	5
Luzerne	383	8	21	0	47	148	20	24	12	6
Lycoming	123	2	9	0	16	49	8	9	8	2
McKean	58	2	3	0	9	20	3	6	3	0
Mercer	81	4	3	0	11	27	13	8	2	0
Mifflin	42	2	8	0	5	12	1	2	1	1
Monroe	38	0	3	0	6	9	5	1	2	0
Montgomery *	279	14	12	0	49	100	27	15	3	6
Montour *	32	0	7	0	6	5	3	0	2	0
Northampton	112	1	9	0	13	47	12	3	3	2
Northumberland	103	3	8	0	10	43	7	8	3	2
Perry	12	0	0	0	0	7	1	2	0	0
Philadelphia *	2143	73	81	4	326	837	154	114	61	67
Pike	4	0	0	0	0	4	0	0	0	0
Potter	12	0	1	0	0	5	4	1	0	0
Schuylkill	225	5	5	0	21	84	13	20	9	7
Snyder *	11	0	1	0	1	5	1	0	1	0
Somerset *	65	3	7	0	10	23	6	5	2	0
Sullivan	4	0	0	0	0	0	1	0	0	0
Susquehanna	33	1	2	0	3	13	5	0	2	0
Tioga	45	2	4	0	4	21	4	1	0	0
Union	13	2	3	0	1	4	0	0	2	2
Venango *	74	0	7	0	6	26	8	2	1	1
Warren *	33	0	0	0	5	17	3	0	1	0
Washington	148	8	10	0	14	57	16	8	9	0
Wayne *	30	0	1	0	2	19	1	0	3	0
Westmoreland *	228	8	11	0	31	93	24	14	10	1
Wyoming	12	0	1	0	1	3	5	0	0	0
York	156	13	17	0	19	62	18	10	6	1
State and Federal institutions	317	1	0	0	34	71	21	20	11	69
State totals	9687	379	542	12	1260	3615	819	529	328	261

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*Page 51, *Infant Nutrition: Jeans and Mariott, 1947.*



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Dillane, W. B. et al.: Treat. Serv. Bull. 2:47, 1947 • Downing, J. G. et al.: J. A. M. A. 133:299, 1947 • Downing, J. G.: Am. Pract. 2:357, 1948 • Downing, J. G. et al.: New England J. Med. 239:62, 1948 • Eichenlaub, F. J. et al.: M. Ann. District of Columbia 17:452, 1948 • Johnson, H. M.: Arch. Dermat. & Syph. 57:348, 1948 • Miller, J. et al.: New York State J. Med. 47:2316, 1947 • Robinson, H. M. et al.: South. M. J. 40:409, 1947.

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Synopsis of Psychosomatic Diagnosis and Treatment

501 pages. Published 1948. Price, \$6.50.

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298 pages. Published 1949. Price, \$3.45.

By A. A. BRILL, M.D.

Nervousness, Indigestion and Pain

488 pages. Seventh Printing 1947. Price, \$5.50.

By WALTER C. ALVAREZ, M.D.

Modern Trends in Psychological Medicine

450 pages. Published 1948. Price, \$10.00.

Edited by NOEL G. HARRIS, M.D., F.R.C.P., D.P.M.

Sexual Behavior in the Human Male

By ALFRED C. KINSEY, WARDELL B. POMEROY and CLYDE E. MARTIN.
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620 pages. 70 illustrations. Published 1948. Price, \$9.00.

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BOOK REVIEWS

ORAL ANATOMY. By HARRY SICHER, M.D., Professor of Anatomy and Histology, Loyola University School of Dentistry, Chicago College of Dental Surgery. With 310 text illustrations including 24 in color. St. Louis: The C. V. Mosby Company, 1949. Price, \$15.00.

This is a text which has long been needed by those interested in the head and neck. Much of the material can be found in texts on general anatomy, but not in a readily available form such as here. It, therefore, serves as a supplement to books on human anatomy rather than a replacement.

It is written in two parts. Part I is descriptive anatomy of the skull, muscles of the head and neck, temporomandibular articulation and viscera, blood vessels, lymphatics, and nerves of the head and neck. Part II is regional and applied anatomy with a consideration of the facial skeleton, alveolar processes, anatomy of local anesthesia, ligation of vessels, propagation of dental infections, tracheotomy and laryngotomy, temporomandibular joint, and the edentulous mouth. The book is well organized and written, easy to read, and contains many practical remarks with some description of surgical exposure.

This book can be recommended to the students and graduates in the fields of dentistry, oral surgery, maxillofacial surgery, otolaryngology, and any others interested in the anatomy of this region.

HANDBOOK OF DISEASES OF THE SKIN. By RICHARD L. SUTTON, M.D., Professor Emeritus of Dermatology and Syphilology, and RICHARD L. SUTTON, JR., M.D., Associate Professor of Dermatology and Syphilology, both of the University of Kansas Medical School. 749 pages with 1057 illustrations. St. Louis: The C. V. Mosby Company, 1949. Price, \$12.50.

A book does not have to be large to be complete. Apparently Dr. Sutton, Jr., has put into the present volume almost as much useful information as is in his father's and his massive classical dermatology. There are almost as many good illustrations and subjects. Certainly for the less than specialist the simpler style, easier reading, and more modern point of view are a distinct advantage. This is a work to be recommended for anyone seeking an authoritative and complete dermatologic handbook.

CURRENT THERAPY 1949. Edited by HOWARD F. CONN, M.D., and assisted by a board of twelve consultants. 672 pages. Philadelphia: W. B. Saunders Company, 1949. Price, \$10.00.

The editorial consultants have utilized the treatment procedures of more than two hundred and thirty American authorities in compiling this book. The information, consisting of the most effective therapy for a given malady, is discussed. In those instances where there are variations in standard therapy the methods of two or more authorities are included. No one method is favored, and they are listed alphabetically in accordance with the author's name.

The contents are arranged into fourteen sections, each of which has a separate table of contents in addition to the general table of contents. Thus, with the aid of a comprehensive index, the reader can easily locate the desired information in a minimum amount of time.

In reviewing this book one cannot help but note the different approach that has been employed in presenting the subject matter. It is clearly and concisely written

and to the point. For those physicians wanting the most effective current therapy to date at their disposal, this book is recommended as most useful.

NEOPLASMS OF BONE AND RELATED CONDITIONS. Their etiology, pathogenesis, diagnosis, and treatment. By BRADLEY L. COLEY, M.D., Attending Surgeon, Bone Tumor Department, Memorial Hospital for Cancer and Allied Diseases; Assistant Professor of Clinical Surgery, Cornell University. With 622 illustrations and 53 tables. New York: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1949. Price, \$17.50.

In reviewing this book, one is immediately impressed with the tremendous amount of work that has been put into its writing. It is a compilation of all the present-day knowledge of the complex field of bone neoplasms. The author has had a wide personal experience in this field, and in addition, he has drawn upon material from the Medical Department of the United States Army and from a widely diversified and complete bibliography. The number of sources listed is truly phenomenal.

The purpose of this book is to present the subject of bone tumors in a form that will be useful not only to the oncologist, radiologist, orthopedist, and general surgeon but also to the general practitioner as well. It is hoped that a wider dissemination of knowledge of bone neoplasms will permit their earlier detection and treatment.

Dr. Coley has divided the subject into the following categories: classification, etiology, diagnosis, benign bone tumors, primary malignant tumors, tumors involving bone by extension, metastatic tumors, tumors of bone in special locations, surgical treatment, radiation therapy, constitutional therapy, and lesions which simulate bone neoplasms. The presentation of each specific neoplasm also includes its classification, etiology, clinical features, roentgenographic findings, differential diagnosis, treatment, and prognosis. The author devotes the greater part of his discussion to the clinical features of each specific lesion, but includes a rather complete presentation of the above-mentioned aspects. This accentuation of the clinical features sets this volume off from any of its predecessors and makes it a useful tool for the diagnosis and treatment of these conditions.

Each clinical entity is extremely well illustrated by many photographs, roentgenograms, diagrams, charts, and photomicrographs. The text is well written in a clear and concise manner.

In addition to the foregoing, the general subjects of surgical treatment and radiation therapy are considered. The former describes the techniques of aspiration biopsy, open biopsy, curettage, excisions, resections, and amputations, and the latter embraces the physical factors used in irradiation of bone tumors, effects of radiation on bone as well as bone tumors, indications for roentgen therapy, methods and dosage, and treatment with radioactive isotopes.

A chapter of this volume is limited to the use of blood chemistry in the diagnosis of diseases of bone. The changes produced by tumors as well as benign conditions are given. Another valuable section discusses the lesions of the skeletal system that may simulate neoplasms of bone, and includes the signs, symptoms, roentgenographic findings, clinical aspects, and laboratory procedures which are helpful in making the differential diagnosis.

This book is an extremely valuable addition to the medical literature and will serve as a convenient and authoritative reference for all medical specialists as well

as the general practitioner. Most men in the field of medicine encounter too few cases to enable them to gain a wide personal experience in the diagnosis and treatment of neoplasms of bone. Thus this volume, which compiles all recent knowledge on this subject plus the wide experience of the author, should be read and studied by all practitioners of medicine.

CARDIAC CATHETERIZATION IN CONGENITAL HEART DISEASE. A clinical and physiologic study in infants and children. By **ANDRE COURNAND, M.D.**, Associate Professor, Department of Medicine, College of Physicians and Surgeons, Columbia University; **JANET S. BALDWIN, M.D.**, Assistant Professor, Department of Pediatrics, New York University College of Medicine; and **AARON HIMMELSTEIN, M.D.**, Instructor, Department of Surgery, College of Physicians and Surgeons, Columbia University. New York: The Commonwealth fund, 1949. Price, \$4.00.

This monograph is devoted to the technique of cardiac catheterization as a means of diagnosing congenital anomalies of the heart and great vessels. It is divided into two sections. In the first section the authors describe in complete detail the methods of introducing the catheter into the heart through the venous system. The technique of blood sampling and taking pressure readings as they are related to the diagnosis of congenital defects is discussed. Many formulas are given for the calculation of systemic and pulmonary blood flow and of blood shunts. The complications of the procedures are also considered.

In the second section the authors describe 17 illustrative cases of infants and young children. These cases represent the most common types of cardiac defects encountered in the non-cyanotic group.

This volume is well illustrated by many roentgenograms, diagrams, and photographs. It is written in a clear, concise manner and is a valuable addition to the literature on this subject.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

CURRENT THERAPY 1949. Latest approved methods of treatment for the practicing physician. **HOWARD F. CONN, M.D.**, editor. Consulting editors: **M. Edward Davis**, **Vincent J. Derbes**, **Garfield G. Duncan**, **Hugh J. Jewett**, **William J. Kerr**, **Perrin H. Long**, **H. Houston Merritt**, **Paul A. O'Leary**, **Walter L. Palmer**, **Hobart A. Reimann**, **Cyrus C. Sturgis**, and **Robert H. Williams**. Philadelphia: W. B. Saunders Company, 1949. Price, \$10.00.

NEUROLOGICAL AND NEUROSURGICAL NURSING. By **C. G. DE GUTIERREZ-MAHONEY, M.D.**, Sometime Fellow of the Rockefeller Foundation; Associate Professor of Neurology, Vanderbilt University School of Medicine, Nashville; Senior Neurosurgeon, United States Army Air Forces (Colonel MC, AUS); Director of the Neurological Division and Neurosurgeon-in-Chief, St. Vincent's Hospital, New York City; Neurosurgical Consultant,

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Fort Totten Army Medical Center, New York; and ESTA CARINI, R.N., B.S., formerly head nurse and supervisor of the Neurological and Neurosurgical Services, Neurological Institute, Presbyterian-Columbia Medical Center, New York City; Clinical Instructor of Neurological and Neurosurgical Nursing, St. Vincent's Hospital, New York City. Illustrated. St. Louis: The C. V. Mosby Company, 1949. Price, \$5.75.

PAIN SYNDROMES. Treatment by Paravertebral Nerve Block. By BERNARD JUDOVICH, B.S., M.D., Instructor in Neurology, Graduate School of Medicine, University of Pennsylvania; Physician-in-Charge, Neuralgia Clinic, Graduate Hospital, Philadelphia, Pa., and WILLIAM BATES, B.S., M.D., F.A.C.S., F.I.C.S., Professor of Surgery, Graduate School of Medicine, University of Pennsylvania; Consulting Surgeon, Babies' Hospital and Philadelphia Home for Incurables; Consulting General Surgeon, Wills Hospital, Philadelphia, Pa. Foreword by Joseph C. Yaskin, M.D., Professor of Neurology, Graduate School of Medicine, University of Pennsylvania, Philadelphia. 181 illustrations. Third edition. Philadelphia: F. A. Davis Company, 1949. Price, \$6.00.

CORONARY ARTERY DISEASE. By ERNST P. BOAS, M.D., Associate Physician, Mount Sinai Hospital, New York City, and NORMAN F. BOAS, M.D. Chicago: The Year Book Publishers, Inc., 1949. Price, \$6.00.

CHILD HEALTH SERVICES AND PEDIATRIC EDUCATION. Report of the Committee for the Study of Child Health Services of the American Academy of Pediatrics. With the cooperation of the United States Public Health Service and the United States Children's Bureau. New York: The Commonwealth Fund, 1949. Price, \$3.50.

THE USES OF PENICILLIN AND STREPTOMYCIN. By CHESTER SCOTT KEEFER, M.D., Wade Professor of Medicine, Boston University School of Medicine; Director of Evans Memorial and Physician-in-Chief of the Massachusetts Memorial Hospitals. Porter Lectures, Series 15. Lawrence, Kansas: University of Kansas Press, 1949. Price, \$2.00.

LET THE BUYER STILL BEWARE

Several weeks ago we commented on a newspaper report that there had been collected \$13,394,000,000 in payroll taxes for old age benefits and that there was a credit in the Federal Treasury of \$10,706,000,000 for this fund. Payments to pensioners had totaled \$2,379,000,000 at an administrative cost of 13 per cent of the disbursements.

Let me quote the newspapers of March 26, 1949: "Arthur J. Altmeyer, Social Security administrator, said that there is a \$7,000,000,000 'deficit' in the Social Security old age and survivors insurance fund. It is not a current cash imbalance, he explained, but a lack of provisions for future obligations created by promised benefits. But Altmeyer told the House Ways and Means Committee that if Congress now raises the payroll tax to 3 per cent against employer and employee, this will wipe out the deficit and provide for increased benefits under the program proposed by President Truman."

The social planners in Washington have a glib way of juggling the words *deficit*, *cash imbalance*, *credit*, *lack of provision*, and it is small wonder that Mr. Average Citizen is developing a deep suspicion that the only place where real money enters the picture is the progressive deduction from his pay envelope—and that from this point on, billions can become imbalances, deficits, credits, lack of provisions, without ever entering the realm of money again. He has good reason to ask that further attempts to increase his payroll "contribution" for other federal services be moved from the sphere of philosophy to the field of honest cost accounting.

For Mr. Average Citizen has a right to certain things, one of which is integrity in those who plan his life for him. And it cannot be said, in the face of this sorry demonstration of the ineptness of the planners of the Social Security system, that he has any reason to expect that he will receive any improvement in his health from another payroll deduction. For won't this, in a decade, become another matter of deficits, cash imbalances, credits, lack of provision of sufficient degree to require another payroll deduction?—Editorial, *De-troit Medical News*.



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JUNE, 1949

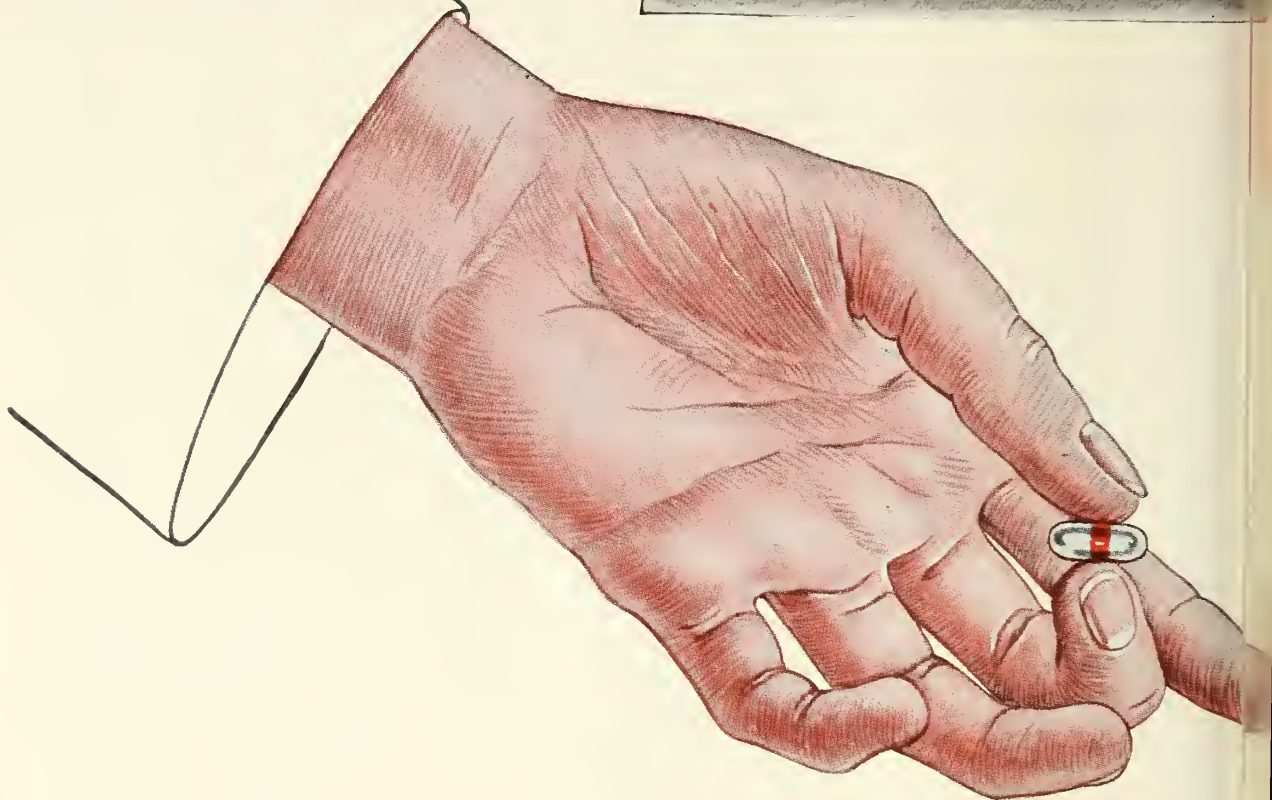
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*Magladery, J.: Therapeutic Conference, The Treatment of Epilepsy.
Bull. Johns Hopkins Hosp., 82:609, (June) 1948.

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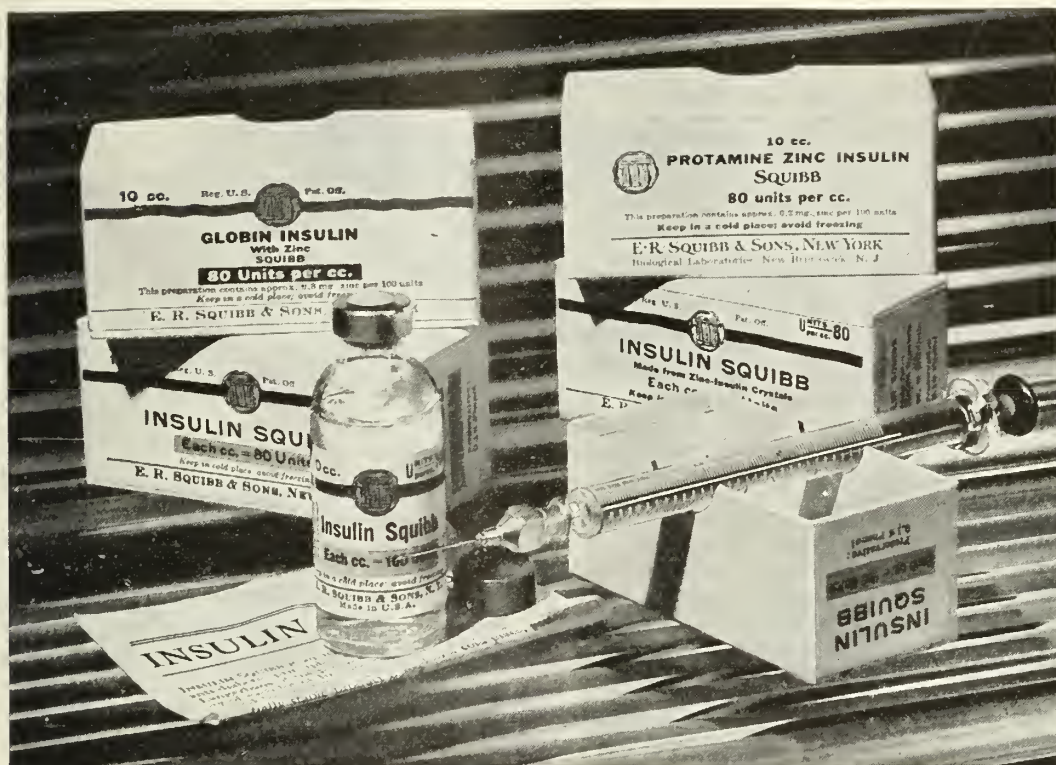
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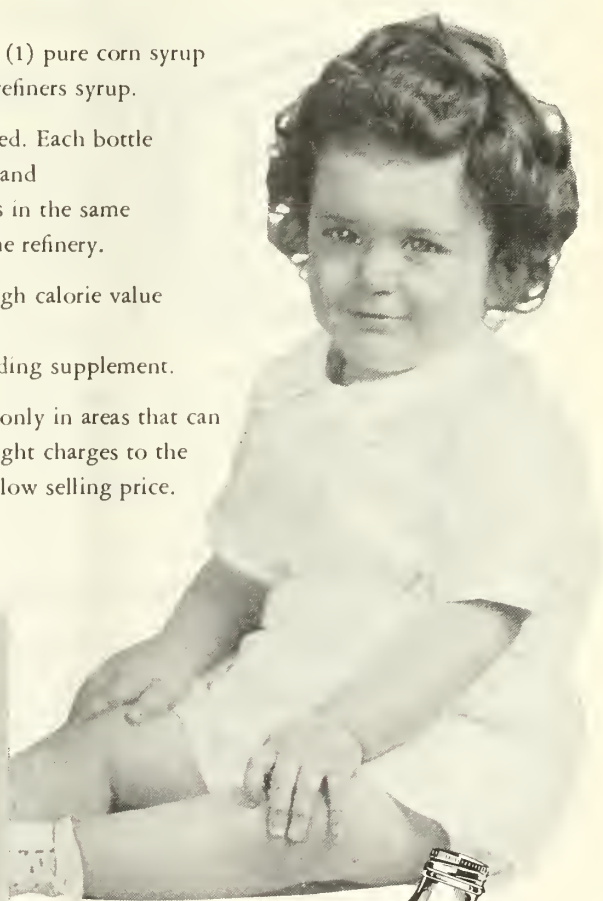
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Sugars, Before Inversion	
As Invert	33.21
As Dextrose	32.13
Sugars, After Inversion	
As Invert	39.13
As Dextrose	37.66
Sucrose	4.50
Glucose	66.3
(211°V)	
Total Sugars after Prolonged Acid Inversion (Includes Dextrins)	
As Invert Sugar	68.3
As Dextrose	65.9
Dextrins (calc.)	25.4
Calories, per fluid ounce (calc.)	144



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AMERICAN DOCTOR

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It is a soldier crying in agony on a thousand battlefields.

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It is the end of pain.

It is Hope.

It is the lonely, unending quest for knowledge.

It is the fight against ignorance, sloth, superstition.

It is the dumb, unspeakable joy in the eyes of a parent.

It is the rock of grief.

It is cold rain and pounding storm and bone-weariness and the
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LETTERS

Erratum

GENTLEMEN:

I regret to say that I was responsible for an error on page 686 of the article "Physiologic Mechanisms of Psychosomatic Phenomena" (April issue) near the bottom of the right hand column of the page under "(6) Neural mechanisms of the nasal reactions"; "branches of the third cranial nerve" should read "branches of the seventh cranial nerve."

I very much regret this oversight and I hope you will have an opportunity to print an erratum.

STEWART WOLF, M.D.,
525 East 68th St.,
New York 21, N. Y.

Appreciation

GENTLEMEN:

Today my fifty years in practice testimonial plaque reached me. I am proud and pleased to receive this honor bestowed upon me by The Medical Society of the State of Pennsylvania. It recognizes "medical services faithfully performed," and I appreciate that my feeble efforts have been officially noted.

I wanted to receive in person this token of honor bestowed, but the distance involved presented an insurmountable difficulty, so the award was granted in absentia.

Best wishes to you and the Society for tireless efforts in the advancement of medical science and services.

HENRY T. PRICE, M.D.,
Lake Placid, Fla.

Request from Hungary

DEAR COLLEAGUE!

For lack of adequate addresses I appeal to you. I would be very grateful to you if you could have the kindness to forward my request to Dr. Nicholls, E.E., for a copy of his interesting paper entitled "The Diagnosis and Treatment of Migraine" (THE PENNSYLVANIA MEDICAL JOURNAL, Harrisburg, 1948, 51/4, 423-26).

Excuse me to give you such a trouble. With many thanks and my best regards believe me to be

Most sincerely,

F. KAJTOR, M.D.,
Neuropsychiatric Clinic
of Debrecen, Hungary.

Repaid

GENTLEMEN:

I am enclosing my check for \$500 in repayment of loan kindly advanced me from the Veterans Loan Fund MSSP.

_____, M.D.,
Eric County.

Residency Available

GENTLEMEN:

Several openings are available in the residency training program in neurology at the Veterans Administration Hospital, Coatesville, Pa. The program, organized by the Philadelphia Deans Committee, has been approved by the American Medical Association. This residency covers a period of three years or less, depending on the previous experience of an applicant, and is designed to prepare residents for certification in neurology by the American Board of Psychiatry and Neurology.

The program includes rotation through the Veterans Administration Hospital, Coatesville, Pa., the Veterans Administration Regional Office, Philadelphia, and the Philadelphia General Hospital. Applications should be sent to the Manager, Veterans Administration Hospital, Coatesville, Pa.

We trust that you will find it convenient to publish this announcement, as we are most anxious to recruit residents in neurology for our training program.

HUGO MELLA, M.D., Manager,
VA Hospital,
Coatesville, Pa.

Hospital Costs

GENTLEMEN:

I have just had the pleasure of reading "Hospital Costs," an editorial reprinted from the January, 1949 issue of THE PENNSYLVANIA MEDICAL JOURNAL.

This philosophy so adequately expresses what we in the hospital field should be thinking at the present time. It would be greatly appreciated if you could send me 25 copies of the reprint. Kindly bill me for any charges incurred therein.

CHARLES V. WYNNE, Superintendent,
Waterbury Hospital,
Waterbury 61, Conn.

Wanted

GENTLEMEN:

The Department of the Army is urgently in need of public health officers to serve in a civilian capacity with the occupation forces in Japan. These positions, which involve supervision of Japanese prefecture (state) health departments in all phases of preventive medicine and medical care programs, offer an excellent opportunity for broad experience in public health. We will greatly appreciate your assistance in locating qualified and interested candidates for this program.

Minimum acceptable qualification requirements are a degree in medicine plus one year internship. Experience in public health is desirable, but is not mandatory.

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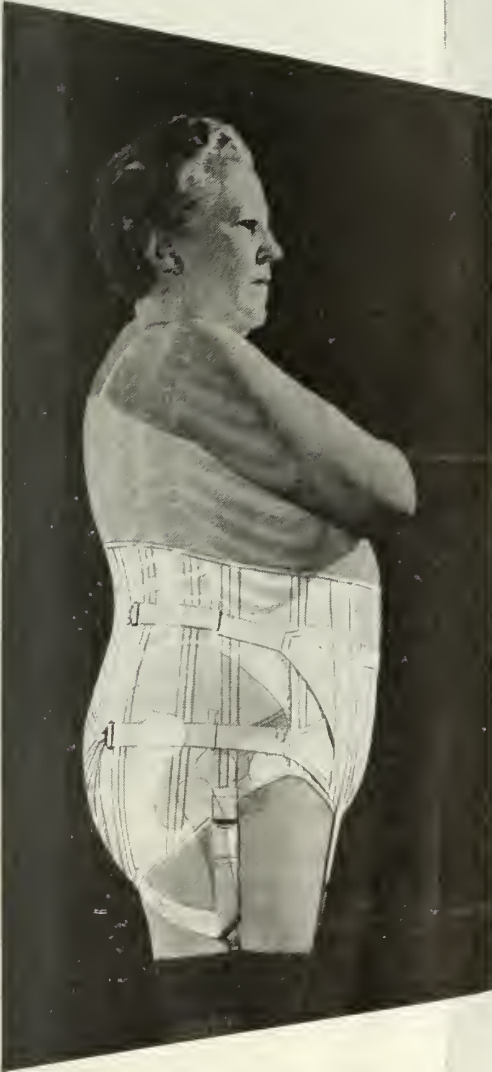
SPECIALIZATION NO ANSWER

"In order to cure the human body," wrote Hippocrates, "it is necessary to have a knowledge of the whole of things." Upon this thesis Dr. Ian Stevenson writes in a recent issue of *Harper's Magazine* under the title, "Why Medicine Is Not a Science." Medicine is not a science, says this writer, in the sense in which mathematics, chemistry, and physics are sciences. The situation in medicine today is that each bodily system is handled by specialists ignorant in other fields and the textbooks of our time are but catalogues of disease states. "Medicine, in short, has succumbed to the twentieth century habit of concentrating on techniques rather than the quest for understanding." The result has been that so great an amount of medical knowledge has been amassed that it is beyond the comprehension of the individual and cannot be used by him. It is a state of affairs that leads Sir Charles Singer to comment, "If from the facts no laws emerge, the facts themselves become an obstacle, not an aid, to scientific advance."

Dr. Stevenson states that we have become so involved in technical procedures that we have lost sight of the patient, for in reality the actual number of differential diagnoses are not less than the number of people in the world. The way out is a greater knowledge of the patient as a whole, a kind of knowledge possessed by physicians of a former generation who followed patients over a period of many years. He cites the well-known Peckham Experiment in Great Britain where families join a health center and are under medical observation under everyday conditions. It is only by a return to this viewpoint that we will be able to discover the laws of medicine. "Some way must be found to combine the general practitioner's breadth of experience with the facilities and influence of the medical schools."

Dr. Stevenson also sounds a note not foreign to these editorial pages in recommending that the training of physicians must be broadened and liberalized so that physicians will become once more humanists and biologists, as well as chemists and physicists. This is a provocative essay and well worth the attention of all physicians who are seeking ways to advance medicine and at the same time combat an ever widening criticism on the part of the public against certain evils of overspecialization.—*Connecticut State Medical Journal*.

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(1) Joslin, E. P.: *Postgraduate Med.* 4:302 (Oct.) 1948. (2) Kemper, C. F.: *Rocky Mountain M. J.* 45:1092 (Dec.) 1948. (3) Pollack, H.: *New York Med.* 4:15 (Dec. 5) 1948.



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1. New York State J. Med. 47:1003

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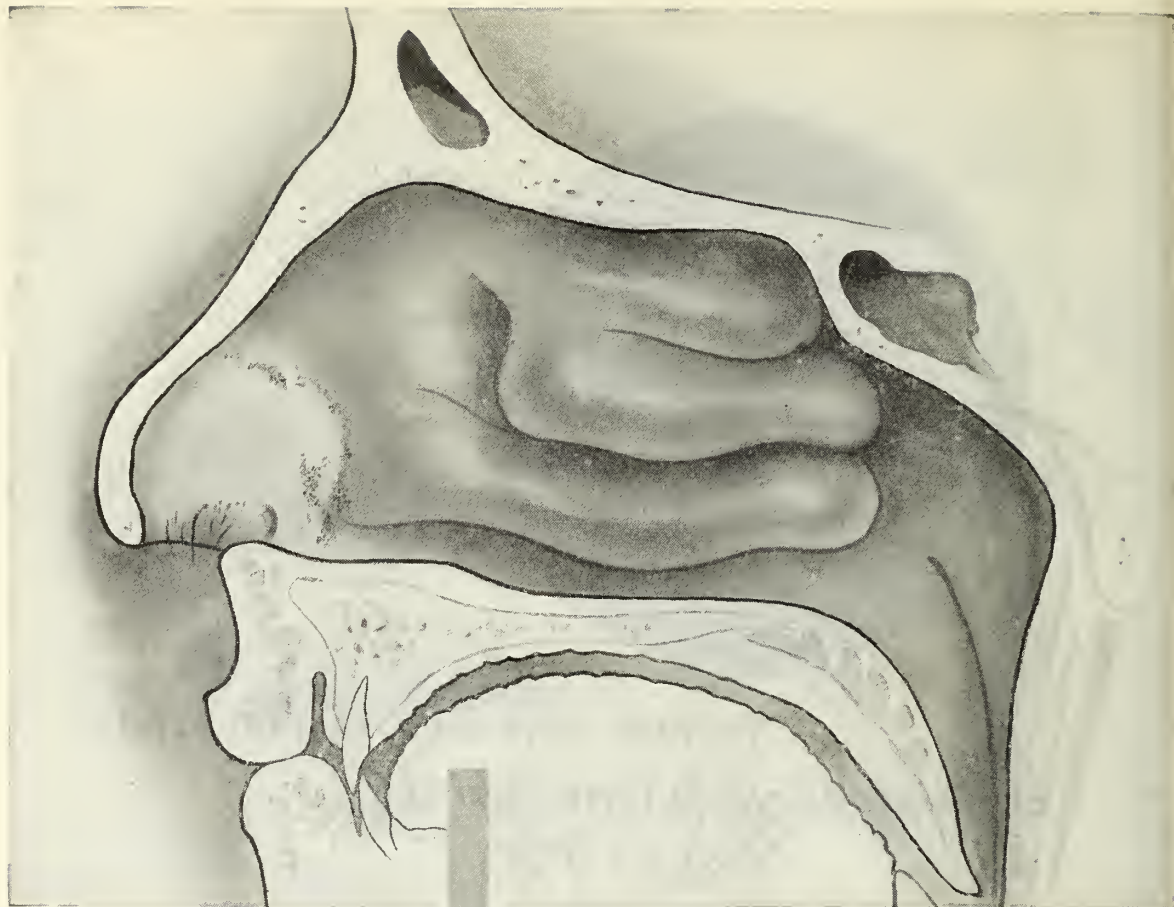
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THE PENNSYLVANIA MEDICAL JOURNAL

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The Present Status of Corneal Grafting

JOHN M. McLEAN, M.D.
New York, N. Y.



THERE is still so much confusion and loose thinking about transplantation of the cornea that it seems worth while to review the present status of our knowledge of that procedure. Misleading or misinterpreted reports in the lay press have done much to raise false hopes in patients for whom transplantation offers absolutely nothing. Even physicians not well informed as to the possibilities and limitations of this type of surgery have unwittingly given undue encouragement and promises to pathetic individuals only to have them face a second period of readjustment, sometimes after expenditure of ill-spured savings on long travel. On the other hand, some physicians and others who care for or have contact with the blind have erroneously advised against surgery or condemned the operation in cases where there is good prospect for restoration of useful vision. Others have accomplished the same thing by negligence in case finding among the blind and near blind.

The questions that need to be answered as clearly as possible are: (1) What cases can and what cases cannot be benefited by corneal transplantation? (2) What other procedures are available in some of these cases to give adequate

improvement with less risk? (3) What are the available techniques when transplantation is in order? (4) What may be expected in the way of results?

All physicians and most intelligent laymen have finally learned that it is still impossible to graft an entire eye. They have also learned that corneal transplantation will not rectify abnormalities beyond the cornea. In spite of this we still occasionally see a patient referred for corneal grafting who has no light perception, much less projection! Among those patients who have lesions confined to the cornea, with the rest of the eye apparently normal, it is important to determine those in whom transplantation is in order. In those who have a good prognosis, it must then be decided whether some other simpler and safer method may not give an adequate visual result. In those who have a less favorable but not hopeless outlook, it is important to weigh carefully the individual merits of the case, the visual needs of the particular patient, the amount to be gained if all goes well, and the loss to be faced if all does not.

Of the usual types of corneal scars, Group 1 * represents a situation ideally suited for corneal transplantation, namely, a cornea without opacity or vascularization. The only cases which fall in this group are those with conical corneas. They fare remarkably well. The improvement is usually great and the risk of complication or failure very small. It is important in these cases to

Read before the Section on Eye, Ear, Nose and Throat Diseases at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 5, 1948.
Dr. McLean is professor of ophthalmology at Cornell University Medical College.

* Referring to lantern slides not reproduced in this publication.

excise as much cone as possible with a large transplant properly seated in cornea of normal thickness. Since there is sometimes considerable eccentricity of the cone, it may be necessary to plan the transplant eccentrically for the best fit. One such case* had a resultant 20/20 vision. It must be remembered that a poorly seated transplant in keratoconus may result in enough irregularity of the new cornea to require a contact glass for maximal postoperative acuity. Such a result, even though the graft be perfectly clear, may not represent much improvement for the patient. I do not believe that transplantation for simple keratoconus is ever justified until all the possibilities of contact lenses have been exhausted.

Group 2* represents cases of central corneal opacity which may be completely excised and replaced. Here, too, the prognosis is good and the risk relatively small. When this situation arises in keratoconus with scarring at the apex of the cone, transplantation is usually the best solution. However, when such central scars occur in corneas of regular curvature, it is important to consider how much the simpler procedure of optical iridectomy has to offer before undertaking the more major operation. Often it is wiser to perform iridectomy first and reserve corneal surgery for the cases not adequately benefited. This is particularly true in the presence of vascularization of the scar or anterior synechia. The likelihood of a permanently clear graft varies inversely with the number of blood vessels leading into the area grafted. If grafting is to be done, such vessels should be obliterated as far as possible by beta radiation, peritomy, or both. In some cases of adherent leukoma, the synechias may be excised at the time of transplantation; in others, preliminary synechotomy, often with air injection, is in order. This maneuver may well be accompanied by trial optical iridectomy.

Group 3* represents cases of larger corneal opacity in which enough clear cornea remains to place a transplant in contact with normal cornea for at least half of its area. In all such cases optical iridectomy under the clear cornea must be considered, and at times tried first. In these corneas, however, the prognosis for transplantation is still good if other complicating factors are not present. It appears to be a necessity for continued clarity of a graft to have half or more of its area in contact with normal cornea. This area need not be surface area with through and through clarity. It is as satisfactory to have this half or more of normal cornea in depth as in groups 4 and 5.

A typical example of group 4* is to be found in healed interstitial keratitis. In such cases the prognosis for transplantation is good and increases as the active vascularization decreases. For some reason not entirely clear the prognosis is better in group 4 where the scarring is deep than in group 5 where the same amount of scarring is superficial.

In group 5,* with surface scarring, the possibility of superficial lamellar keratectomy must be considered. Although the operation rarely yields vision above the order of 20/70 to 20/200, it is better than an opaque graft and may be all that such a patient requires.

Group 6* represents cases with a completely opaque cornea in all layers from limbus to limbus. Such a cornea will practically never maintain a clear transplant and need not be attempted. It has taken many eyes and much experience to prove this, but there seems to be no further excuse for operating on such patients. Careful distinction between group 6 and group 4 must be made, for the one has a poor and the other a fairly good prognosis. Determination of the thickness of such opacities is best made on the biomicroscope, but at times is aided by transillumination and stereoscopic infra-red photography. This latter method may help to disclose details of the iris condition and, in a stereoscope, anterior chamber depth.

Factors, other than the cornea, which influence the prognosis include glaucoma, anterior peripheral synechias in the shallow anterior chamber, and aphakia. The presence of glaucoma, even controlled, presages further complications and postoperative rise in tension with clouding of the graft. The presence of uncontrolled glaucoma is a definite contraindication. Aphakia is a complicating factor which will be considered presently. Since it is a complicating factor, when a cataract is present, it is far better to perform the transplantation first and wait the better part of a year before extracting the lens. When this is done, a short deep incision is indicated to avoid interference with corneal nutrition as far as possible, for clouding of a clear graft may follow early or extensive limbal incisions. Intracapsular extraction is in order to avoid the reaction to retained cortex which may also impair clarity of a successful graft.

Dystrophies may be divided into two groups. The hereditary stromal types seem to have the same prognosis as other stromal opacities and may be considered on the same basis. The endothelial-epithelial dystrophies of the Fuchs type, in contrast, are never improved for any appreciable length of time and may be made worse by

* Referring to lantern slides not reproduced in this publication.

transplantation. Active inflammatory disease is a contraindication to grafting for optical purposes, but there may be occasion to insert a graft for structural reasons. The most common example of this situation is seen in a descemetocele about to rupture. I have usually found that the easiest and safest repair of such eyes is made with a small penetrating circular graft taken with a 2 mm. Elliott trephine.

Postoperative cooperation is so important that young children and highly "nervous" adults who cannot be counted on must be considered very carefully before operation is undertaken. I have had particularly poor luck with small youngsters.

Of the general types of graft available, type 1* in which the entire cornea is transplanted is never successful and may result in loss of the eye from intractable glaucoma. Type 2* represents the procedures in which a circular disk of cornea is rotated or a rectangle turned end for end to replace a central scar with clear peripheral corneal tissue. This is a true autograft and should theoretically be highly desirable, but experience has shown it to be quite unsatisfactory. Type 3* represents a large or small, round or square, lamellar transplant which is applicable to scars too deep for lamellar keratectomy in the presence of aphakia. The scar at the posterior union between graft and cornea precludes restoration of perfect vision, but the thin posterior layer of retained cornea is an important barrier to pre-

vent loss or incarceration of vitreous. Corneal transplantation in aphakia is risky enough to make this safety procedure at the expense of some potential vision highly desirable. Type 4* represents the typical partial, penetrating graft, round or square, generally used. It is the most satisfactory in the average case. Shape of graft and details of retaining sutures are a matter of preference of the individual surgeon. Rather wide variations in these techniques make little or no difference to the eventual outcome. The size of graft is more important. The most satisfactory plan is to use the largest graft compatible with structural stability and sparing of the structures in the anterior chamber angle.

Much has been learned about donor material. It must be human, but no attention need be paid to race, sex, or age as long as the cornea is in good condition. There seems to be no difference in result whether the donor eye is obtained from a living individual or one deceased within about six to eight hours. Nor is there a choice between donor material freshly obtained or that stored up to three days in a sterile, moist chamber at a temperature just above freezing. It is probable that storage longer than a three-day period is also satisfactory, but adequate data are not yet at hand to demonstrate this. The establishment of eye banks has greatly facilitated the procurement and exchange of donor material. Finally, it must be pointed out that any large general hospital which has a blood bank and good cooperation between departments can set up its own efficient eye bank at negligible expense.

* Referring to lantern slides not reproduced in this publication.

FIND ANTIBIOTIC EFFECTIVE AGAINST VIRUS PNEUMONIA

Virus pneumonia responds favorably to aureomycin, according to two doctors who made a controlled study of the newer antibiotic drug as a treatment for this virus disease of the lungs.

No previously available drug has been found effective against virus pneumonia.

Gordon Meiklejohn, M.D., Berkeley, Calif., assistant professor of medicine at the University of California Medical School, San Francisco, and consultant in virology for the California State Department of Health, and Capt. Robert I. Shragg, M.D., Fort Ord, Calif., of the Medical Corps, Army of the United States, report their study in the May 28 *Journal of the American Medical Association*.

All of a group of 22 patients treated for virus pneumonia with aureomycin at the Station Hospital, Fort Ord, responded rapidly to the drug, and 12 were clear of fever forty-eight hours after it was first administered, the doctors say.

Out of a control group of 20 patients at the hospital treated for the disease with penicillin, six became clear of fever forty-eight hours after the first dose of the drug was given.

THE A.M.A CAMPAIGN

The efforts of individual doctors in this campaign are of paramount importance. The help of every doctor is needed to inform people about political medicine.

Every American should know how political medicine destroys the quality of medical care, how it breaks down physician-patient relationships, how it raids the pocketbook of every taxpayer, and how it threatens personal freedom.

Our people deserve honest information.—*Connecticut State Medical Journal*.

Malignant Lesions of Nasal Fossae and Sinuses

Diagnosis and Treatment

AUSTIN T. SMITH, M.D., and THEODORE P. EBERHARD, M.D.
Philadelphia, Pa.

Diagnosis

“EARLIER diagnosis for prompt and successful treatment” is the slogan of the national campaign for cancer control. In no other area is this slogan more applicable than in cancer of the nasal fossae and sinuses. The purpose of this paper is to briefly review some cases studied in the tumor clinic, x-ray, and laryngologic departments of the Jefferson Medical College Hospital, and to offer a few suggestions which may aid in earlier diagnosis and more effective treatment.

The ideal to strive for is diagnosis early enough to permit excision of the malignant growth through normal tissue. This is practically impossible in the nose or sinuses because symptoms are rarely produced until the growth has spread beyond the limits of the mucous membrane and has invaded the bony walls of the cavities. Adequate surgical excision then requires section of a portion of the base of the skull. Consequently, we must resort to radiation therapy in practically all cases. With the steady improvement in the efficiency of this agent, we have come to depend more and more upon its application, so that at the present time it is used in at least 90 per cent of cases. This wide use of radiation therapy is illustrated in Schall's recent summary of treatment of 219 patients.*

Because of the joint responsibility between clinician and radiologist in handling the problem, this has been made a joint presentation. I will discuss one or two phases of diagnosis, and leave the real burden, that part pertaining to treatment, to Dr. Eberhard.

A critical review of the average case of malignancy of the nose or sinuses reveals that one of the difficulties in making an early diagnosis is that the patient does not complain until the growth is of considerable size. When it occurs in the nose, causing almost complete obstruction,

pain is not an early symptom, and respiratory difficulty and rhinopharyngeal discharge are often slight. The patient gives little concern to these symptoms. He has become aware of the possibility of cancer in other parts of the body, but he does not think of it in this area. When the neoplasm primarily involves a sinus cavity, the initial symptom is usually external swelling in the cheek, floor of the orbit, or bridge of the nose, and the patient will have no occasion to seek medical aid until this occurs. The growth has then penetrated the bony walls of the cavity and reached the subcutaneous tissues. An occasional case is observed in which a malignancy of a sinus will first manifest itself by symptoms of slight pain, numbness, paresthesia in cheek, eye, upper teeth, or ear some months before external swelling appears. However, such symptoms cause no apprehension in the mind of the patient. They are readily accounted for by a “draft,” “bad tooth,” “catching cold,” neuritis, or some other common complaint. Cancer does not enter his mind. Consequently, in order to obtain earlier diagnosis, patients must realize the importance of adequate examination to determine the cause of all symptoms referable to the nose and sinuses regardless of how inconsequential they may seem.

Greater awareness of cancer on the part of the patient may lessen the problem of early diagnosis, but it will be of no avail if the physician is not alert to the possibility, either in the history or physical examination. The lack of any characteristic symptoms or appearance in the early stages of malignant neoplasms to distinguish them from common benign lesions is a common obstacle to early recognition. In the nasal fossae the visible part of a malignant growth often presents the physical appearance of ordinary mucous polyps. Also, edematous tissue or large myxomatous polypi may spring up around the neoplasm and effectively disguise it. Hemorrhagic discharge or repeated hemorrhage from an obstructed nasal chamber are suggestive

Read before the Section on Eye, Ear, Nose, and Throat Diseases at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 6, 1948.

* SCHALL, LEROY A.: Malignant Tumors of the Nose and Nasal Accessory Sinuses, *J. A. M. A.*, 137: 1273, Aug. 7, 1948.

symptoms, but a slow growing tumor with abundant connective tissue and thick-walled vessels will not give rise to bleeding.

The physician, as well as the patient, must be constantly on guard against the possibility of malignancy in the nasal fossae and sinuses. He knows that microscopic section is the only means of making a positive diagnosis, and if he is alert to the danger, he will see that sections are made of all tissue removed. He will consider any obstructive growth malignant until the microscope proves it otherwise, and he will make sure that the specimen submitted to the pathologist is from the deep part of the growth, and not from innocent polypoid tissue which conceals the malignant neoplasm. Symptoms of slight pain, numbness, paresthesia in the cheek, eye, upper teeth, or ear must be looked upon with suspicion until a definite etiologic diagnosis has been made. Repeated roentgen examinations, which are invaluable in early cases, should be done, and prompt exploratory operation insisted upon to determine the exact nature of any suspicious shadows.

A brief review of the following three cases indicates what the physician is up against. They illustrate that the only way to recognize cancer earlier is to have it constantly in mind in the history and physical examination.

CASE 1.—A female, aged 52 years, was well until four weeks prior to admission to hospital when her

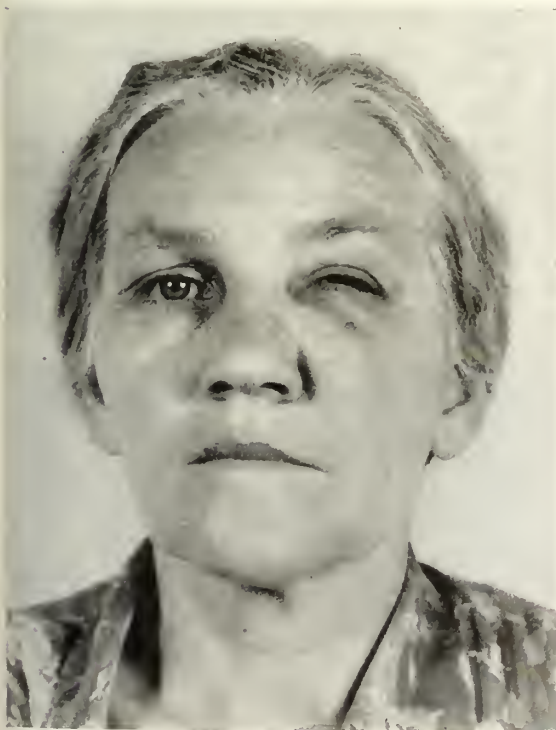


Fig. 1, Case 1. Carcinoma of left antrum. First symptom noted was swelling beneath left eye.

left eye began to water profusely. A few days later she noticed a swelling beneath the left eye. Dilatation of the lacrimal duct gave temporary relief. Three weeks later tenderness and pain developed over the left antrum with increased swelling of the cheek. She was admitted to the hospital and a diagnosis of cancer of the left antrum was made by means of a biopsy obtained with the Vim-Silverman biopsy needle. The antrum was entered through the inferior meatus. (This instrument is useful. It is possible to secure with it an adequate tissue specimen with a minimum of trauma. If there is any doubt about the specimen obtained, however, prompt exploratory operation is imperative.)

Earlier diagnosis was impossible in this case. The first symptom occurred after the growth had penetrated the bony walls of the sinus into the subcutaneous tissue.

CASE 2.—A female, aged 49 years, was admitted to the hospital with a diagnosis of malignancy of the right antrum because of proptosis of the right eye, swelling of the right cheek, and pain over the right side of head and face. She had complained of slight pain and numbness for four months prior to the onset of the proptosis and swelling, and had been under treatment for neuritis by a local physician. The diagnosis was confirmed by biopsy obtained by means of a Caldwell-Luc exposure. The growth had invaded the walls of the antrum, and palliation by surgery, radium, and roentgen therapy was only temporary.

An earlier diagnosis would have been made in this case if the physician who first saw her had thought of cancer and had insisted upon immediate x-ray examination, followed by prompt exploratory operation to determine the exact nature of the shadow that it would have revealed.

CASE 3.—A female, aged 49 years, consulted a physician in June, 1946, because of left nasal obstruction of several months' duration. He made a diagnosis of nasal polyp, which he removed in his office. The obstruction returned and with it pain in the left side of face and head. She consulted another physician who gave her new glasses and treated her nose until May, 1947, when she was referred to the tumor clinic. Examination revealed neoplastic tissue filling the left nasal chamber and invading the nasopharynx. A biopsy from the anterior part of the growth was reported as squamous cell carcinoma.

Many months' delay in making the diagnosis of cancer occurred in this case, not because the lesion was obscure or inaccessible, or because the physicians who examined her lacked the ability, training, or means to do it, but because they didn't think of it.

Fortunately, malignant tumors of the nasal fossae and paranasal sinuses are relatively rare, comprising about 0.2 per cent of all human cancer and about 3 per cent of cancer in the upper respiratory and alimentary tract.* Unfortunately, however, they have no characteristic features in the early stages to distinguish them from benign lesions which occur much more frequently. The current educational campaign for the eradication of cancer should publicize the nose and sinuses as well as other regions of the body; and medical students and physicians, as well as the

* MARTIN, HAYES: Cancer of the Head and Neck, *J. A. M. A.*, 137: 1366, Aug. 14, 1948.



Fig. 2, Case 1. Vim-Silverman biopsy needle. Useful for obtaining specimen from antrum with minimum of trauma.

general public, should be made alert to the possibility of cancer in this area. Until this has been done, we will continue to see misdiagnoses because of failure to interpret symptoms properly, to make repeated roentgen examinations, to study microscopically tissue removed, and to do an exploratory operation in suspicious cases.

Treatment

Irradiation treatment of these patients involves a knowledge of adequate tumor dosage, some knowledge of pathology, meticulous attention to technique, and an incurable optimism. The optimism is necessary in order to carry the radiotherapist through the heartbreaking failures which generally accompany his efforts and to give him the courage to attempt treatment on the most hopeless appearing cases, all for the sake of the occasional long-term arrest which he achieves.

There are two reasons for treating practically all cases that come to one's attention. The first one is that there are no good criteria by which one may judge probable success or failure in any given case. The histology helps one only in determining whether the tumor is an epithelioma or a lymphosarcoma, in which case the patient is suitable for radiation treatment, or whether it is a fibrosarcoma or some other type of connective tissue tumor. These latter tumors are highly radioresistant and will seldom respond even to the extent of temporary palliation. Once the diagnosis of an epithelial tumor has been definitely established, one has no right to state that that particular tumor is radioresistant. On a statistical basis, radiosensitivity does vary in inverse proportion to the degree of differentiation, that is, the less differentiated the tumor, the more likely it is to be a radiosensitive tumor. But when one is considering the individual case, he must disregard statistical probabilities. Also, one must not confuse radiosensitivity and radio-curability.

A highly differentiated tumor may require somewhat higher radiation dosage, but because of its low malignancy it invades slowly, does not metastasize, and allows the radiotherapist time in which to administer a cancerocidal dose. An extremely undifferentiated tumor, on the

other hand, may melt away over night in one area but will invade and metastasize outside of the field while the radiation is being administered. It is also true that extensive bone destruction nearly always spells defeat for the therapist. But again this is not always true. Here we meet the second reason for giving all of these patients a chance. That is the matter of palliation.

If one accepts ten-year arrests of disease as the sole criterion for treatment, he must conclude that any therapy at all is rarely, if ever, of value. No case series presented to date has showed even a five-year salvage rate of better than 20 per cent. But this is not the whole story. As you all know, the great majority of these patients come to your attention only when increasingly severe symptoms have begun to make them miserable. Left untreated, the history of these patients from there on out is one of increasing misery. Their duration of life varies from six months to two and one-half years. Now let it be granted that we do not cure more than one out of ten of these patients. Let it be further granted that we do not even prolong their lives. Still, if we can even render them relatively symptom-free for periods of six months to one year, if we can maintain or restore them to a state of comfort and efficiency for twelve out of the eighteen months of life that are left them, I say that almost any measures are worth while.

The technical aspect of the treatment of these patients is not simple. The radiotherapist must have at hand as complete knowledge as he can possibly obtain concerning the location and extent of the primary lesion, its extensions and its metastases. He must then proceed to outline the portals through which he is going to treat and calculate the percentage depth dosage which he may expect to obtain from each of these fields. Measures must be taken to protect the eyes whenever this is at all possible. The fields used

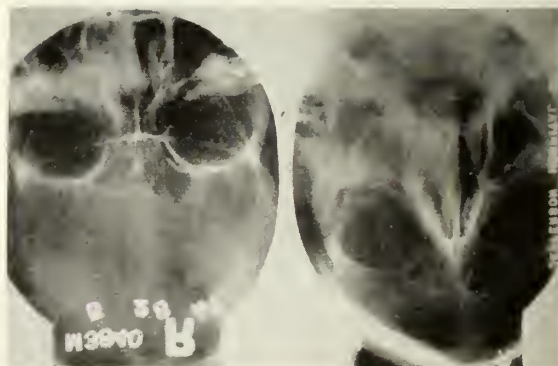


Fig. 3, Case 3. Roentgen illustration of carcinoma of the left nasal chamber.

in the treatment of these lesions are usually small, and the tumors are generally located deep inside the skull. This means that the angle of the central beam must be carefully calculated and exactly reproduced in the daily treatments. The reaction of the patient's skin and mucous membranes must be watched from day to day. Many of these patients suffer extremely from the dryness and irritation of the mucous membranes caused by the radiation. Hospitalization and the combined efforts of the otolaryngologist and the radiotherapist on symptomatic and supportive measures are often necessary. All of this means that the radiotherapist himself and not just his technician must supervise and treat these patients.

Any treatment to be effective must be intensive. Again, no one can say with any accuracy what is an adequate dose. About all we can say is that probably at least 5000 tissue roentgens are necessary to control the average tumor. Not all tumors require this dosage, while some require more. Not all patients can tolerate this dosage. The time element is also important, for even a dosage of 7000 or 8000 r will be ineffective if the treatments are given only once or twice a week and protracted over a period of many months. On the contrary, a dosage of only 2000 r into the tumor may be necrotizing to normal tissue if administered in a few days.

A few slides may illustrate what will occasionally be accomplished and the severity of the reactions necessary. The first slide shows a patient who had a squamous cell carcinoma of the floor of the nostril. The presenting portion of the tumor appears quite small, but actually it penetrated through to the mucous membrane of the lip and backward for at least a centimeter along the floor of the nose. Treatment was started in January, 1946. When last seen in March, 1948, the patient was apparently free of disease. The next slide shows a patient with carcinoma of the antrum and the picture simply illustrates the degree of the skin reaction which was produced. The next slide illustrates the appearance of a case of carcinoma of the antrum which had invaded the orbit and displaced the eye. Obviously, in a situation such as this it was impossible to protect the eye. This patient remained at work and living in relative comfort for a period of one year.

ABSTRACT OF DISCUSSION

JOHN O'KEEFE (Philadelphia): Delay in diagnosis is certainly the one responsible factor accountable for the high mortality rates in cancer, no matter of what part of the body. Especially in regions of the body not in direct view and inadequately accessible to thorough ex-

amination and silent in many respects, this delay, in part, is obviously a factor beyond human control. Delay, as such, is either the fault of the patient or the fault of the physician. Too often, of course, in being the fault of the patient, we can do little in our efforts to effect cure. However, the more pertinent factor is delay due to physician procrastination. In this respect there is but one thought that strikes me as being worthy of emphasis, and that is the virtue and value of thorough examination—even repeated thorough examinations.

In a recent survey of the cases of malignancy of the nose and sinuses at the Philadelphia General Hospital, we have been amazed to note the varying lengths of time that these patients have been treated by physicians before the thought of cancer was entertained. It has also been a shocking revelation to find patients ultimately referred to us by physicians reputedly capable of doing an adequate examination, but in which patients an attempt to make a diagnosis was deferred until evidence of regional metastasis had occurred.

If anything, then, the tenure of this meeting should be a plea to you, first, to always and forever be consciously aware of the possibility of cancer of the nose and sinuses and, second, to give your patients the benefit of a thorough otolaryngologic examination.

Concerning the treatment of diagnosed cancer of the nasal fossa and sinuses, it is true that many patients are initially referred to the roentgen therapist for irradiation, but this is because of two facts. One which we accept as legitimate is that epidermoid carcinomas, as a rule, are radiosensitive and tend to metastasize late. These two factors make irradiation the primary choice of therapy. In other types of malignancy, if still within the confines of a sinus, uncomplicated by regional metastases or by bone destruction, the burden of treatment rests on surgical intervention. Electrosurgery allows for wide excision and has been a major advance in the technique of sinus surgery in recent years. The paper by Drs. Smith and Eberhard illustrated and adequately emphasized these facts. They are to be congratulated on their presentation and for having brought it to our attention at this very appropriate time.

ISAAC S. TASSMAN (Philadelphia): The importance of this subject is and should be recognized by the ophthalmologists and those who are interested in ophthalmology.

During the past three years I have had the opportunity to observe and study at least four cases in which the diagnosis was proved to be malignancy in the sinuses with ocular complications in the advanced stage.

Strangely enough, at least three of these cases did not come under observation until the ocular complication was obvious. In all of these cases there was extension of the process from the sinuses to the posterior wall of the orbit, involving the apex of the orbit and the structures passing through the sphenoidal fissure and along the posterior apex of the orbit, and involving also the optic nerve as it enters the optic canal. This we recognize as the orbital apex sphenoid fissure syndrome which, I feel, can be abbreviated to the "S-O" syndrome—the sphenoidal fissure and the optic canal syndrome.

In this syndrome the third, fourth, fifth, and sixth nerves are involved as they pass through or enter the sphenoidal fissure and, by further extension along the posterior wall of the orbit, the optic canal becomes involved, with subsequent involvement of the optic nerve and accompanying visual disturbance.

Perhaps one of the earliest signs in these cases is a sudden ptosis of the eyelid on either one or both sides,

then ophthalmoplegia, with limitation of rotation of the eyeballs, depending upon whether the third, fourth, or sixth, or all of these nerves are involved.

I have slides of two of these cases which show only the external appearance. In both of these, the patients did not come under observation until the ocular signs were obvious.

In the first case the ocular condition was preceded by recurrent attacks of epistaxis, and the diagnosis was that of carcinoma of the nasal accessory sinuses, presumably primary, in the sphenoid sinus, which I understand is rare. The ptosis was more marked on the right side in this 58-year-old woman, who has since passed on, and there was limitation of rotation, particularly on the right side. The eye was fixed. She had several attacks of epistaxis before the onset of ptosis. She was

admitted to the hospital for vascular hypertension and headaches. There was no knowledge of any sinus pathology prior to that time. The diagnosis was confirmed by an autopsy and in the laboratory.

In the second case also the ptosis was rather marked and there was limitation of rotation. In both of these cases the third, fourth, and sixth nerves and part of the fifth, as evidenced by corneal anesthesia, were involved.

The last case, which is still under observation (the first three patients having passed away), was caused by a growth in the nasopharynx and the patient had shown considerable improvement the last time he was seen. Although I recognize that this is perhaps a late complication and that the pathologic process is rather far advanced, nevertheless, these cases come under observation because ocular complications are prominent.

MEDICAL RESERVE CORPS OFFICERS GET QUESTIONNAIRES

A survey among reserve officers of the Army Medical, Dental, and Veterinary Corps is being taken by means of a questionnaire, it was announced May 20 by Major General R. W. Bliss, the Surgeon General of the Army. The purpose of the survey is to determine the availability of these officers for short periods of duty ranging from one to twenty-nine days a month and for longer duty tours of varying lengths.

The questionnaire is simple in form and requires not more than a few minutes to fill out. Accompanying the questionnaires will be a letter of instruction containing all necessary information. The questionnaires and letters of instruction will be forwarded to the reserve officers by the state senior instructors. Return of the completed questionnaire does not in any way pledge or obligate the reservist to a return to active duty.

The response to the questionnaires will determine the possibility of establishing the program and the number of physicians, dentists, and veterinarians who would be available for either the short or longer periods of duty to help relieve the Army's critical shortages of these professional categories occasioned by the imminent separation of approximately 2000 Medical Department officers trained under the Army Specialized Training Program.

The questionnaire is broken down into four plans, which would permit the reserve officer to enter active duty for periods of one day to three years. In brief, the plans are as follows:

Plan 1. Reserve officers may volunteer for periods of active duty of one or more days a week, to perform professional duties at neighboring Army or Air Force installations. The officer may serve in his present (terminal leave) rank, earn points toward retirement, and carry on his private practice without undue interference. The procedure of issuing orders, certification, and payment will be performed locally in order to avoid administrative delays and to permit the officer to devote full time to caring for patients. On a simple mathematical basis, under this plan, if 5000 reserve officers of the more than 21,000 in the country volunteered for only three days a month for a year, the man-hours con-

tributed would be equal to the full-time services of 600 physicians, dentists, and veterinarians.

Plan 2. An officer may enter active duty for periods of from one month to a year. This plan is limited to specialists subject to certain provisions, namely: (a) movement of dependents or household goods, or travel by private conveyance are not authorized; (b) officers volunteering for periods of at least six months will be permitted overseas assignments, but dependents may not accompany officer.

Plan 3. An officer may enter active duty from one to three years, and by doing so receive \$100 a month in addition to pay and allowances. Assignment, either in this country or abroad, will be made according to military requirements and the professional qualifications of the officer. Dependents and household goods may accompany officers.

Plan 4. An officer may enter active duty for one year at an Army or Air Force installation immediately adjacent to his home. He will not be moved during the year, and may continue as much of his private practice as does not interfere with his military duties. He will receive \$100 a month in addition to pay and allowances.

"The Army Medical Department is faced with an unparalleled peacetime emergency in carrying out medical requirements satisfactorily," General Bliss stated. "In time of military emergency, it is the reserve officer upon whom the great burden of effort and sacrifice has fallen. Today, we are again turning to reserve officers of the Medical Department for help."

"The truth is that medical care is only one factor in our quest for health. And it's by no means the most important one. Good health depends on many things—healthy parents, a stable society, a satisfactory job, a happy family, education, nutrition, housing, sanitation, soap and water, accident prevention, good judgment, good luck, and avoiding bad medicine. To a greater extent the doctor's role today remains what it was in Hippocrates' day—to comfort, reassure, and relieve the sick."—GREER WILLIAMS in *Better Homes and Gardens*.

Reduction of Mortality in Surgery of Aged

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THE problem of treatment of the ailments of the aged has in this present era been persistently and more vividly thrust upon the medical profession inasmuch as life expectancy has been so greatly increased. Life expectancy for a child born in 1900 was forty-eight years; in 1948 it is estimated to be sixty-eight years—a twenty year gain in a forty-eight year period. Certainly in the cross section of patients who present themselves for treatment the aged are steadily gaining in numerical strength. It is obvious that in this group surgical mortality at a higher than average level is to be anticipated. Measures that tend to reduce this anticipated mortality should be of interest to both general practitioner and surgeon. Therefore, a study has been undertaken to ascertain recent trends in mortality in an older age group—which has been under surgical treatment in the past six years—to determine the actual causes of death, in what fields surgical mortality seems to be located, and to seek out ways and means whereby the death rate from surgical procedures in the aged may be kept at a minimum.

While the term aged is necessarily vague and indefinite, inasmuch as many individuals age prematurely before sixty and many others show no detectable senile deterioration until well after seventy, for the purposes of this study all persons *sixty and over* who have come to surgery in the period examined have been included, notwithstanding potential protestations from those of us who have reached threescore years and feel far from the aged category.

This is also a series of patients from a single service, so that the element of variation in judgment or technique can be eliminated. Four hundred consecutive cases requiring surgery have been investigated. There were 26 deaths—an over-all postoperative mortality of 6.5 per cent. Inasmuch as the general postoperative mortality including all ages for these six years was 2.1 per cent, it is obvious that the aged group does provide and indicates statistically the age period of greatest mortality.

TABLE I

POSTOPERATIVE MORTALITY

Age	No. of Cases	Deaths
60 and over (special group)	400	26 (6.5%)
All ages	17,539	368 (2.1%)

An analysis of the operations performed on this group of 400 aged shows that they fall largely into 16 categories as summarized in Table II.

Surgery of the aged may be classified as emergency or elective operations.

Emergency Operations

In this series there were 55 emergency operations including 25 operations for acute suppurative or gangrenous cholecystitis (none of which were immediate operations) with 9 deaths—a mortality rate of 16.4 per cent.

LESIONS REQUIRING EMERGENCY OPERATION

	Cases	Deaths
Acute appendicitis	11	1
Strangulated hernia	12	1
Acute intestinal obstruction secondary to carcinoma of the colon	5	2
Perforation of carcinoma of peptic ulcer	2	1
Suppurative cholecystitis with or without perforation	25	4
	55	9

CAUSES OF DEATH

Disease	Cause of Death
Appendicitis	Sepsis—lobar pneumonia—infarct
Strangulated hernia	Operation over 24 hours after acute onset—gangrene of intestine—peritonitis—uremia
Peptic ulcer with perforation	Acute pulmonary collapse (pneumothorax)—anesthetic ?
Suppurative cholecystitis	Admission to hospital late in disease — uremia — rupture — abscess—cardiovascular disease
Intestinal obstruction in carcinoma of colon	Coronary occlusion — auricular fibrillation

COMMENT: The preventable deaths would seem to be those in which earlier operation ought to have been done or there should have been earlier recognition of the lesion causing the acute complication, and operation performed before the

Read before the Section on Surgery at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 6, 1948.

TABLE II

	<i>Total Cases</i>		<i>Deaths (Cause)</i>	
1. Gastric surgery	28			
Gastric resection (subtotal)	20		1	(pulmonary tuberculosis)*
Gastro-enterostomy	4			
Total gastrectomy	1		1	(peritonitis)*
Closure of perforated ulcer or carcinoma	2		1	(acute pulmonary collapse)*
Gastrostomy	1			
2. Appendectomy	29			
Acute suppurative	9		1	(abscess, lobar pneumonia, pulmonary embolus ?)
Abscess	2			
3. Hernia	30			
Femoral	6			
Inguinal	20		1	(late strangulation, over 24 hr., intestinal gangrene) peritonitis*
Ventral	4			
Strangulated (12)				
Resection (6)				
4. Uterine prolapse	20	0		
Vaginal hysterectomy	7			
Watkins-Wertheim operation	6			
Anterior and posterior vaginal repair ..	7			
5. Breast resection	31	0		
Radical	18			
Simple	13			
6. Amputation of thigh (supracondylar)	14	3	(1) coronary occlusion—EKG	
			(2) cerebral embolism*	
			(3) diabetes and carbuncle with sepsis	
7. Surgery of bladder	29	2	(1) uremia and cerebral hemorrhage*	
Suprapubic prostatectomy	26		(2) acute fibrinous pericarditis and pulmonary tuberculosis*	
Excision of papilloma	1			
Total cystectomy	1			
Suprapubic cystostomy	1			
8. Surgery of colon and rectum	34			
Palliative	5			
Cecostomy	1			
Colostomy	4		2	(1) coronary occlusion
Radical resection	27			(2) auricular fibrillation, myocardial infarct*
Anterior resection of sigmoid ...	10		2	(1) lobar pneumonia*
Resection of right half of colon ..	7			(2) uremia, hepatic insufficiency*
Perineal resection of abdomen ..	8			
Post-resection of rectum	2			
Release of volvulus or adhesions of sigmoid	2			
9. Abdominal hysterectomy	7	0		
10. Minor rectal operations	12	0		
Excision of anal fistula	4			
Drainage of ischiorectal abscess	1			
Hemorrhoidectomy	5			
Excision of rectal prolapse	2			
11. Open reduction	3	0		
Fracture of femur				
12. Cholecystectomy	53	76	4	(1) uremia
+ Choledochostomy	23			(2) cerebral embolism*
(acute suppurative or gangrenous 25)				(3) coronary occlusion
				(4) peritonitis
13. Renal operations	6	0		
Nephrectomy	4			
Nephrolithotomy	1			
Bilateral nephrostomy	1			
14. Thyroidectomy	6	1	(coronary occlusion—EKG)	

* Autopsy.

	Total Cases		Deaths (Cause)
15. Exploratory laparotomy (inoperable carcinoma)	16	5	(four, advanced carcinoma)* (one, pulmonary embolus)*
16. Miscellaneous (consisting largely of)	62	2	(1) coronary occlusion (2) uremia
Excision of superficial tumors	16		
Insertion of radium or radon seeds in uterine or advanced cancer	10		
Block dissection of neck	4		
Vein ligations	4		
Embolectomy	1	5	
Death occurred following:			
Excision of carbuncle and advanced diabetes			1—coronary occlusion
Insertion of Kirschner wire in fracture of femur.....			1—uremia

terminal phase of the disease. In one the choice of anesthetic might have been a factor in the fatality; in another the choice of operation—cholecystectomy instead of cholecystostomy—might have been responsible.

In emergency surgery in the aged, Cutler has advocated:

1. The utilization of every quick available measure for support.
2. Operation with least delay.
3. Operation with minimum trauma in the shortest possible time and use of the simplest procedure to relieve the emergency.
4. Employment of every means to safeguard against postoperative complications.

Elective Operations

There were 345 elective operations with 17 deaths—a mortality rate of 5 per cent. They were performed largely for: carcinoma of the stomach, colon, breast, and rectum, peptic ulcer, appendicitis, hernia, uterine prolapse, diabetic and arteriosclerotic amputations, prostatectomy, gallbladder disease, hysterectomy, and fracture of the neck of the femur.

The causes of death in this group were: pulmonary embolus, lobar pneumonia with pulmonary infarct, hepatic insufficiency, cerebral thrombosis or hemorrhage, uremia, coronary occlusion, pulmonary tuberculosis, diabetes with sepsis, multiple metastases of carcinoma, and cirrhosis of the liver. These may be summarized as: (1) advanced carcinoma, (2) vascular accidents, (3) renal and hepatic insufficiency, (4) pulmonary lesions, and (5) emboli.

The preventable causes of death were: (1) pulmonary embolism, (2) results of operation late in disease, and (3) uremia and hepatic insufficiency.

COMMENT: While two fatalities from pulmonary embolism in 400 cases may seem minimal,

nevertheless they must be considered preventable deaths. Measures for their prevention will be discussed later.

Delay in operation in the aged can be viewed as a threefold problem—delay on the part of the patient, the family physician, or the surgeon. The viewpoint of all three must be altered by the fact that delay in operation, particularly in acute disease in the aged, will be attended by higher mortality than in a similar group of younger people. In the presence of an acute surgical emergency early operation is particularly imperative in the aged. The reluctance of patients in the older age groups to consent to operations must be overcome. That mortality lies not so much in the operation when indicated but in unnecessary delay before the operation, must be stressed. Finally, the tendency to regard most complaints of the aged as functional, customary to old age, and to be treated symptomatically without thorough investigation must be abandoned. The approach to this geriatric problem should be that any complaint in the aged demands thorough evaluation by repeated physical examination or by adequate diagnostic survey before definitive treatment is begun.

Acute cardiovascular accidents and attempts to afford palliation or perhaps cure in the patient with advanced cancer would seem to be legitimate causes of postoperative deaths, but mortality should be kept at a minimum by careful and complete preoperative study of the patient, adequate preparation of patient for operation, and avoidance of too long or prolonged bed rest.

Mortality from renal and hepatic insufficiency presents a challenging problem. If preoperative tests of function indicate deficiency, the need for appropriate preoperative treatment is revealed, but the cases in which preoperative tests for function are within normal limits and acute postoperative deficiency supervenes must give us pause. It is conceivable that many older people have little renal or hepatic reserve and with their

* Autopsy.

customary daily routine can maintain normal function, and tests for function will be approximately normal, but that any acute change or deviation from normal requirements, such as result from acute trauma or operative procedures, may throw them into acute deficiency in large part irreversible. Nevertheless, the problem of post operative renal and hepatic deficiency seems a fruitful field for further investigation, and particularly search for more efficacious remedies for prophylaxis and therapy than those at our present command.

The work of Fine, Collier, and others is leading the advance toward solution of this problem.

The causes of death found in this series follow quite closely those reported by Cutler, Carp, Quigley, Brooks, Rankin, and Beck. However, Cutler, Carp, and Brooks report a high incidence of fatal postoperative pneumonia in their patients and urge careful guarding of the aged against exposure to respiratory infection.

Therapeutic Plan for Reduction of Postoperative Mortality

While study of end results in surgery of the aged will indicate specific opportunities for reduction of mortality, the over-all handling of the aged patient for surgery offers another field whereby fatalities following operation may be kept at a minimum. A therapeutic plan for reduction of postoperative mortality in the aged may be outlined as follows:

Preoperative Care

EMERGENCY CASES

Careful Evaluation of Acute Abdominal Symptoms. It is well known that in the aged there may be a lack of characteristic symptoms and abdominal findings in acute disease (Cutler and Brooks) with a perfectly atypical white blood count, although the differential estimate may show a relatively high number of juveniles. There must therefore be a careful evaluation of history and abdominal findings, pulse rate, and urinary and blood studies if the disaster of delay in operation is to be avoided and the indication for operation accurately estimated. Repeated examination at short intervals in doubtful cases will be helpful.

Emergency Diagnostic X-ray of Abdomen and Thorax. A flat plate of the abdomen to visualize a pneumoperitoneum or the location of intestinal gas is invaluable when gastro-intestinal rupture, perforation, or acute intestinal obstruction is suspected.

Negative findings, however, *in no way* eliminate either the possibility of perforation or obstruction. Positive findings only are of value. Delay for x-ray should never be considered when indications for operation are clear. X-ray of chest will be helpful in revealing pulmonary or cardiovascular pathology which may influence both diagnosis or choice of anesthetic.

Early Operation. While immediate operation may occasionally be undertaken safely in the aged, an hour or two for appropriate preoperative intravenous therapy and check of bladder and cardiac function is frequently preferable and may be life-saving. Early operation *and operation definitely early* should be the customary plan of campaign.

ELECTIVE CASES

Thorough Preoperative Study and Preparation for Operation. If there is any group in which thorough preoperative study is indicated, it is in the aged. The diagnostic survey must be complete—not only of the specific complaint but of the entire patient. It should include:

Cardiovascular estimate — daily blood pressure check and electrocardiogram—chest x-ray—extent of previous physical activity.

Nutrition and alimentary tract study—evidence of avitaminosis, dehydration, x-ray, and gastric analysis when indicated (anorexia).

Blood chemistry studies, blood sugar, urea, protein, calcium, etc.

Bladder and urinary tract function—bladder retention, prostatic disease.

Liver function.

Pulmonary survey—pulmonary tuberculosis, unsuspected disease—carcinoma.

The aged may have more than one active disease. Priority for treatment must be determined.

Correct Remedial Defects:

Hypoproteinemia.

Avitaminosis.

Dehydration—hypocalcemia (Bortz).

Cardiac function—auricular fibrillation.

Liver and renal deficiency.

Bladder retention—permanent catheter.

Anemia—restore blood volume.

In the aged there may so often be an unrecognized or long-standing depletion of blood volume, protein or calcium. Preoperative restoration of

blood volume is especially essential. The use of preoperative antibiotics is exceedingly valuable. Group study and consultation of experts in cardiovascular, pulmonary, gastro-intestinal, and renal care are particularly to be recommended. Time for operation must await as complete restoration to normal as possible, but as Thewlis advises, "restoration should be to the patient's normal state of maturity—and not attempt to re-establish his *pre-senile* state of normalcy."

Choice of Patient for Operation. Wangenstein believes that a well-prepared older patient tolerates operation well, and Rowntree states that those who have attained to "a great age are good lives and take a lot of killing, at any rate if it is done gently." However, frail old people need careful evaluation for surgery. Wilson and Claggett believe that the feeble and soft-skinned, with little pulses, bad appetites, and weak digestive powers tolerate extensive surgery badly. The important essentials that Bancroft stresses are estimation of cardiac reserve, ability to take an anesthetic, and just what surgery can accomplish in the weak and frail. Nicety of surgical judgment is put to the test in deciding upon just what surgery is indicated and how much can be tolerated in each individual case.

Operation:

- Carefully chosen anesthetic—cyclopropane, spinal, pentothal, etc., refrigeration.
- Gentle handling of tissues—minimal trauma.
- Prevent blood loss by:
 - Careful hemostasis.
 - Transfusion (plasma) to maintain blood volume.
- Proper choice of operation (what patient can stand).
- Careful closure of wound with through-and-through sutures of non-absorbable cotton, silk, or wire.

Postoperative Care

It is far better to plan to avoid postoperative complications by prophylaxis as far as possible or correct abnormalities in the stage of early deviation from normal than to await onset of a definite symptom complex before therapy. Therefore, the patient should be followed very closely in his postoperative course.

Prophylaxis

1. At operation, avoid shock and infection by careful technique, ample blood replacement, and intravenous therapy.
2. Postoperative continuation of preoperative

supplementary intravenous therapy—glucose, protein, blood, plasma.

3. Adequate but not excessive sedation.
4. Early ambulation should not be a rigid procedure: while most patients may be out of bed in forty-eight hours and encouraged to walk, each patient must be considered an individual problem and the time interval before ambulation varied accordingly. Patients should be encouraged to move immediately postoperatively, to sit on side of bed, and to get up when erect position can be tolerated.

The important contraindications to early ambulation are: (1) heart lesions, such as auricular fibrillation or heart block; (2) shock; (3) infection—peritonitis, etc.; (4) toxic goiter requiring bed rest.

5. Phlebitis—phlebothrombosis — pulmonary embolism.

Early movement in bed—keep restless, no fixed position.

Deep breathing exercises at regular intervals.

Extremity exercises.

Avoid all tight binders or dressings.

Get out of bed to void, if necessary.

Bandage (elastic) all extremities with varicose veins.

Ample fluid intake.

6. Antibiotics.

The parenteral use of penicillin or streptomycin or both, especially for forty-eight to seventy-two hours postoperatively and particularly following pulmonary, gastro-intestinal, or urinary tract operations, is to be recommended. Sulfonamides at times may be indicated.

Psychotherapy

An aged patient not uncommonly has a preconceived conviction that it is difficult for a person of advanced years to recover from an operation. From the very outset, therefore, the patient behind the disease must be treated every day and in every way; indirect methods are far more effective than direct. The fact that stress is laid by the operator himself upon voluntary movement in bed, active bed régime, early ambulation, and participation of the patient in the treatment, is the very greatest stimulus toward the patient's optimistic outlook toward recovery. Focusing attention upon the signs of improvement is likewise helpful. The patient must be surrounded by an optimistic atmosphere (Cutler, and Brooks).

Maintenance of Nutritional Requirements

While intravenous therapy is invaluable in maintaining adequate food and vitamin intake in the early postoperative period, normal feeding by mouth should begin as soon as possible following operation. Anorexia should be corrected promptly. Adding food particularly craved to the menu, the use of insulin, or dilute hydrochloric acid when indicated, ample vitamin intake, correction of hypoproteinemia, and exercise all may be helpful. Many older people have been living at too low a calcium, protein, or vitamin level; they particularly require and easily tolerate large quantities of vitamin well beyond what is considered normal, particularly vitamins B and C.

Results

In essence this is the régime and therapeutic plan that we have been employing, particularly in the past three years. Comparative mortality by years of our series of 400 cases would seem to lend support to its potentialities.

COMPARATIVE MORTALITY BY YEARS

Years	No. of Cases	No. of Deaths
1943	49	6
1944	73	7
1945	82	8
1946	62	2
1947	67	1
*1948	67	2
	400	26

POSTOPERATIVE MORTALITY

Years	No. of Cases	Deaths	Mortality Per Cent
1943-1945	204	21	10
1946-1948 (therapeutic plan) ..	196	5	2.55

Summary

A review of 400 operations performed on individuals over sixty indicated that these represented a rather broad cross section of surgical procedures, but largely comprised gastric, gall-bladder, colon and rectum, genito-urinary tract, breast, hernia, amputation, open reduction of fracture of femur, and exploratory operations. These could be divided into (1) emergency and (2) elective procedures.

After 55 emergency operations there were 9 deaths—a postoperative mortality of 16.4 per cent, to which apparently delay in consent to operation by patient and delay in diagnosis of acute emergency largely contributed. Uremia or coronary occlusion accounted for three.

Following 345 elective procedures, there were

17 deaths—a postoperative mortality of 5 per cent. The causes of death were largely cardiovascular accidents, uremia, cirrhosis of liver or hepatic insufficiency, advanced carcinoma, and pulmonary embolism.

The preventable deaths might be considered as those due to pulmonary embolism, hepatic and renal insufficiency, and advanced carcinoma. One pulmonary embolism occurred in a case of advanced carcinoma in which full prophylactic measures were difficult to maintain. Deaths from advanced carcinoma of the gastro-intestinal tract might have been prevented by diagnosis and treatment earlier in the disease. The problem of postoperative renal and hepatic insufficiency has been discussed.

A therapeutic plan for reduction of mortality in the aged has been outlined.

Conclusions

1. A higher postoperative mortality in the aged than in people of younger years is to be anticipated. In a series of 400 aged a mortality of 6.5 per cent is reported in contrast to 2.1 per cent at all ages in the same time interval.

2. Postoperative mortality is particularly high in emergency surgery (16.4 per cent) as contrasted with elective surgery (5 per cent).

3. Delay in operation due largely to delay in diagnosis of an acute emergency and delay in consent of patient to operation is a major contributory cause of high mortality in emergency surgery.

4. Early operation in emergency surgery in the aged and proper choice of operation should reduce the extraordinarily high statistical mortality rate.

5. In elective surgery, cardiovascular accidents, advanced cancer, and hepatic and renal insufficiency were found to be the major contributions to postoperative mortality; pulmonary embolus was a factor in two cases.

6. Earlier diagnosis and recognition of gastric and colon cancer in the early stages and better measures to avoid and treat hepatic and renal insufficiency in the aged should aid in reduction of postoperative mortality.

7. Early ambulation and measures to prevent phlebothrombosis and thrombophlebitis play an especially important role in postoperative therapy in the aged and serve to keep pulmonary embolism at a low incidence.

8. A therapeutic plan for reduction of postoperative mortality in the aged and its maintenance at a minimum has been outlined.

9. With a meticulously executed and suffi-

* Fiscal year ends June 1.

ciently comprehensive therapeutic plan, elective surgery in the aged may be performed with a reasonably low postoperative mortality rate.

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ABSTRACT OF DISCUSSION

LEWIS K. FERGUSON (Philadelphia): I have nothing but congratulations for Dr. Estes for his wonderful results in this group of patients. I think that his figures and statistics show what can be done in a group of over-age patients who have been thoroughly studied and well operated upon. Surgery of the aged is really the major surgery that we have to do. It is the surgery of cancer, the old ulcer, the old gallbladder, and the various vascular accidents that occur, especially in the extremities. These patients, who are frequently under par physically, demand the utmost in preparation, and I think the advances that have been made in surgery of the aged can be placed in three categories:

First is improvement in the preparation of these patients. Before we knew anything about blood proteins and blood volume, these patients came to operation without adequate preparation, as we know it today. With replacement of protein that is lost or deficient, with treatment of avitaminosis, and with replacement of blood volume, these patients come to operation in a relatively good state.

The second thing that has improved our results—more than anything else probably—is the excellent anesthesia now being provided by professional anesthetists. For years the men who have worked in large clinics, with an excellently set-up professional anesthesia department, have been able to accomplish a great deal more than we who have worked with no anesthetist. As the late war

proved, adequate professional anesthesia takes away from the surgeon the burden of attempting to choose an anesthetic and of watching the anesthesia and the patient while he is operating. There is no doubt that a professional anesthetist gives both the patient and the surgeon a better break.

I don't believe that we, as surgeons, are much better than our predecessors. However, we may have acquired some skill and knowledge that permit us to perform operations more rapidly, and perhaps more skillfully. I think the improvement is in the fact that we can work easily, comfortably, and rapidly. It is important to get these older patients on and off the table as rapidly as possible. They can stand a four- or five-hour operation, but they don't stand it well. A one- or two-hour operation is much better. I don't mean that we have to slip over things that should be done, but the more rapidly the patient is cared for, the better chance he has for a smooth recovery.

The third factor that is extremely important in the excellent results that can be obtained in the older age group is the postoperative care. I like to think of their convalescence as a continuation of life and the operation as simply an incident in their lives. In other words, they can go back to as normal a diet as is possible with the operation that they have had, and they can again be up and about almost as they did before the operation.

Many of these patients are out of bed the day after operation, some of them even the day of operation, and with no more restriction than is necessary. They should be watched so that they do not become overtired, but the sooner they can be about, the more smooth their convalescence, the less morphine needed, the less enemas, and the less danger there is of pulmonary and vascular complications.

I have a personal liking for wire suture material in these wounds because I feel more secure about allowing these patients up and about early. However, I am sure that many of you have the same feeling in regard to the use of cotton, silk, or even catgut. My experience has been that there is much less reaction in the wound with wire.

One other thing that I consider important in the care of the older age group is the addition of the antibiotics and sulfa drugs to our armamentarium. Before we had these drugs, a slight reaction in a wound or about a gastric resection occurred often enough to give these patients vascular difficulties, and I feel certain that such a reaction, for instance, in the pelvis, following an abdominal peritoneal resection was often the cause of phlebotic complications in the leg. As time has gone on, we have learned to use these drugs prophylactically as well as therapeutically, and there is therefore a reduction in the incidence of reactions that occur locally as well as of phlebotic complications.



Contrasting Methods in the Management of Uterine Malignancy

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THE purpose of this presentation is to consider, in a relatively generalized way, the contrast that exists in the management of the two outstanding types of uterine malignancy, viz., carcinoma of the cervix and carcinoma of the fundus or corpus. To do this with clarity requires some discussion of essential etiologic and pathologic factors pertinent to each of these lesions, but such reference must, understandingly, be greatly limited in scope in an article of this sort. The results of any treatment in vogue reflect the ever-present necessity of early detection and diagnosis, so that phase should be stressed more completely. Since many of the observations presented are based on personal experiences encountered in the Uterine Cancer Clinic of the Division of Gynecology, Department of Obstetrics and Gynecology, at Jefferson Medical College and Hospital, a summary of the results noted and a résumé of the methods used are in order, together with appropriate reference to the achievements of colleagues elsewhere—achievements that have been productive of a broadened horizon of provocative and controversial thought with respect to management.

Contrasting Concepts in Etiology, Pathology, and Symptomatology

Carcinoma of the uterine cervix is actually and relatively the commoner lesion. It occurs much less frequently in nulliparous women, and nearly one-third of the cases observed by us occurred in women 40 years of age or younger. It is occasionally symptomless, but generally abnormal vaginal bleeding or "spotting," often induced by local trauma, is admitted by the patient when a searching history is taken. What initiates the abnormal cell growth is still the unsolved etiologic riddle of malignancy anywhere, and it would be purposeless in this type of paper to pursue further the academic questions involved.

Of far more importance are the significant pathologic and clinical leads by which the gynecologist can chart his course of action. We do know that the first microscopic evidence of cancer is in the "transitional zone"—at the squamo-columnar junction of the external os—and that unquestioned invasion only becomes evident when the atypical growth has broken through the basement membrane in its extension toward the cervical glands, the epithelial surface, or elsewhere in the cervical stroma. While non-invasive carcinoma has certainly been demonstrated by numerous observers, the controversial fact remains as to whether or not the process is initiated by hyperactivity in the basal cell layer and whether or not actual invasion must necessarily follow. TeLinde and Galvin¹ seem to have shown that this can happen. On the other hand, as emphasized by Martzloff² and others, it is difficult to predict with certainty that such a non-invasive area will necessarily go on to the fulfillment of a malignant career even though such instances have been so reported by TeLinde and Galvin.³

An important fact to be borne in mind is that apparently "carcinoma in situ"—non-invasive cancer—can remain dormant for a long period of time. Hence it is difficult to prove, except by long-time observation and avoidance of radical treatment, whether regression, too, can occur, and whether or not the primary cervical biopsy or amputation may not have completely eradicated the malignancy. The situation that has arisen with respect to "carcinoma in situ" has placed a tremendous responsibility upon the pathologist in making the diagnosis, as well as upon the gynecologist whose decision as to proper therapy for his patient is an even more critical one to make. Squamous cell carcinoma of the portio is far more common, of course, than adenocarcinoma of the cervical canal.

Invasive carcinoma follows a pattern of dissemination that is well known to all of us. The local lesion is obvious, though variable in char-

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acter and extent; parametrial induration does not always represent extending malignant tissue, but may be merely an inflammatory reaction. The factors of regional lymph node involvement and of remote metastases are difficult to evaluate. Probably 40 to 50 per cent of nodal metastasis occurs, not necessarily in direct relationship to the appearance of the cervical growth itself, but governed perhaps by the aggressiveness of the cancer strain on the one hand and the fortitude of the host on the other. It is this imponderable characteristic that tends to make therapeutic predictions so unsound.

Regardless of the various theories entertained as to the cause of cervical cancer, we are all aware that a lacerated, everted, and eroded cervix is a menace and that a normally appearing cervix seldom becomes malignant. For these reasons alone our strategy should be plain—judicious care of the abnormal cervix, based on the need revealed by periodic pelvic examinations.

Carcinoma of the uterine fundus or corpus is encountered much less frequently than cervical cancer, the ratio varying from 8 to 2 to 7 to 3. It is comparatively rare before the age of 40, about one-third of the victims have never been pregnant, and it is most commonly observed in post-menopausal women. This latter fact perhaps gives rise to the striking impression that there is a "corpus cancer type"—the relatively obese person, sometimes diabetic, frequently hypertensive, but not unusually in good general health and without evidence of anemia or serious cardiorenal disease. Either frequent and/or profuse bleeding in the pre-menopausal patient or post-menopausal "spotting" in the older woman is practically always present. The cervix is usually intact; concomitant fibroids are often found, to the extent of 25 to 40 per cent.

From the etiologic standpoint, certain controversial views have arisen since the earlier concepts of deficient uterine drainage and the presence of fibroids were advanced as provocative factors. The acceptance of endometrial hyperplasia as a direct precursor of adenocarcinoma has certain loopholes. The possibility of direct and unopposed estrogenic stimulation, not necessarily of ovarian origin, with resultant metaplastic change in the endometrium progressing to malignancy, is worthy of continued investigation. Such a thesis is strengthened by the confusing endometrial patterns observed that render differentiation between bizarre hyperplasia, papillary adenoma malignum, and adenoma malignum so difficult.

Fortunately, carcinoma of the fundus tends to remain localized for awhile in the endometrium; infiltration of the myometrium is delayed for a considerable time, and this is particularly true of the lesions of low-grade malignancy (Grades I and II). Metastases are usually late. Sometimes it is even difficult to distinguish the site of primary growth when similar lesions are present in the ovary and the uterus. Lesions of high-grade malignancy offer the poorest prognosis. The picture of adeno-acanthoma is relatively rare; the metaplastic picture presented is often difficult of evaluation. It is also puzzling at times to differentiate between an adenocarcinoma of the cervical canal and a down-growth of similar nature from the endometrium.

Contrasting Diagnostic Problems

As previously stated, the most successful management of uterine malignancy depends upon early diagnosis and prompt treatment. Both the public and the profession have been made aware of the consequences of delay, for which both the patient and the physician share responsibility. Significant symptoms are rarely absent, but still the delay period seems to thrive. Women hesitate to report abnormal bleeding and peculiar discharge, not only because of indifference or unwise advice but perhaps by virtue of a desire to shun the truth. On the other hand, the physician too often is not alive to his responsibility. Thorough examination is neglected or postponed, the suspicious lesion is treated locally or, as is so often the case today, injudicious endocrine therapy is relied upon to relieve irregular bleeding, without even making a pelvic examination.⁴ Again, early consultation or referral to a hospital is either avoided or not insisted upon.

That the profession is aware of its own delinquencies is apparent if one will only take time to read the pronouncements of organized medicine at all levels. In addition to this is the magnificent propaganda of the American Cancer Society and its various divisions. The medical schools and public health groups—local, state, and national—fit into this educational scheme and willingly cooperate with the various state cancer commissions. The upshot of this activity has been the organization of cancer detection and cancer prevention clinics, for in view of the negativism exhibited on the part of some patients and physicians, it has been recognized that the answer to early diagnosis lies in periodic pelvic checkups. At these sessions, other physical abnormalities may be noted as well. I would at this time and in this connection like to comment enthusiastically upon the work of the Committee for the Study

of Pelvic Cancer, organized in Philadelphia for the purpose of educating the general practitioner, and the specialist as well, in the practical aspects of the delay problem. It would certainly seem that the general practitioner should take his rightful place in making indicated and periodic internal surveys. If he feels that he cannot equip himself to do this, then he should certainly give his patient the benefit of proper reference for such service.

The abnormal cervix should be treated whether symptoms are present or not. The benefits of routine cauterization for eversion and erosion are well known, and excellent reports on this procedure have appeared in the literature from time to time. The problem of necessity is to know when such lesions should also be biopsied. My own feeling is that the presence of decided hypertrophy and cystic degeneration, together with eversion and papillary erosion that is prone to bleed when touched, should be managed by circular excision with the scalpel (circular biopsy) and followed by endothermic resection. This had better be a hospital procedure for several reasons: (1) a complete sample of the cervix, including the squamo-columnar junction and without charring, is made available to the pathologist for serial study; (2) diagnostic curettage of the endometrial cavity and cervical canal can be accomplished at the same time and for the same purpose; (3) the cervix is relieved of its abnormality; (4) additional pelvic pathology may be brought to light by the advantages of so thorough an examination and procedure under operating room conditions.

Of course, an obvious ulcerative or friable lesion of the cervix can and should be biopsied immediately upon discovery and this can easily be an office procedure. It is not often that a strong suspicion of cervical cancer is not verified; it is the minute or hidden lesion that will be found by the method just described rather than by hit or miss single, or even multiple biopsies. The great value of the Papanicolaou vaginal smear test lies in its possibilities as a screening procedure—and whenever a positive or even a suspicious report is received, biopsy as well as curettage is definitely indicated. The unfortunate phase of this test is the negative report, for if relied upon without repetition or respect for the clinical picture, it can give rise to a sense of false security.⁵ Furthermore, much depends upon the experience of the examiner, as has been brought out by numerous observers in commenting upon the enthusiasm expressed in certain quarters of the lay press in supporting and popularizing the test.⁶ The Schiller test and colposcopic examination

contribute little to diagnosis, for these procedures only point out abnormally appearing areas that might well be biopsied for pathologic study. Proper biopsy studies by competent pathologists are still the final word in the diagnosis of cervical cancer.

Much that has just been said naturally applies to the diagnostic problem presented by abnormal bleeding from inside of the uterus. Given an absence of visible lesions in the external genitalia, vagina, and cervix—and especially in a patient in the pre- and post-menopausal epochs—there is only one way in which to prove or disprove cancer of the endometrium, and that is by careful and systematic curettage. I do not favor the aspiration curet for this procedure; it is even easy to miss an early, tiny area with orthodox curettement. Curettage can be carried out as an independent procedure, postponing treatment until the result is known, but some operators are willing to proceed immediately on the basis of a frozen section report. This many pathologists are loath to do, for nothing can require more prolonged or expert study than the bizarre picture so often presented by uterine scrapings. A procedure that is well in line with present-day concepts is to apply intracavitary radium in these suspect patients while awaiting a rapid but permanent histologic four-hour report. If malignancy is found to be present, a cancerocidal dose can be administered at once as a preliminary step in treatment. If the tissue is benign, dosage can be regulated on the basis of a non-malignant condition being present, such as hyperplasia or metropathia haemorrhagica (so-called fibrosis uteri).

It is pertinent at this time to emphasize the hazard in treatment apparent in the patient whose abnormal bleeding is thought to be due solely to palpable fibroids. If such a patient is treated either by surgery or irradiation without preliminary or concomitant curettage, cancer of the endometrium if present may easily be overlooked should the surgery be inadequate (i.e., supravaginal hysterectomy and adnexal conservation) as far as a malignant lesion is concerned. If x-ray therapy is proceeded with on the basis of fibroids alone, irreparable harm may be done the patient, for in such instances, too, proper treatment for fundal cancer has not been given. The same situation holds true when cancer of the cervix in company with fibroids or an adnexal lesion is unrecognized, for the end-result is equally so or even more devastating.

While it is evident that certain contrasts exist with respect to the diagnosis of malignancy in the two principal uterine sites, the general prob-

lem differs but little. First, early and accurate diagnosis based upon the universal symptom of abnormal uterine bleeding, followed promptly by appropriate diagnostic methods, would give more patients a better chance for recovery with the methods at hand. Second, a specific program of periodic pelvic examinations in apparently well women challenges the imagination with its potentialities. Our responsibility is clear.

Management and Treatment in Contrast

Just seventy years ago the first accredited abdominal hysterectomy for cancer of the uterine cervix was reported by and credited to W. A. Freund, and until the dawn of the present century surgery remained as the unchallenged weapon in the fight against this sort of malignancy. In 1903 came the earliest reports of the use of radium locally, but these attempts had been preceded by intravaginal applications of roentgen rays. Improvements in the technique of both internal and external irradiation gradually established its supremacy over operative treatment in the great majority of patients suffering with cervical cancer. True enough, a few operators of outstanding ability both here and abroad continue to practice and advocate surgery within rather wide limits of operability. Victor Bonney⁷ is the leading exponent of this group. Some use radiotherapy as an adjuvant, but in general radium and x-rays have long been regarded as the method of choice in the largest proportion of patients seen.

Within the past five years, however, the pendulum has swung toward surgery again. Meigs' leadership in this endeavor is well known to all of us, and he deserves unstinted praise for the development of a bold and meticulous technique.⁸ Aided by modern surgical methods and suitable antibiotic therapy, the hazards of primary mortality and postoperative morbidity incident to the earlier days have been largely overcome in his capable hands. But Meigs has wisely stressed the necessary criteria that must be observed in the selection of patients for the truly radical Wertheim procedure as primarily conceived by Clark and Reis. Too often, unfortunately, these criteria are not being observed by some whose enthusiasm is not equaled by their judgment and performance, and the results are not particularly satisfying in many instances. In support of such careful selection I need only quote from the report of the work of the late Frank W. Lynch,⁹ and of D. G. Morton,¹⁰ both master gynecologists at the University of California Hospital, where the radical procedure was carried out completely

in only 94 out of 119 patients selected over a period of thirty years. Sufficient time has not yet elapsed, as Meigs rightly says, to truly evaluate the merits of this present procedure in terms of five and ten year survivals. It will be tremendously advantageous to observe this experiment of a master, based on his continuing experience, for a longer period of time before discarding irradiation therapy even in the treatment of the relatively early lesion that Meigs delineates as the primary indication for a surgical approach—and this thought likewise applies to the management of intra-epithelial cancer, so-called "carcinoma in situ."

The unknown quantity in cervical carcinoma is regional node invasion as previously stated. The late F. J. Taussig¹¹ reported brilliant results in long-term survival by combining local irradiation and lymphadenectomy; Morton's experience has shown that fewer lymph nodes were involved in those patients who had been irradiated prior to radical pelvic surgery. These reports may eventually lead to a tenable conclusion, namely, that surgery and irradiation need not and should not be regarded as competitors in the treatment of cervical carcinoma, for in selected early cases it may prove to be advantageous to follow such irradiation with suitable pelvic surgery. I shall mention this possibility again when discussing our personal experiences in the Jefferson Clinic. For the present, and until we arrive at a point where all patients are seen with malignancy limited to the confines of the cervix, irradiation remains the treatment of choice in most instances. Time and space will not permit me to quote in detail the outstanding achievements in irradiation therapy as reported by many outstanding clinics and individuals from coast to coast. I could not mention some without offending others.

Fundal cancer, as previously mentioned and for the reasons stated, offers a much better prognosis in management and treatment when contrasted with cervical cancer. There is less controversy, too, with respect to the role that surgery plays. It cannot be denied that early removal of the uterus will cure the patient if the lesion is relatively small and well localized. It is also true that irradiation therapy alone will entirely cure or at least arrest some malignant growths for varying periods of time. Continued experience in this country tends to show, however, that preliminary irradiation, and subsequent radical surgery whenever possible, have very definitely increased the survival rate, even where infiltration of the myometrium has occurred. Metastases outside of the uterus natural-

ly decrease the chances of long-term survival. It is believed by many that the possibility of vaginal vault recurrence is likewise lessened by preliminary irradiation. Radium is favored by the majority as a preliminary procedure, and ingenious applicators and varied techniques have been devised by Heyman,¹² Arneson,¹³ Schmitz,¹⁴ Crossen,¹⁵ Friedman,¹⁶ and others. X-ray is employed by some, also with definite benefit, and notably by Norman Miller.¹⁷ Should visual metastases be encountered in the pelvis, postoperative x-ray therapy is indicated. Although patients with corpus cancer are almost always in the upper age brackets, the surgical technique of today and the antibiotic adjuvants available make it almost mandatory to follow irradiation with surgery in every patient in whom it can possibly be employed.

Management and Results of Treatment in the Jefferson Clinic

Cervical Carcinoma: Since the establishment of the Uterine Cancer Clinic in 1921, 609 patients have been seen, and 561 treated on the ward service, Division of Gynecology, as of Sept. 1, 1948. Eligible for a five-year or longer survival report are 457 patients observed and 422 treated prior to Sept. 1, 1943. All but 12 patients have been traced, representing a follow-up figure of 97.3 per cent of all patients seen, and 97.8 per cent of those treated, of whom six had survived from five to twenty-one years when lost sight of, at least temporarily. Nineteen patients (4.1 per cent) had carcinoma of the cervical stump.

Few patients have been treated solely by surgery, which was abandoned as a primary method of treatment at Jefferson in 1923. Of the few operated upon, postoperative irradiation was the important factor that allowed but one of a surgical group of patients to survive recurrence. Patients treated elsewhere by surgery have been irradiated by us for recurrence, but with discouraging results in most instances, as noted in a previous paper by Hahn and myself.¹⁸ This report therefore is concerned entirely with irradiation results and technique.

The over-all picture of more than twenty-five years' experience in the Jefferson Clinic is very revealing. Conscientious care of ward patients, their reception at the weekly follow-up clinic, accuracy of records, and persistence in tracing those who fall by the wayside cannot be accomplished without loyal and efficient personnel. It has been my good fortune to have such a group about me, and I pay tribute to my associates in this work, Drs. Thudium, Farell, Hahn, and

Lang, who together with the house staff, secretaries, and social workers have done so much in helping to carry on our work. I do not propose to analyze the present findings in detail at this time, but only to emphasize striking points. Three previous surveys¹⁹ of such a nature have been published during the past twenty years, and a similar intensive study will be presented in the near future.

Our methods of irradiation have undergone an evolutionary change as the years have passed, but we have insisted upon a sufficient period of trial for each in order to recognize any deviation in results more precisely. Although over-all survival figures are of less value than are comparative results with different techniques studied in relation to the stage of the lesion treated, it is of interest to see exactly what happens to a large group of patients thoroughly followed over a long period of time irrespective of technique. In this instance the absolute survival figure among 457 patients living from five to twenty-seven years after treatment, with and without arrested disease, is 25.3 per cent, or 116 patients. Of 422 patients treated, the relative figure is a bit higher—26.5 per cent. Six years ago the figures were 21.8 per cent and 23.1 per cent respectively, and perhaps the increased rates represent a changed technique that can now be really evaluated; this, too, in spite of the fact that exactly 14 per cent of our patients, or approximately only one in seven, have had Group 1 or 2 lesions (Schmitz). Compared with the stage grouping of the League of Nations, this is indeed a low figure, for the latter classification allows more latitude in placing patients in Stages I and II, although Heyman tells me that Stage I and II cases that he has reported in the "Annual Reports of the Results of Radiotherapy in Cancer of the Uterine Cervix" vary anywhere from 1 to 24 and from 10 to 24 per cent respectively. According to grouping, the following results have been achieved: Group 1, 70 per cent (absolute and relative); Group 2, 49 per cent (relative); Group 3, 24.8 per cent (relative); Group 4, 6.8 per cent (relative); Group 5, 11.1 per cent (relative).

We have learned, too, that all early lesions do not respond equally well to the same type of treatment, and that conversely advanced lesions may respond advantageously. The histologic picture matters but little either; evidently the question of arrest depends upon the virulence of the growth, irrespective of cell type generally, as opposed by the resistance of the host. In other words, certain patients offer a more fertile field for carcinogenic growth than do others.

In order to render this report more illuminat-

ing, I have attempted to compare the results obtained after a sufficient trial of several innovations in technique. These I shall not describe in exact biophysical detail. Radium applications have consistently been made by the members of the staff; the x-ray therapy has been administered under the direction of the late Drs. Manges and Kornblum, with Drs. Swenson and Eberhard in charge in recent years, and I wholeheartedly acknowledge their valuable cooperation. In general, from 1921 until 1931 radium was used almost exclusively for treatment. X-ray was employed sporadically in isolated cases, and usually subsequent to radium when unarrest of the lesion was apparent, or sometimes entirely in very advanced cases. Silver (0.3 mm.) and brass (1.0 mm.) filtration was used for 50 mg. intracavitary applications, and monel metal (0.3 mm.), 12.5 mg. needles, was used interstitially. The dosage was relatively low, and in single massive applications, being gradually increased from 2000 mg. hr. to 4000 mg. hr. or a bit less. Between 1935 and 1938 a change was made to platinum screening of improved units (0.5 mm. and 1.5 mm.) for both interstitial and intracavitary applications. At about this time, and occasionally prior to it, the fractional method of external irradiation with x-ray (200 k.v. machine) began to be used more and more as a planned procedure prior to the radium application, and sometimes subsequently as well, extending the time range of exposures to multiple external ports, while in 1942 a vaginal port was added. The maximum dosage has reached an average of between 1600 and 2400 r. to each port, measured in air. Thus we have essentially three epochs in technique for comparison. Naturally there has been some overlapping of technique; some patients during recent years have still been treated with radium or x-ray alone for definite reasons, but I have carefully segregated the patients treated by the different methods for critical analysis, as follows:

1. Between 1921 and 1943, and principally until 1936, 305 patients were treated chiefly with radium, sometimes with subsequent x-ray but only occasionally with x-ray prior to radium. X-ray has been used alone sometimes and reirradiation for local unarrest has been resorted to frequently. No definite plan of external irradiation preliminary to radium was followed in these patients, however. Sixty-eight patients, or 22.2 per cent, survived from five to twenty-seven years; in fact, 23 of this group are alive today (7.5 per cent). About half died of recurrence, one as late as fourteen years afterward. Several

succumbed to primary neoplasms elsewhere. The other half died of systemic diseases incident to old age. Twenty-one of the 68 five-year survivors were in Groups 1 and 2, 67 and 43 per cent respectively.

2. Chiefly between 1936 and 1943, 100 patients were treated in a planned manner with preliminary x-ray and radium. Occasionally a subsequent course of x-ray was administered. Of this group, 38 have survived from five to fifteen years (38 per cent). Today 27 are alive (27 per cent), of whom only one shows evidence of unarrested disease. Of eleven who died after surviving five years, two died of other causes, and nine of carcinomatosis. Eight of the 38 five-year survivors were in Groups 1 and 2, 100 and 54 per cent respectively.

3. A vaginal port, as mentioned, was added to the technique in 1942, and eligible for evaluation are 17 patients, of whom six (35.3 per cent) survived for five years or more. One of these had a supravaginal hysterectomy for a large myoma six months after irradiation therapy. Total hysterectomy was not possible because of the expected fibrotic fixation of the cervix and broad ligaments. Postoperative convalescence was protracted and the vaginal vault showed necrobiosis for a long time. Four of the five-year survivors had Group 2 lesions, or 80 per cent, there being no Group 1 patients.

Four-year and three-year trends mean little. Suffice it to say that of 15 patients similarly treated in 1943-44, nine are alive without evidence of disease (60 per cent), five are dead, and one untraced for six months. Of these four-year survivors, three were in Group 2 and one in Group 1. Post-irradiation surgery was carried out in the latter patient. Total abdominal hysterectomy was performed; no enlarged retroperitoneal nodes were found in the exposed right side, but it was not possible to mobilize the ureter in the base of the left broad ligament. Healing of the vaginal vault was prolonged because of devitalization of the tissues. Incidentally, four Group 2 patients died within one to three years of unarrested and widespread carcinomatosis.

In 1944-45 a total of 14 patients were treated with the same technique. Of these, seven are alive (50 per cent), each being a Group 3 case. A Group 2 patient died from cancer after four and one-half years. There were no Group 1 patients thus treated.

It would appear from this survey that, in comparison, preliminary irradiation has added appreciably to the survival rate. Optimism is countered, however, by the obvious deduction that the

patients in the preliminary x-ray category are relatively less removed from the date of their primary treatment than are those who were treated in the earlier period of this survey. The passage of time will prove or disprove the better survival rates that we are able to quote today.

In retrospect, certain thoughts are provoked. Having observed patients with an excellent primary response to irradiation, one that continues well beyond the five-year period, and when unarrest—or call it recurrence if you will—occurs six to fourteen years later, as has happened in 20 of our five-year survivors, should we not perhaps consider lymphadenectomy after we have observed these favorable irradiation reactions for a reasonable length of time? Taussig was a consistent advocate of this, and Meigs has recently stressed certain advantages in such a procedure. That is one thought I wish to leave with you. The other is much more obvious. If we can present survival figures such as these based on only 14 per cent of Group 1 and 2 patients observed, what figures could we present if we saw 85 per cent of our cancer patients in those brackets? Detection clinics and periodic examinations, alert attention to the universal symptoms of abnormal bleeding and discharge, and early care of the abnormal cervix are better answers to the cancer problem than all the radiologic and surgical innovations that we can possibly initiate.

Fundal Carcinoma: During the same period noted above, 216 patients have been observed and 214 treated on both the ward and private services of the Division of Gynecology, of whom 139 are eligible for five-year evaluation. The follow-up is 100 per cent. In 74 per cent of cases it has been felt that the lesion was limited to the uterus (1A, American College of Surgeons classification). Here again there has been a progressive and evolutionary change in management and treatment, and three interval reports with respect to this have been published in the past, the most recent one having appeared in 1946.²⁰ At this time I cannot possibly deal intimately with all the details that have customarily appeared in these previous communications, but will merely bring up to date further results achieved with continued experience in this field of uterine cancer.

In the earlier days of our experience immediate surgery was often performed when fundal carcinoma was suspected, either because of clinical evidence or by virtue of prior curettage. Sometimes this resulted in incomplete or inadequate surgery for compelling reasons of technique. Again, x-ray would be utilized as a post-

operative measure when extension beyond the uterus was evident. There was a tendency also to treat patients solely with radium and with x-ray in addition in quite a proportion of patients.

Continued symptoms, indicative of unarrested cancer in certain instances, prompted our decision to use radium only as a preliminary adjunct to surgery, and to depend no longer upon irradiation alone. The development of a four-hour laboratory technique, whereby a satisfactory report on the curettage could be rendered in suspected cancer cases while radium was already in situ in the endometrial cavity, was another factor in our reasoning. By this procedure proper dosage could be administered for the alleviation of bleeding if the report was benign, or the dosage could be increased to the maximum amount if cancer were found to be present. Furthermore, this plan served a double purpose, for in some substandard risk patients, and in those instances where extensive involvement was apparent, irradiation had to be depended upon as the curative agent, and immediate placement at the time of the curettage advanced the initiation of treatment considerably.

The final impelling reason for following preliminary irradiation with adequate surgery eight to ten weeks later in all conceivable circumstances has been the finding of residual cancer in about 50 per cent of removed uteri, but in nearly every instance the growth showed decided attenuation as a result of radioactivity, evidently a factor also in reducing infection and subsequent morbidity. In addition, the absence of recurrence, especially in the region of the cul-de-sac and the vaginal vault, and ascribed to devitalization of the malignancy, was and has continued to be a gratifying observation. While tandem applications have almost always been used since the adoption of the plan during the past ten years, in dosage averaging 5000 mg. hours, we have recently been using multiple small units in uterine cavities that are sufficiently large to accommodate them.

Results in terms of five-year survivals in the different categories of treatment mentioned are as follows:

1. Fifteen patients treated solely but by adequate surgery only—9 survivors (60 per cent). There were two postoperative deaths, occurring in 1929 and 1932 respectively, a mortality of 13.3 per cent.

2. Adequate or inadequate surgery, together with radium and/or x-ray at some phase of the treatment, but without any planned sequence or

procedure, was carried out in 34 patients—16 survivors (47 per cent). No postoperative mortality.

3. Of 29 patients, treated solely by radium—15 survivors (51.7 per cent).

4. Two patients treated solely with x-ray did not survive.

5. Thirty-five patients received combined radium and x-ray therapy—16 survivors (45.7 per cent).

6. Twenty-three patients have been treated only with preoperative radium and subsequent adequate surgery—21 survivors (91.2 per cent). No postoperative mortality.

Of these five-year survivors, one died of recurrent cancer, and one committed suicide eight years after operation. Of the remaining two patients not surviving for five years, one died of recurrent cancer four years after operation, and one died two years after operation, reportedly of cerebral embolism. Nineteen are now alive five to sixteen years after operation.

Between Sept. 1, 1943 and Sept. 1, 1948, 36 additional patients have been managed by this same planned procedure. To date 35 are alive from one to four years. One died within a year of recurrent cancer. There has been no postoperative mortality. Postoperative x-ray therapy has not been employed in any of the entire group of 59 patients treated in the fashion described.

Comment

1. Irradiation with x-ray and radium remains the treatment of choice for the vast majority of patients with cervical carcinoma observed today. Under present conditions immediate and primary surgery has a very restricted field of application.

2. Preliminary irradiation, preferably with radium, followed subsequently at an appropriate interval by adequate pelvic surgery has proved in our experience to be the most satisfactory method of treatment for fundal carcinoma.

3. Early and prompt diagnosis with proper management, when all is said and done, is the real answer to improved survival rates in uterine carcinoma.

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ABSTRACT OF DISCUSSION

FRANKLIN L. PAYNE (Philadelphia): Dr. Scheffey is to be congratulated upon his excellent results. An increased five-year survival rate from 22 per cent to thirty-eight per cent in cervical carcinoma and the recovery of 91 per cent in corpus carcinoma is a record of which to be proud. Improved outcome in the treatment of uterine malignancy depends upon three things—an early diagnosis, the development of more effective therapeutic measures, and competent follow-up care. The preceding report reflects both recognition of these prerequisites and the ability to fulfill them.

The importance of early diagnosis cannot be emphasized too strongly, for the ratio of therapeutic success to failure is in direct proportion to the ratio of prompt treatment to its delay. The measures aimed at early diagnosis include considerable lay education, routine interval pelvic examinations, repeated study of exfoliated genital cells by competent cytologists, immediate investigation of abnormal bleeding, particularly metrorrhagia or post-traumatic spotting, and (most important) adequate biopsy and thorough curettage with microscopic analysis upon the slightest provocation. Truly, the universal adoption of this program would produce a picture to "challenge the imagination of all of us."

In considering the results of treatment, the simple tabulation of percentages is futile unless it prompts the question: "How can these results be improved?" One senses the constant presence of this question in the mind of Dr. Scheffey as his paper progresses. The answer is elusive, but it seems to lie in the selective use of surgery and in the constant effort to improve the timing and the technique of irradiation. Immediate surgery has its place in the treatment of cervical cancer if it is employed in the very earliest stage, that is, the so-called "cancer in situ" or the intramucosal carcinoma.

For the next group, clinical carcinoma, Stages I and II, the question of the superiority of radical surgery over irradiation awaits the reports of the results of such modern surgical pioneers as Meigs, Morton, and Taylor. Following irradiation, if operation is to be done, it should include radical node dissection as well as excision of the parametria and the entire uterus. To simply remove the uterus and cervix, which are readily accessible and usually responsive to irradiation, and to leave the nodes and parametria, which are relatively inaccessible and unresponsive, is tantamount to sending a boy on a man's errand.

As to irradiation, we believe that its full possibilities in the treatment of uterine cancer have not yet been utilized. The recent introduction of preliminary x-ray therapy and of vaginal portals has increased life expectancy in cervical carcinoma. Further improvement may be expected from individualization of each problem, rigid care in the local application of radium, and the employment of multiple small sources of radium administered in repeated applications until the ultimate dose is attained in the terms of tissue units rather than in terms of milligram hours. We believe that such

measures are conducive to more destruction of cancer with less injury to the adjoining pelvic organs.

Corpus carcinoma, because of both its tendency to remain localized and its surgical accessibility, offers a different problem. Unlike Dr. Scheffey, we believe that immediate operation has a place in this condition provided the lesion is slow growing, early, and localized, and provided that every precaution is taken to prevent spill and spread at the time of operation and a complete job is done. The advantages are obvious and statistical proof is lacking that preliminary irradiation in a comparable group does produce better results than immediate operation. For the majority of corpus cancers, however, preliminary irradiation and surgery are indicated. For some we must depend upon irradiation alone because of constitutional or local conditions that prohibit operation. Here again, further improvement in results is bound up with individualization, careful intra-uterine placement of multiple low intensity sources, repeated applications of radium, and correlated use of x-ray therapy until the desired dose is reached in terms of tissue units.

The third prerequisite is adequate follow-up care. Two years ago, before this meeting, I made the following statement: "The clinic with the highest percentage of personal follow-up returns will show the highest percentage of long-term survivals." Dr. Scheffey's follow-up record of 98 per cent in cervical and 100 per cent in corpus cancer, with his splendid survival rate in both, furnishes additional testimony to support this statement.

CATHARINE MACFARLANE (Philadelphia): I express admiration of Dr. Scheffey's and Dr. Payne's results. For the past two years I have been following Dr. Scheffey's technique in the treatment of cancer of the body, and I believe that we are having less recurrence in the vaginal wall, as he said, as a result of that preliminary radium treatment.

DR. SCHEFFEY (in closing): Dr. Payne, I wish to thank you for your very generous remarks, and also for

disagreeing with me in certain respects. I do not think that a paper is worth very much unless there is some disagreement. Dr. Payne had an opportunity to read my paper in detail, which, of course, is something that I would not have imposed upon my audience, for I am already taking more time than I should. Many of the points that I would like to talk about more fully are in the text, and Dr. Payne has remarked about some of those things.

With respect to Dr. Payne's remarks about multiple source dosage, etc., I am in agreement with him in that respect, but only since we have begun to use small multiple radium units in the cavity of the uterus. Please remember that this work has been more or less of a pioneer procedure, and the results that I have presented today are based solely upon what might be regarded as inadequate irradiation which, I grant you, may exist with the tandem application; furthermore, I am not claiming that these results are the best in the world, or will prove equally good in other hands; or that in another ten-year period they will appear to be as effective as they seem to be today. I am merely presenting the results of our own experience with the plans of therapy described.

Naturally, as Dr. Payne showed with his excellent diagrams, we gynecologists, unless we are also expert radiotherapists, cannot get along too well without thorough cooperation with the radiologists. At Jefferson, Drs. Swenson and Eberhard have been working with us in recent years, and the late Drs. Manges and Kornblum cooperated with us in the past.

In closing, I should like to pay tribute to the men associated with me in this work. You cannot see patients as meticulously as we try to do and present a follow-up record such as this without loyal and consistent aid. I speak particularly of Drs. Thudium, Farell, Hahn, and Lang, in the Follow-up Cancer Clinic, and of the entire staff of the Division who have submitted their private fundal cases to me for evaluation.

THE FAST DOLLAR

Under this title a recent issue of the *Hartford Courant* publishes a letter which reads in part, "In the fight against socialized medicine the A.M.A. likes to cite the humanitarian practice of their profession. But, according to patients who have felt the financial lash of young doctors, this dogma has been dead for years." The writer gives examples of exorbitant fees charged by physicians, one of which was that of a woman of 75 who had to seek state aid after spending \$2,000 for an operation.

It would be idle for anyone to suppose that our profession is unaware of such unethical behavior on the part of a few physicians, a practice which is so unfair to the vast majority of doctors who practice according to honest principles. When these degrading episodes become known, as a certain number do, the question is rightfully asked as to what medicine is doing about the situation. Unfortunately, the actual facts in many of such cases are often difficult to ascertain. There exists,

however, machinery within our society for dealing with such matters and it is certainly the duty of physicians to report such "racketeering." The county medical associations do act in dealing with these situations from time to time, although public knowledge of such action is properly withheld. These things do not need such airing, but the public should be informed that we do have washdays and that we do try to keep our linen clean.

The theme of exorbitant fees is a favorite argument for those who advocate government control of medical practice. Physicians who are guilty of such charges are, therefore, not only disloyal to themselves but to the profession to which they belong. Such individuals, however, are usually deaf to appeal on any such basis. Medical schools and examining boards make sincere efforts to protect medicine from such men, but the doctors themselves through the county medical society can do an important service by bringing these sharpers to account.—*Connecticut State Medical Journal*.

Traumatic Arteriovenous Fistula of the Lower Extremity

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TRAUMATIC arteriovenous fistula is the result of a penetrating wound which involves a major artery and its concomitant vein with the formation of a fistulous communication between the two. The injury, which occurs most frequently in the extremities, is usually due to a bullet or knife wound, and contrary to what might be expected of a vascular injury, is not often accompanied by profuse hemorrhage. In the absence of extensive soft tissue damage, fracture, or nerve injury, the wound is frequently considered to be trivial in nature, and the patient is discharged from the hospital as soon as healing occurs.

Although the presence of a fistula can be detected at any time after its inception by the demonstration of a continuous thrill and bruit over the site of injury, the gross changes which it produces in the circulatory system are insidious and may be many years in reaching a symptomatic stage. The majority of cases seen in civilian practice fall into this category. The lesion is important because it produces alterations in the heart and peripheral vessels which are disabling and which can be partially reversed by its surgical extirpation. Because of the frequency with which war wounds involved the extremities, we should all be familiar with their sequelae and be prepared to see them any time during the next twenty years.

During the past few years I have had occasion to observe and treat five cases of arteriovenous fistula of the lower extremity in which the original injury had been sustained from three to twenty-four years previously. In spite of the fact that the common femoral vessels were involved in four of the cases and the superficial femoral vessels in the fifth, bleeding was profuse at the time of injury in only one instance. Four of the five cases had a brief and uneventful period of hospitalization and received nothing in the way of treatment at that time beyond local care of the skin wound. In no instance was a diagnosis of arteriovenous fistula made during the

initial hospital stay. Although not abstracted here, these cases form the basis of this paper and serve as the source material for the illustrations which demonstrate most of the cardiovascular changes which occur, their disabling character in the more advanced stages, and the degree of reversibility and residual sequelae following surgical excision.

The interpolation of an arteriovenous shunt in the peripheral circulation permits the easy passage of arterial blood under arterial pressure from the involved artery through the fistula to the involved vein and back to the heart without passing through the peripheral vascular bed. This loss of peripheral resistance in the artery, together with the increased volume of blood under increased pressure which courses through

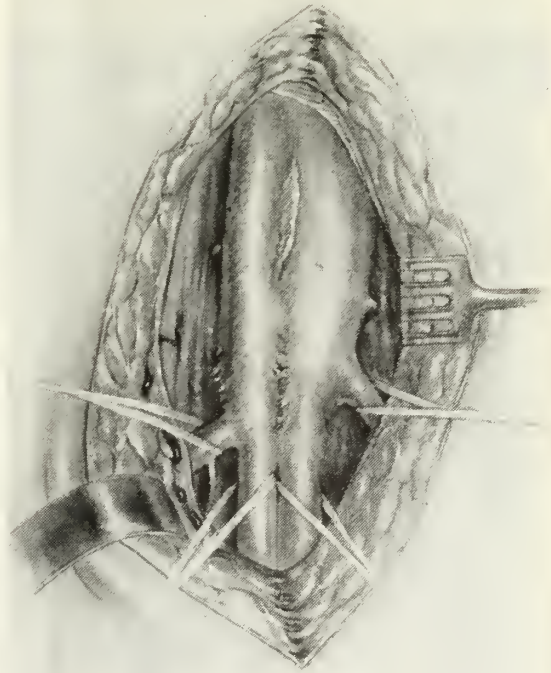


Fig. 1. Illustrating the disparity in size of the artery and vein proximal and distal to an arteriovenous fistula of the common femoral vessels of eighteen years' duration. The tapes are around the long saphenous and superficial femoral veins on the left side and the profunda femoris and superficial femoral arteries on the right.

the vein from the fistula to the heart, accounts for most of the organic changes as well as for most of the signs and symptoms which characterize the disease. The degree of cardiovascular damage which occurs is dependent on the size of the vessels at the site of the fistula, the size and duration of the fistula, and the prior integrity of the circulatory system.

In the involved vein the structural changes consist essentially of hypertrophy and dilatation of that segment between the fistula and the heart. The hypertrophy occurs in the intima and media, at times giving the vein an appearance not unlike an artery, a change which has been referred to as "arterialization" of the vein. The dilatation may be maximal locally at the site of the fistula where it represents an almost constant finding (Fig. 1), or may be diffuse and extend for some distance proximal to the level of the fistula. It may be less marked in the extremity where the vein is surrounded by muscles and their fascial compartments than proximally in the retroperitoneal portion of the abdomen where there is nothing more resistant than areolar tissue. This doubtless explains the occasional presence of abdominal aneurysms of either venous or arterial origin in association with arteriovenous fistula of the lower extremity. In 1904 Osler¹ presented a

case of arteriovenous fistula of the femoral vessels before the Johns Hopkins Medical Society in which the dilatation of the vein extended for some distance proximal to the fistula and was sufficiently large to produce an abdominal tumor. The "tumor's origin was, however, not perfectly clear, and so far as he knew, there were no other cases like this one in the literature." In 1943 I² reported a similar case in which the abdominal tumor was proved beyond doubt to be an extreme dilatation of the external iliac vein.

The venous trunk distal to the fistula ordinarily does not become dilated. Callander³ has shown that as long as the valves remain competent, no changes are apt to occur, the increased venous pressure at the level of the fistula merely obstructing the passage of blood from below by imposing an obstacle to it. Should the valves yield or become insufficient due to the increasing dilatation of the vein above them, the adjacent distal segment may then undergo the same changes as seen above. Holman⁴ reports such an instance in which there was a large saccular dilatation just distal to an arteriovenous fistula of the superficial femoral vessels. Such distal dilatation is apparently uncommon, for the arterial blood, taking the course of least resistance, passes through the fistula and into the proximal vein. The integrity of the vein distal to the fistula can be demonstrated by venography, and in three cases in which I⁵ used this procedure it was normal in each instance.

The superficial veins of the involved extremity manifest all the changes seen in deep venous obstruction of other origin with the result that there is edema, varicosities, and even varicose ulceration (Fig. 2). These changes are permanent in cases of long duration, although there may be some improvement after removal of the fistula. The presence of unilateral varicosities should always suggest the possible presence of an arteriovenous fistula, especially when the patient also presents symptoms referable to the heart.

The heart is subject to the same adverse conditions which produce dilatation in the proximal vein, the increased volume of blood flowing to and through its chambers, gradually distending and dilating them (Fig. 3) until they lose their efficiency and decompensation occurs. Although Mason⁶ reported a case of fistula of the subclavian artery and vein in which cardiac decompensation occurred within a period of nine weeks of injury, the time element for such a complication is almost invariably measured in terms of years.

The artery between the level of the fistula and

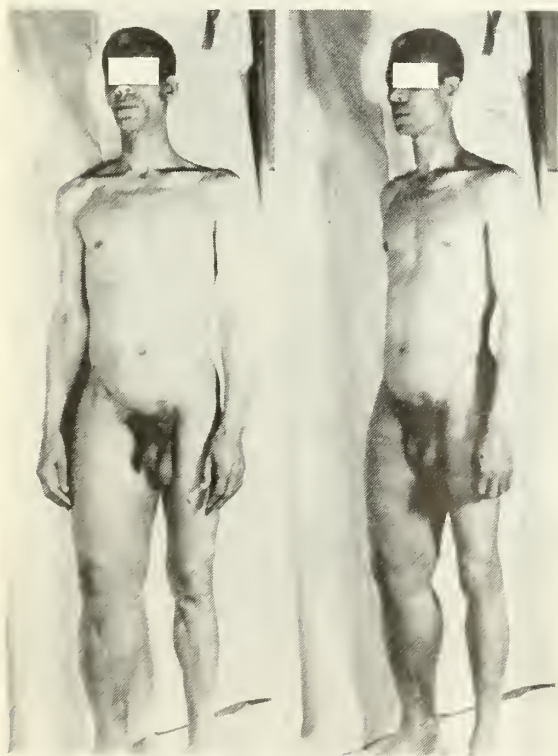


Fig. 2. Patient with arteriovenous fistula of the common femoral vessels of eighteen years' duration showing unilateral edema, varicosities, and the scars of healed varicose ulcers.



Fig. 3. Extensive cardiac dilatation in a case of arteriovenous fistula of the common femoral vessels of seventeen years' duration with cardiac decompensation.

the heart becomes thin-walled, dilated, and frequently shows marked degenerative changes in its walls. According to Reid,⁷ these changes are due to the alterations in the arterial blood pressure which invariably occur with interference in the nutrition of the arterial wall, while Holman⁸ stresses the factor of increased blood volume which he maintains is present throughout the entire circuit comprising the heart and the artery and vein between it and the fistula. This dilatation is almost constant in the segment of artery just proximal to the fistula in all cases of long duration, but may extend centrally for some distance and may include the entire aorta (Fig. 4). It rarely reaches such magnitude as to form an aneurysm, although Donald⁹ reports one of the common iliac artery secondary to a fistula of the popliteal vessels and states that he found nine other such cases in an admittedly incomplete review of the literature.

Differentiation between the arterial and venous origin of such abdominal aneurysms may be difficult, as the bruit which occurs at the site of the fistula may be transmitted for some distance along the vessels. In fact, the decrease in the size of the aneurysm reported by Donald following ligation of the artery and vein would suggest that it was of venous rather than arterial origin. In the personal case which I referred to above I was able to determine the venous origin of the tumor before operation by noting its ten-

dency to disappear on digital compression over the fistula and I submit this test as a means of differentiating between the two.

A false aneurysm is occasionally found at the level of the fistula and is the result of the appearance of a large hematoma at the time of injury with its subsequent organization and epithelialization. It represents a coincidental finding.

The artery distal to the fistula rarely shows any change in its caliber or appearance and, if anything, is apt to be somewhat reduced in size.

The smaller arteries and veins about the fistula become dilated and invariably provide a rich collateral circulation to the distal part of the extremity. Over a period of months or years this collateral circulation may develop to such a degree that it exceeds the normal circulation with a resulting measurable increase in skin temperature. In growing individuals where the fistula is near an epiphysis, its presence may result in abnormal growth of the bone.

On the basis of such vascular changes a definite group of signs and symptoms will gradually appear and will become progressively more pronounced the longer the fistula persists. These signs and symptoms may be classified as local, central, and peripheral. Locally, they are due to the passage of blood under arterial pressure through the fistula and consist of a continuous machinery-like thrill and bruit which are constant throughout the entire cardiac cycle with ac-

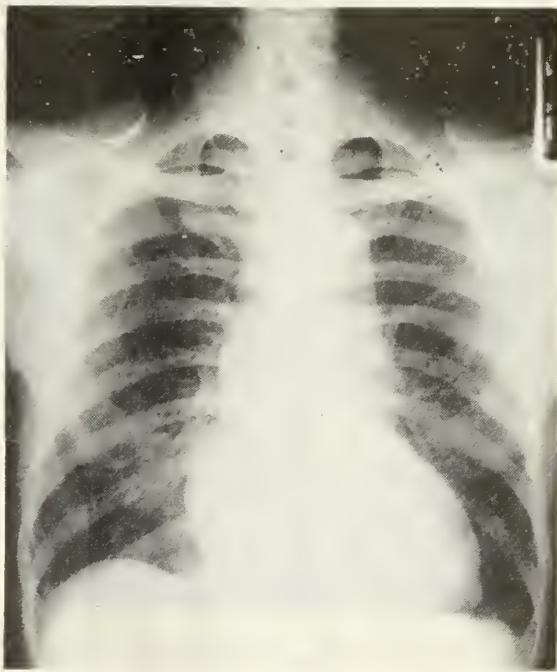


Fig. 4. Dilatation of the heart and thoracic aorta in a case of arteriovenous fistula of the common femoral vessels of twenty-four years' duration.

centuation during systole. Centrally, they are due to the effects of cardiac dilatation with a slowly progressive clinical sequence of events consisting of tachycardia, palpitation, dyspnea, and eventual cardiac decompensation. The presence of murmurs and even cardiac irregularities may be detected while teleroentgenograms will reveal evidence of cardiac enlargement. Electrocardiographic studies have not been found to have any diagnostic significance. Peripherally, the signs and symptoms are those of deep venous obstruction with unilateral edema, varicosities, and varicose ulcer. The edema may be marked and may be accompanied by bouts of acute lymphangitis, while the varicosities may be so pronounced as to rupture and bleed.

Signs not so readily classified are the high systolic and low diastolic blood pressures with a resulting high pulse pressure—the phenomenon known as Branham's brachycardiac sign in which digital compression over the fistula sufficient to close it results in a drop in the rate of the pulse, and lastly the laboratory test devised by Brown¹⁰ whereby blood obtained from a superficial vein in the region of the fistula is shown to carry an oxygen saturation which approaches that of arterial blood.

The treatment of arteriovenous fistula is con-

cerned with its elimination from the circulatory system. The presence of an artery and vein, each of which may be dilated to several times its normal size, the presence of many local branches which are also dilated, as well as the abundance of scar tissue which is invariably present and which not only surrounds the vessels but binds them together, serve to make the operation tedious. The presence of cardiac damage, even to the extent of heart failure which will not respond to bed rest and digitalization, may make its risk formidable. In spite of all these handicaps, operation is justified for it offers the patient the only opportunity he has for recovery. Price has reported a series of five patients who had untreated fistulae of many years' duration. One had died of hemorrhage from a ruptured varix, one had died of heart disease, while the remaining three were cardiac invalids with an excellent prospect of ultimate death from this cause.

Following elimination of the fistula, the heart reveals a surprising ability to diminish in size and to again become an efficient organ (Fig. 5). Heart disease secondary to arteriovenous fistula is reversible, and it is not uncommon for patients who have been cardiac invalids to be restored to almost normal activity.

While a number of methods have been devised and utilized, there are only two operations which find any place in the management of the mature lesion. These are transvenous closure of the fistula with preservation of the artery and sacrifice of the vein, and quadruple ligation of the artery and vein with excision of the fistula. Generally speaking, the latter procedure presents the lesser danger and offers the greater promise of cure.

The method of transvenous suture which was described and utilized by both Matas and Bickham at the turn of the century, and which has been hailed with renewed interest during the recent war, is theoretically a preferable procedure in that it spares the artery. Its danger lies in the possible failure to obtain or maintain a complete closure of the fistula, for even a minute opening will gradually re-establish itself as an active fistula while the presence of venous branches in the region of the fistula will provide a ready alternate pathway back to the heart in the absence of the ligated vein. This procedure seems to have its greatest value in the management of cases of short duration in which there is some question as to the presence of an adequate collateral circulation to the distal limb.

Quadruple ligation of the artery and vein with excision of the fistula is a more radical procedure, but is attended by a greater promise of success. In the presence of considerable fibrous



Fig. 5. Same case as shown in Fig. 3. This film was taken nineteen days after quadruple ligation of the artery and vein and excision of the fistula. There was a decrease of 5.1 centimeters in the transverse diameter of the heart and a clinical disappearance of the signs and symptoms of cardiac decompensation.

tissue reaction about the lesion, as well as degenerative changes in the arterial wall in the form of calcified plaques, it would also seem to be safer. It assures complete elimination of the many arterial and venous communications which are invariably present and which can result in reactivation of the fistula when they are not interrupted. Lastly, the excellent collateral circulation which is invariably present in cases of long duration eliminates the necessity for preserving the artery. In my experience peripheral vascular disabilities following this operation are due to the persistence of the pre-existing varicosities and their complications rather than to any arterial deficiency. Most important of all is the high promise of success of the operation, especially when the lesion is associated with cardiac invalidism. Such an operation may well be considered to be conservative if it spares the patient's life and restores him to a useful occupation.

Conclusions

It has been the purpose of this paper to describe the late changes which occur in the circulatory system in the presence of an arteriovenous fistula, to describe the signs and symptoms which it produces, and to justify the radical operation of quadruple ligation of the vessels and excision of the fistula in such cases in preference to transvenous closure of the fistula.

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ABSTRACT OF DISCUSSION

HAROLD A. ZINTEL (Philadelphia): Dr. Watson should be complimented on this very excellent presenta-

tion. He has emphasized the late changes in the circulatory system and has discussed the methods of treatment of arteriovenous fistula.

I should like to emphasize again that the bleeding at the time of the original injury may not be very serious. It is therefore necessary in any large wound which requires débridement, and which extends to the vicinity of the large vessels, that a careful inspection be made of these vessels and that any defects in the large vessels be closed immediately to prevent the formation of an arteriovenous fistula.

A pulsating hematoma following aneurysm can be confused with an arteriovenous fistula. A pulsating hematoma appears as a pulsating mass with a to-and-fro bruit within one to eight weeks after the original injury. Apparently a defect in the artery, which is not recognized at the time of the original débridement, becomes plugged with muscle or other tissue. When the patient is mobilized and becomes active, massive hemorrhage from the arterial defect takes place. The history of the development of the mass, the Branham phenomenon, and the systolic accentuation of the to-and-fro murmur in the arteriovenous fistula are useful in establishing the diagnosis. Pulsating hematoma requires immediate operation for fear of subsequent massive hemorrhage; on the other hand, an arteriovenous fistula does not represent a surgical emergency in the absence of cardiac decompensation. The presence of an arteriovenous fistula is an excellent stimulus to the development of collateral circulation. One should wait at least three months and preferably six months before operation in order to allow sufficient time for development of the collateral circulation.

The procedures of reconstructive and obliterative endo-aneurysmorrhaphy as developed by Dr. Matas are those in which the artery is either reconstructed or obliterated from the inside of the aneurysmal sac. These procedures, together with exo-aneurysmorrhaphy and lateral obliteration, are designed to close the fistula with a minimum of interference with the collateral circulation. As Dr. Watson mentioned, there is a likelihood of leaving abnormal vascular tissue in the functioning vascular system as well as leaving smaller vascular connections. Either of these situations might lead to the production of a simple aneurysm or a recurrence of an arteriovenous fistula.

In general, the best results will be obtained when the entire lesion can be excised without compromising the collateral circulation. Elkin has stated that he had no recurrences of an aneurysm when the lesion was completely excised.

I should like to make one addition to Dr. Watson's discussion and that is the use of vein grafts to restore the continuity of the artery. Whenever the major artery of an extremity is obliterated, if frank gangrene, intermittent claudication, or muscle atrophy does not develop, the limb will never be the equal of its mate. With the increased knowledge and experience in vascular surgery, anyone attempting surgery of the type discussed, in the future, should be prepared to do a vein graft and use it to restore the arterial blood flow if it is at all possible.

Intestinal Intubation in the Field of Pediatrics

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INTESTINAL intubation in the management of pediatric patients with disorders of the gastro-intestinal tract did not achieve much popularity until after 1938, when Andersen¹ reported a series of original studies on congenital fibrocystic disease of the pancreas. These showed clearly that while this disease may be diagnosed with probability on clinical grounds, the diagnosis can be proved only by the assay of the pancreatic enzymes. Many other reports²⁻¹⁵ since then have established the importance of intestinal intubation in the study of normal and abnormal functioning of the small bowel and pancreas in infants and children.

This is an analysis of impressions gained in approximately 350 intestinal intubations on infants and children, of which 250 were performed personally, and 100 by the resident staff. Many of the earlier intubations were performed on normal subjects in order to improve the intubation technique and laboratory procedures. Various types of equipment were tested in an effort to increase the percentage of successful intubations and shorten the time required to obtain duodenal juice for analysis. The purpose of this paper is to emphasize the value of this procedure in the diagnosis and management of pediatric patients with digestive disturbances, to discuss experiences with various types of equipment, and to give the technique of intestinal intubation in detail.

Indications for Intestinal Intubation

One major indication for intestinal intubation of an infant or child is to aspirate duodenal juice for enzymatic analysis in patients suspected of having the celiac syndrome. For within the framework of the celiac syndrome lies a variety of conditions, among them being starch intolerance, cystic fibrosis of the pancreas, sprue, extreme degree of gastro-intestinal allergy, heavy infestation of the small bowel with intestinal parasites, chronic disease of the intestinal tract,

and chronic malnutrition. Disease of the pancreas usually manifests itself in a complete or partial deficiency of one or more of the three enzymes—trypsin, lipase, and amylase.

Reports on the status of pancreatic enzymes in idiopathic celiac disease are conflicting. In a paper based on more than 150 determinations of pancreatic enzyme activity, Farber and associates¹¹ state that the pancreatic enzymes are normal in this type of the celiac syndrome. In contrast, Andersen¹⁵ is convinced from her studies that celiac disease is a form of the celiac syndrome due to an absence of pancreatic amylase, which results in an intolerance to the dietary starch.

Most patients with fibrocystic disease of the pancreas will in time develop the clinical picture so graphically described in pediatric textbooks. Nevertheless, the symptoms and signs can vary considerably in intensity and character among patients with this disease. In some the gastro-intestinal picture predominates, whereas in others the lung involvement may be so pronounced that attention is diverted from symptoms referable to the digestive tract. Many patients develop signs and symptoms at a much earlier date and to a more marked degree than others. Every child suspected of having any form of the celiac syndrome should have an analysis of the pancreatic enzymes in order to make a correct diagnosis, plan proper therapy, and give the parents an appraisal of the patient's prognosis. Here are two brief case histories which illustrate the value of pancreatic enzymatic analysis in the study of patients with the general picture of the celiac syndrome.

Case Reports

CASE 1.—M. J. W., age 7 months. This infant never gained weight at a normal rate, and her best weight was 11 pounds 13 ounces two days before admission. She had had an average of five stools daily, which were mushy and malodorous. The abdomen had always been large. There were no respiratory symptoms until two weeks before she was seen at this clinic, when a cough developed which had become progressively tighter. The appetite had always been good, and the diet and vitamin intake had been supervised by her physician. The physical examination showed a poorly nourished infant with

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a distended abdomen and scattered rhonchi in the lungs. The significant laboratory findings were 11.5 grams of fat in a 24 hour stool specimen, a negative tuberculin test, and an x-ray picture of exaggerated bronchovascular markings throughout both lungs. Assay of the duodenal juice showed the pancreatic enzymes to be absent.

This patient represents a relatively mild clinical picture of fibrocystic disease of the pancreas. Her symptoms were no more pronounced than those of many difficult feeding cases, yet the absence of the pancreatic enzymes enabled the physician to plan the proper course of therapy and to inform the parents of the gravity of the prognosis.

CASE 2.—F. F., age 2½ months. Five weeks prior to admission, this baby became very irritable, due apparently to an excessive amount of mucus in the nose. This condition first improved and later increased during the interval prior to the admission. Three weeks before admission the stools became frequent, loose, large, and malodorous. Following this, some of them had become green, slimy, and watery. The appetite had been good, but the baby had gained only 1 pound 6 ounces since birth. A cough developed two weeks prior to admission, which had been frequent and dry in character.

Physical examination revealed a male infant weighing 9 pounds 6 ounces and in fairly good nutritional state. He was irritable and coughed frequently. The pharynx was injected, and there were a few cervical nodes anteriorly and posteriorly. The heart and lungs were normal, and the abdomen soft and moderately distended. Laboratory studies showed a moderate degree of hypochromic anemia. X-ray of the chest showed "some exaggeration of the bronchovascular markings beneath the right hilum, which could be due to fibrocystic disease of the pancreas; cardiac silhouette within normal limits." One month later another roentgenogram indicated that the lungs were normal. Duodenal juice analysis showed normal enzyme levels for trypsin, amylase, and lipase. The baby steadily improved in the hospital, and was discharged after a month, by which time the cough had cleared, the stools were normal, and there had been a gain of 1 pound in weight.

This patient's clinical picture was certainly no better than that of the first case, but the normal enzymatic analysis made soon after the child was admitted to the hospital enabled the physician to rule out fibrocystic disease of the pancreas, and to give the parents a more favorable prognosis.

A second indication for intestinal intubation is the preoperative preparation and postoperative care of patients with surgical lesions of the small bowel. Removal of gas and other contents from the small bowel and injection of fluids through the tube may at times be of considerable value in the management of these patients.

Third, it has been shown* that deep intestinal intubation may be of great help in locating bleeding points along the intestinal tract. Samples of intestinal contents carefully collected so as to avoid any trauma are studied for the pH value and occult blood reaction. Confirmatory evidence of a Meckel's diverticulum can sometimes

be obtained by demonstrating a change from the normal alkaline pH of the intestinal samples to an acid reaction due to the presence of acid secreted by the aberrant parietal cells in the diverticulum. Barium can be instilled through the intubation tube and x-ray films made to aid in localizing the bleeding point.

Fourth, duodenal intubation has other uses. Maris,⁹ for example, in a study of children with abdominal pain, discovered that in a small percentage of patients with giardiasis, the stools may be negative, yet the duodenal juice may contain many active *Giardia*. Maris et al.¹⁰ have also shown that the introduction of barium via a tube in the small bowel may be valuable in locating the site of congenital obstructive lesions, and the metal tip can be used at the time of operation to assist the surgeon in locating and rupturing an obstructing membranous diaphragm. Intubation can be used to study the physiology of digestion after the administration of foods and drugs. When doubt exists as to atresia of the common bile duct, intubation may aid in the diagnosis by determining the presence or absence of bile in the duodenal juice.

Methods and Equipment

Hess¹⁶ in 1911 described the use of a soft rubber catheter, 5 mm. in diameter, with a silver-plated ball on one end. He suggested that the tube could be used to intubate the stomach and duodenum in order to "study secretions, enzymes, effect of drugs on secretions, and the influence of foods on the enzymes and secretions." As Shwachman and associates¹⁷ have pointed out, a tube can be passed in most infants and children with little difficulty in less than an hour. However, there is a small percentage of patients, especially in the age group between 5 and 10 years, who are very difficult to intubate in spite of hours of tedious work. Infants less than a year old are not only easier to restrain but seem to develop stronger gastric peristalsis than do older children. Several methods designed to reduce the percentage of failures have been reported.¹⁸⁻²² These and other methods and equipment will be discussed in the light of our experience.

Types of Tubes

1. Semi-stiff tubes.

As was pointed out by Davison,⁸ it is sometimes possible to force a tube gently through the pylorus if one alternately removes some of the slack and then pushes while slowly rotating the tube so as to keep its tip free. The plain No. 10 or even No. 12 tube is quite flexible and often

* MARS, E. P.: Unpublished data.

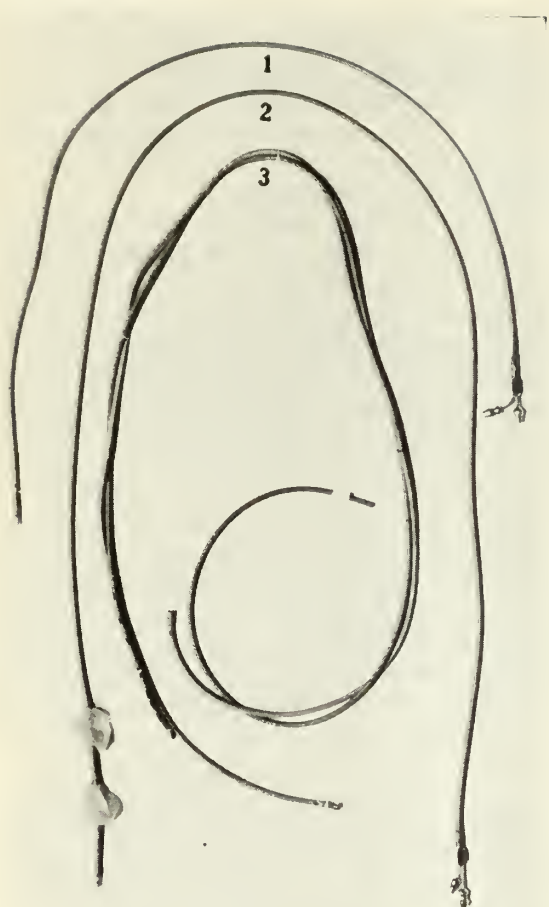


Fig. 1

coils in the stomach as a result of peristalsis. At present we are experimenting with two types of semi-stiff tubes. One is a No. 12 Miller-Abbott tube from which the balloon has been removed and a hollow blind metal tip substituted. A stylet of stainless steel is inserted through the half of the tube leading to the metal tip, thus making the tube fairly stiff (Fig. 1). The second type is the woven silk catheter used in catheterization of the heart. We have not used these tubes sufficiently often at this writing to draw any conclusions.

2. Tip-weighted tube.

Twenty years ago, Wilkins¹⁸ published a report on intubation of the small bowel with the aid of metallic mercury in a balloon attached to the end of a single lumen tube used for gastric and duodenal lavage and feeding. He stated simply that the weight of the mercury made duodenal intubation easier. Harris²⁰ and Swertsen¹⁹ used a Miller-Abbott tube, with 5 cc. of metallic mercury in the balloon, to facilitate the passage of the tube along the small bowel. Both

felt that the mercury hastened the passage of the tube through the pylorus. Cantor,²² in an effort to improve on the Miller-Abbott tube, experimented with a mercury-weighted single lumen tube, with three series of four holes each for decompression of the bowel. He stated that the mass of mercury improved his technique of maneuvering the tube through the pylorus in every one of the 22 cases he reported, all of which were adults. He stressed the value of keeping the patient lying on the right side for two hours after the tube is in good position in the stomach, with the foot of the bed elevated 12 inches.

The writer has tried a Miller-Abbott tube, using 5 cc. of metallic mercury in the balloon as a weight, and has been unable to demonstrate any advantages of this type over a plain (Levine) tube. It should be pointed out that the removal of a tube with an irreducible mass of mercury attached may be dangerous in infants.

3. The use of an electromagnet to facilitate the passage of a tube through the pylorus.

Mayer²¹ used a magnet in duodenal intubation in adults and concluded that it was of considerable value in getting the tube through the pylorus. He failed to describe the type of magnet, or



Fig. 2

to record the time required to successfully intubate his patients, all of whom were adults. On the basis of Mayer's encouraging report, we decided to experiment with a strong electromagnet, which was very kindly made for the study by the Westinghouse Electric Company (Fig. 2).

Because of the possible risk of rupturing the bowel, the first experiments with the strong magnet were performed on cases post mortem. A small high-grade piece of metal was attached by a string 3 inches long to the tip of a No. 10 plain duodenal tube. This was placed in the open stomach so that the metal end was in the antrum of the pylorus, with a little slack in the string, and the edge of the magnet was pressed snugly against the right loin directly opposite the pylorus. When the electric current was turned on, only a slight tug on the metal could be produced, and the tube could not be moved at all. It was therefore concluded that even this strong electromagnet, which is at least four times stronger than the Sweet Eye Magnet, could not be of any practical value in facilitating the passage of the tube through the pylorus. Furthermore, the impression was gained that use of any stronger magnet would carry some danger of rupture of the bowel.

4. Modified Miller-Abbott tube.

On the assumption that the peristaltic waves of the stomach might be able to propel a tube with an attached mass better than a plain tube, a No. 12 Miller-Abbott tube was modified as follows: The balloon on the end of the tube was removed and a blind metal tip substituted. Two smaller balloons, each about one-half the size of the original balloon, were attached, one being placed an inch and a quarter, and a second balloon two and one-half inches proximal to the tip of the tube (see Fig. 1). Two balloons were employed on the hypothesis that two separate masses might be better propelled along the stomach than a single one. Also, the tube can be manipulated so that the tip is in the first part of the duodenum, with the two balloons on either side of the pylorus. Inflation of the balloons with the tube in this position aids in fixing the tube and in decreasing the flow of gastric juice through the pylorus. Although such a double balloon is more expensive than a plain tube, and difficult and costly to keep in proper repair, nevertheless, it is valuable for intubation of infants under one year of age. In such infants this tube will pass the pylorus more quickly than will a plain (Levine) tube.

Before 1946 no record was kept of the data concerned with the technique of intubation, but



Fig. 3

since that time a special blank has been filled out for each patient referred for intubation. During the past one and a half years, 96 intubations have been attempted with the double balloon tube. Of these, 76 (80 per cent) proved successful. There were 31 patients less than a year old, and the average length of time required for the tube to enter the duodenum in this group, indicated by first appearance of alkaline juice, was 43 minutes. There were 45 cases over one year of age, and the average time for successful intubation in these was 75 minutes. That the younger age group can be more quickly intubated is further demonstrated by the fact that, in 13 patients under one year of age, successful intubations were accomplished in less than one-half hour.

Two plain (Levine) tubes taped together have been successfully used in only 19 cases. Of these, 13 were in patients under one year of age, with an average time of 47 minutes needed for successful intubation. There were six over one year of age in whom the average time was 58 minutes. It is difficult to tell whether the results obtained with a double-balloon type of tube are better than may be obtained with a single (Levine) tube or two (Levine) tubes taped together. We have recently been experimenting with two (Levine) tubes taped together for the simultaneous aspiration of gastric and duodenal juice. No one has as yet published adequate data concerning the use of various types of tubes. It is my feeling that the double-balloon tube will give a somewhat higher percentage of successful intubations in a shorter time for young subjects than would be obtained with a plain (Levine) tube.



Fig. 4

More reliable methods of analysis of the blood and stools for pancreatic enzyme activity may eventually replace diagnostic duodenal intubation. Intubation is still attended with difficulties, and there is great need for improving the technique so that it may be sure, safe, and rapid.

Technique of Intestinal Intubation

Intubation of the gastro-intestinal tract, although not very painful to the patient, is a very annoying operation that usually requires several hours of tedious work to complete. Patients between 1 and 5 years of age are especially difficult to manage and require constant attention on the part of the intubator and attendant. Vomitus, mucus from the respiratory tract, and an excessive amount of saliva may increase the danger of pulmonary aspiration. Many candidates for intubation are not in good physical condition, and in hot weather dehydration of a considerable degree can occur during the procedure if much time is taken.

Any infant or child who is not too small, too weak, or too ill can be safely intubated. Patients who are febrile, and those with serious cardiac lesions, do not stand the procedure well. The use of a sedative such as phenobarbital is sometimes helpful in patients who are difficult to manage, but in my experience the drugs of the sedative group have little effect on the actual passage of a tube through the pylorus.

Since one is seeking a picture of the enzyme levels during fasting, no food is allowed the patient for six hours prior to the time of intubation. Food in the stomach will increase the danger of aspirating material into the lungs and interfere with removal of samples of juice. Several ounces of water given two hours before the tube is passed will not affect the study. Careful psychologic preparation of older children for what lies ahead is a valuable part of the operation. A

competent attendant can contribute a great deal by diverting the child's attention during the procedure. It is best to restrain small patients, and in those patients with teeth a mouth gag made of four tongue depressors taped together will often be useful.

We have found that the best results are obtained if the intubation begins not later than 8 a.m. At this time the patient will not have been without food too long, and there will be an adequate amount of time during the morning to attempt the intubation. If the procedure is still unsuccessful after four hours, it should be terminated. The patient should be in the fluoroscopy room when the tube is passed so that checks can be made when indicated on the position of the tube. We prefer keeping the patient in or near the fluoroscopic room throughout the procedure. Andersen * returns her patients to their beds because she feels that they are less upset and more cooperative there. It is vitally important that the intubator takes every precaution to protect both himself and the patient against overexposure to roentgen rays. We allow a maximum exposure with the fluoroscope of five minutes within a period of a week.

Passage of a tube into the stomach can be accomplished without difficulty in most patients, although gagging and a sense of choking is very

* Personal communication.



Fig. 5

disturbing to children. The tube when first introduced into the pharynx evokes an excessive amount of mucus in those subjects with pulmonary disease, and this should be aspirated if necessary. The length of tube needed to enter the stomach is that which corresponds to the distance between the patient's crown and the zygoid tip. A plain type of tube can be passed nasally, and many workers prefer this route. The oral route appears to be much less painful and permits greater ease of manipulation. With either route the tube should be lightly lubricated, while chilling the tube prior to use is of little value.

When using the oral route, the patient's tongue should be depressed with a tongue blade, and the tip of the tube passed back and down along the pharyngeal wall in the mid-line. The procedure should be halted after the tip has passed the pharynx to determine if the patient is in respiratory distress. If crying is adequate and the skin color normal, the measured amount of tube is steadily passed, and the position of the tube tip is then checked under the fluoroscope. Sometimes the tube will curve toward the cardia, in which case it should be retracted several inches, the patient turned on the right side, and the tube slowly repassed. This nearly always results in the tube being directed toward the pylorus. The stomach should now be gently aspirated, as distention seems to hinder the passage of the tube through the pylorus. A moderate amount of slack in the tube is desirable (Fig. 3).

The position of the tube should be checked after about ten minutes, because the patient is seldom cooperative at this early stage and the tube may be out of position. Too much slack will cause the tube to coil in the stomach (Fig. 4). One can then try to advance the tube gently and slowly into the duodenum. If this fails, one is usually compelled to watch and wait, checking with the fluoroscope once in perhaps 20 minutes, and meanwhile keeping the stomach empty by gentle aspiration. The latter can be accomplished either by suction with a syringe, by a suction machine, or by a gravity apparatus. Special care is essential to avoid all trauma during the passage of the tube, including suction, when intubating the small bowel in search of a bleeding point.

The passage of the tube through the pylorus can be facilitated at times by keeping the patient lying on his right side and gently stroking the upper part of the abdomen.

The following suggestions are of value in passing the double-balloon tube: Before the tube is used, the balloons should be tested for leaks, and then thoroughly deflated and lubricated. The

tube can be passed with little more difficulty than a plain tube, but is somewhat more comfortable for the patient if its tip is halted for a minute or two after the first balloon has passed the pharynx. Once the tube attains a proper position in the stomach, the latter should be aspirated of all contents. The balloons should then be inflated by the injection of 60 cc. of air, and the tube clamped to which they are attached. Inflation with this amount of air will cause the balloons to attain approximately the size of ping-pong balls. When alkaline juice is obtained, the air in the balloons should be removed gently via syringe and the tube tip checked with the fluoroscope. With experience one can usually maneuver the tube so that the balloons are on either side of the pylorus. Re-inflation, using only 40 cc. of air, will aid in anchoring the tube, and decrease the amount of gastric juice that enters the duodenum. If the tip of the tube is just through the pylorus, there is always danger of the tube slipping back into the stomach, and an effort by gentle force should be made to advance it until it is in correct position (Fig. 5). If a large coil of tube is in the stomach when the tip is in the duodenum, peristalsis eventually propels the tip too far along the duodenum.

When the tube lies in the duodenum of a normal subject, the juice obtained is about the color of concentrated urine, rather viscid in consistency, and has an alkaline reaction. The reaction can be satisfactorily determined with nitrazine or similar testing paper. Occasionally duodenal juice is regurgitated into the stomach and aspirated before the tube enters the duodenum. This juice is rather light in color, and although alkaline at first, subsequent samples become acid in reaction as they become diluted with gastric juice.

After a true sample of duodenal juice is obtained, the first cubic centimeter is aspirated and discarded, since this sample will be mixed with some gastric juice from within the tube. Collection of final samples by gravity can now be started with careful inspection of the juice for evidence of gastric juice. It is wise to collect the juice in two or three lots, and to keep it at ice-box temperature, inasmuch as the enzymes are not very stable at room temperature. Removal of the tube after the completion of the procedure should be done gently and slowly. It is important to deflate the balloons completely before the tube is removed. Attention to detail of preparation for the intubation, selection of the right equipment, and the use of great patience in handling will enable one to successfully intubate most infants and children.

Analysis of Duodenal Juice

The duodenal juice is assayed for the three pancreatic enzymes, and a sample examined microscopically for ova and cysts when requested by the patient's physician. The analysis for trypsin activity is the most important single test for pancreatic digestive capacity. Salivary amylase may reach the duodenum in appreciable amounts when the gastric acidity is low,¹⁵ and the duodenal juice may exhibit weak lipolytic capacity due to a gastric lipase.²⁴

Trypsin activity is determined by its effect on 7.5 per cent gelatin substrate incubated for one hour at 37°C., and then refrigerated at 4°C. for 24 hours to stop enzymatic activity. The highest dilution in which the gelatin has been liquefied is recorded as the number of milliliters of juice which produced liquefaction of gelatin. The normal value by this method is 0.02 ml. or less.

The amylase analysis is based on the formation of maltose from a 1 per cent soluble starch solution by a 1-50 dilution of duodenal juice. The normal value in 30 minutes is 20 mg. or more in infants over one year of age. The value for younger subjects is quite variable and lower than the 20 mg. figure.

Lipase assay is determined by the degree of acidity produced when 1 cc. of duodenal juice is incubated for 24 hours at 37°C. with 2 cc. of olive oil. The acidity is determined by titrating the mixture with 0.1 NaOH, and the result is reported as the number of milliliters of 0.1 N NaOH necessary to neutralize the fatty acids formed by the lipolytic activity of 1 cc. of duodenal juice. The normal value is 10 milliliters or more of 0.1 N NaOH.

The exact effect on the pancreatic enzymes of the gastric juice that may be mixed with duodenal samples has not been determined. Andersen¹⁵ believes that the gastric juice, when it enters the duodenum, dilutes the pancreatic enzymes equally and not to an important degree. Davison,²³ in a study of the accelerating action of gastric juice on hog pancreatic extract, showed that the addition of gastric juice to the extracts increased the starch liquefying activity nearly eightfold. This, he concluded, was due to the amylase originally derived from the saliva. The use of two tubes tied together, as described above, permits gastric and duodenal juice to be aspirated separately. By these studies it may be possible to determine which is the most satisfactory method of collecting duodenal samples for the analysis of the pancreatic enzymes.

Summary and Conclusions

1. Intestinal intubation in the management of pediatric patients with disorders of the gastrointestinal tract has become an important procedure within the past ten years. This paper is based on experience with approximately 350 intestinal intubations in infants and children.

2. The most important indications for intestinal intubation in the pediatric age group are: (1) aspiration of duodenal juice for the analysis of the pancreatic enzymes—trypsin, lipase, and amylase; (2) preoperative preparation and postoperative treatment of surgical patients with lesions of the small bowel; (3) detection of bleeding points in the small bowel; (4) miscellaneous: microscopy of duodenal juice in suspected giardiasis; as an aid in locating the site of congenital obstructive lesions of the small bowel, and for assisting the surgeon in rupturing an obstructing membranous diaphragm; and for the study of small bowel physiology.

3. The case histories of two infants with clinical features of the celiac syndrome are described. The pancreatic enzymes were normal in one patient and absent in the other. On the basis of this information, the physician in charge could plan the management of the case and appraise the patient's prognosis.

4. Methods and equipment that have been studied in an effort to improve the technique of intestinal intubation are discussed. It was found that a strong electromagnet was not of value in assisting the movement of a tube through the pylorus. A mercury-weighted tube was impractical, chiefly because of the problems associated with keeping most small patients in what should be an ideal position for the weight to remain over a considerable period in the pyloric antrum.

A double-lumen size 12 Miller-Abbott tube was modified by removing the balloon attached to the end, and substituting two smaller balloons, placed respectively at 1¼ and 2½ inches proximal to the tip of the tube. It was felt that two such masses might be better propelled by gastric peristalsis. Ninety-six intubations have been attempted with this type of tube, and of these, 76 (80 per cent) proved successful. Thirty-one of the 96 patients were less than one year of age, and in this group alkaline juice first appeared in an average time of 43 minutes. In 45 cases over one year of age, the average time required to obtain alkaline juice was 75 minutes.

5. The technique of intestinal intubation is described. The procedure is usually difficult and requires great patience on the part of the intubator. Because the position of the tube should

be checked at 15 or 20 minute intervals, the intubator must guard himself and the patient against overexposure to roentgen rays. Great care should be taken to avoid trauma to the gastro-intestinal tract. Duodenal juice should be collected by the drip method, if possible, and three lots of 2 cc. each should be obtained. The samples should be kept on ice until analyzed.

A brief description is given of tests which can be used for the enzymatic analysis of the duodenal juices.

6. The value of intestinal intubation in the field of pediatrics is sufficient to warrant more widespread use of the procedure.

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GERMANTOWN AND JEFFERSON
HOSPITALS TO AFFILIATE

Germantown Dispensary and Hospital and Jefferson Medical College and Hospital have announced a proposed affiliation under which the two institutions will combine their efforts and will cooperate with each other in major activities to the advantage of the public at large and for their mutual benefit.

The affiliation and the implementing agreement will not in any way constitute or contemplate a merger. Germantown and Jefferson will maintain their separate identities and will continue their own business affairs under control of their respective governing boards and officers; the two, however, agree to joint consultation at the appropriate level on "all matters arising in connection with any activity of either institution which would directly and substantially affect the other institution to the end that the decisions shall be approved by both."

A formal agreement approved by the boards and staffs of the two institutions is planned to go into effect within the course of the next few months.

The immediate objectives of the affiliation are: to secure for the Germantown Dispensary and Hospital the cooperation and assistance of the Jefferson Medical College and Hospital in increasing the services rendered the public by Germantown and to secure for Jefferson the privilege of using the facilities of Germantown's hospital for the teaching of Jefferson's medical students. In this way the Germantown area will continue to be served by its own community hospital and Philadelphia will benefit by an increase in teaching facilities, in conformity with the modern trend in efficient hospital practice of utilizing to the fullest extent all available opportunities for medical training.

Officials of the two institutions pointed to certain advantages expected to result from the affiliation: Germantown, being in a position to offer to its physicians

an opportunity to teach and develop specialties under the auspices of an outstanding medical college, will increase its standing and efficiency in the community.

The staffs of the two hospitals will be enlarged and improved by providing that certain personnel shall be members of the staffs of both hospitals.

The exchange of ideas and advice between the personnel of the two institutions on operation and management matters should be beneficial to both.

Jefferson Medical College, one of the oldest and largest medical schools in the country, and now short on available beds for teaching purposes will obtain the privilege of using Germantown's facilities for the clinical training of its medical students.

The affiliation will make it possible to effect certain economies in the operation of the Germantown Hospital and is expected to result in a substantial increase in the number of patients entering that hospital, with a resultant increase in Germantown's operating income.

Jefferson Hospital, which has continued to be crowded to the limit and has a long waiting list, will plan to fill beds not now occupied at Germantown. Jefferson Hospital in its Philadelphia divisions has approximately 900 beds and Germantown Hospital about 400.

TREATMENT OF LEUKOPENIA

Liver extract containing folic acid reverses neutropenia and leukopenia produced in rats by a purified diet containing an insoluble sulfonamide, but does not correct a similar state produced by benzol. Platt and associates state that methyl acetamide with para-chloroxylenol, 25 per cent CXM, reverses, by direct action on the bone marrow, benzol-induced agranulocytosis and leukopenia, but fails to correct neutropenia produced by a purified diet containing succinylsulfathiazole.—*Yale Journal of Biology and Medicine*.

ENDOCRINE FACTORS IN DERMATOLOGY

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MANY workers have reported an influence of certain hormones on the integrity of the human skin. Much has been written on the use of desiccated thyroid in the treatment of a wide variety of skin conditions. Conditions such as acne vulgaris,^{1, 2} urticaria,¹ atopic dermatitis,¹ generalized myxedema,³ ichthyosis,² and psoriasis² have all been benefited by administration of this substance. More recently the role of estrogen in the treatment of skin lesions has been studied.

That estrogen is valuable in the treatment of lesions of the mucous membrane of the genital tract is acknowledged. Estrogenic substances have been used both by local application and systemic administration in the treatment of senile vaginitis and kraurosis vulvae.^{7, 8, 9, 10, 11} There is also abundant evidence that atrophic changes which result in fissuring of the mucous membranes and skin of the vulva, which is symptomatically evident as pruritus vulvae, respond well to estrogen locally applied or otherwise administered.^{7, 8, 9, 10, 11}

It is perhaps not so well accepted that skin and mucous membrane in other areas of the body may benefit from the application of estrogen. It is nevertheless somewhat surprising that more curiosity has not been manifest in the effect of estrogen in abnormalities of the skin in general. It has long been recognized that abnormal pigmentation, various dermatoses, papillomata, rosacea, and other conditions are prone to appear with waning ovarian function or after the menopause.¹² Data are available to show that estrogens tend to cause proliferation and increased keratinization of surface epithelium. Further, a certain degree of local hyperemia can be elicited by topical application of this hormone to certain skin areas.¹³ It has also been reported that topical application of estrogen has resulted in histologic regenerative changes, improved hydration and blood circulation,²³ and partial regeneration of elastic fibrilla of the aged skin.^{15, 16}

A considerable number of papers have appeared since 1942 which indicate the value of estrogen in keratoconjunctivitis sicca,¹⁴ skin changes in senile women,^{15, 16} atrophic changes in the buccal and gingival mucous membranes,^{17, 25, 29} keratoderma climactericum,^{18, 4} bullous lichen planus,¹⁹ and in atrophic rhinitis.^{20, 21, 22} From this it would appear that there is a wide variety of skin and mucous membrane lesions which will respond to estrogen.

Methods and Patients Studied. During the last three to four years more than one hundred patients have been studied who had previously been treated for psoriasis, seborrheic dermatitis, pityriasis rosea, lupus erythematosus, sarcoid, dermatophytosis, contact dermatitis, and neurotic excoriations. In all of these patients it was suspected that some hormonal deficiency might be a factor in the causation of the skin lesions. From this series ten cases have been selected to illustrate skin lesions which responded to the administration of estrogen or thyroid. In this study conditions which have ordinarily been recognized as susceptible to treatment with hormone therapy are not included. Those lesions which have been shown to respond to estrogen are as follows: menopausal pruritus vulvae et ani, generalized pruritus, keratoderma climactericum, mucous membrane lesions, neurodermatitis of the nucha or lateral aspects of the neck following surgical or radiation menopause, acne vulgaris with a definite premenstrual flare, and rosacea.

Laboratory Studies. The following laboratory studies were made in the majority of these patients: urinalysis, basal metabolism, complete blood count, sedimentation rate, non-protein nitrogen, blood urea nitrogen, blood sugar, blood cholesterol, and serology. In the cases reported in this paper there were no abnormal findings except in Case 9, in which the blood cholesterol was high and the basal metabolism rate was low and thyroid was given.

Complete dental x-ray studies were made when indicated, as in Case 7.

Read before the Section on Dermatology at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 5, 1948.

Biopsies were made in Cases 2, 3 and 4 of this series.

Gynecologic consultations were had in Cases 1 and 3.

Medications Used. The patients were given estrogen by intramuscular injections, by mouth,

and by topical application. The estrogens injected were estradiol benzoate, assayed in rat units and containing 10,000 R.U. per cc., or estrogenic substances assayed in estrone international units, containing 10,000 I.U. per cc. The oral medication used was conjugated estro-



Fig. 1, Case 1. (A) Psoriasis-like eruption of five and a half years' duration before estrogen therapy. (B) One year after discharged. No recurrence in meantime. No maintenance therapy. (C) Generalized distribution of psoriasis-like eruption. (D) One year after discharged. No recurrence in meantime. No maintenance therapy.

gens (equine)* and was given in 1.25 mg. tablets. Topical administration was accomplished by applying conjugated estrogens incorporated in a vanishing cream-type base and containing 0.625 mg. of conjugated estrogens per gram of cream.* The estrogen cream was applied to each skin lesion twice a day. An area the size of both palms would receive about two grams of the cream (one-half level teaspoonful) containing 1.25 mg. of conjugated estrogens at each application.

Case Reports

CASE 1.—Psoriasis-like eruption (Fig. 1). Mrs. B. G., white widow, age 57.

History: This patient reported that the eruption had appeared first on her left elbow sixteen months after her menopause and had spread rapidly over the entire torso and extremities except for the area between the shoulders. Her face became involved last. Her menopause occurred at 50 years of age and was followed by extreme emotional irritability and a feeling of weakness. For several weeks prior to her first visit she had suffered from nausea and vomiting.

Clinical findings May 13, 1947: Upon her first examination the patient presented a more or less generalized, dry, scaly, psoriasis-like eruption on her face, elbows, knees and other extensor areas. The flexor surfaces of her forearms, wrists, and inframammary area were involved, showing an acute, inflammatory, oozing eruption. These areas were extremely tender.

Treatment was started immediately and consisted of 10,000 R.U. of estradiol benzoate intramuscularly twice a week and estrogen cream topically twice daily. Approximately 8 Gm. of the estrogen cream, containing 5 mg. of estrogen, was used at each application.

Clinical course: Improvement was dramatic. After two injections of 10,000 R.U. of estradiol benzoate and the thorough application of the estrogen cream twice daily, the eruption was improved, and the nausea, vomiting, and extreme nervousness had completely subsided. By June 10, after seven injections of estradiol benzoate and the application of the estrogen cream twice daily, all areas of dermatitis were practically healed. There was very little scaling and no bleeding points showed when the scales were removed. The previously moist, inflammatory areas were normal in texture except for slight erythema. Her appetite had improved and she was sleeping well. The injections were reduced to one a week, but the topical application of the estrogen cream was continued. On June 17 all skin lesions were completely healed. Medication, both parenteral and topical, was discontinued.

Starting June 24, there was vaginal spotting for two days. The patient had had nine injections of estradiol benzoate. Pelvic examination was negative, but a diagnostic curettage was recommended if there was any further spotting. There was no return of the skin lesions. On July 15 the skin was entirely clear except for residual pigmentation in the previously involved areas.

On July 29 a slight recurrence of skin lesions was

noted and consisted of three or four small, slightly scaly lesions on the right knee. This recurrence probably would have been avoided if the topical application of the estrogen cream had been continued. However, there were no general or emotional symptoms due to estrogenic deficiency. One injection of 10,000 R.U. of estradiol benzoate was given and a thorough application of the estrogen cream, two grams (one-half level teaspoonful), was made to the lesions twice a day. On Aug. 15, 1947, the skin was entirely clear and the topical application of the estrogen cream was stopped. On Sept. 15, 1948, there had been no recurrence of any skin lesions since the slight recurrence she had had July 29, 1947. No further estrogenic medication was required or given. Her general health was good and she worked every day.

CASE 2.—Lupus erythematosus-like eruption (Fig. 2). Mrs. W. H. M., white woman, married, age 47.

History: This patient stated that she spent two weeks of February, 1944, in Florida. At that time she complained of being physically and emotionally exhausted and her hair had started to fall out. She had always been subject to sun poisoning even on moderate exposure, the reaction being characterized not only by erythema but by a pruritic, papular eruption. She had such a reaction, probably more severe than usual, while she was in Florida. Two weeks after her return she broke out on both cheeks and the right ear with an erythematous, infiltrated eruption apparently similar to the one present on her right cheek at the time of her first consultation. She immediately sought treatment from a specialist and was given one injection of a gold preparation to which she had considerable reaction. This therapy was discontinued and she received a series of injections of a bismuth compound. Later she was given smaller doses of a gold preparation to which she responded more favorably. The patient was discharged from treatment in February, 1945. There was an acute recurrence of the skin lesion on her right cheek in July, 1945.

Additional laboratory studies Sept. 21, 1945: A biopsy† was taken from the lesion on the right cheek. The pathologic diagnosis was adenoma sebaceum (formes fruste?). Microscopic description: The epidermis is atrophic with absence of interpapillary pegs. The only abnormality in the corium consists of hyperplasia of the cells in the sheaths of the hair follicles. These are strictly confined to the hair follicles; they do not infiltrate the surrounding parts. These cells are more closely crowded than normal and their nuclei are of the young and proliferative type. This has led to enlargement of the hair follicle and a certain amount of distortion of its form.

Clinical findings Sept. 17, 1945: Upon her first examination a large, annular, sharply margined, and erythematous lesion was observed on the right cheek. Peripheral infiltration of the lesion was marked and the margin was slightly elevated. There was no central atrophy.

Treatments tried were unsatisfactory. This patient was shown at the Philadelphia Dermatological Society Oct. 19, 1945 (this meeting was reported in the *Archives of Dermatology and Syphilology* for June, 1947). From the following excerpts of the discussion it readily can be judged that the case presented unusual aspects which were difficult to diagnose: Dr. E. R. Gross said that he and Dr. Carroll S. Wright had observed this patient for over a year and thought the case came under the "head of Darier-Roussy sarcoid." Dr. Morris Markowitz said, "Histologically, the picture is not that

* The oral estrogen used in this study was premarin and the estrogen cream used was premarin cream, made available through the courtesy of J. Murray Scott, M.D., Medical Director, Ayerst, McKenna & Harrison, Ltd.

† All biopsy material in this series of cases was studied by Fred Weidman, M.D.

of sarcoid or lupus erythematosus. I think the lesion is a form of erythema elevatum diutinum perstans." Dr. Fred Weidman discussed the section which he had previously studied for me. Dr. Donald Pillsbury said, "This case is representative of a group of cases with sensitivity to sunlight in which the eruption appears like lupus erythematosus. It is difficult at times to classify such cases accurately." Lupus erythematosus and chronic erythema multiforme were other suggested diagnoses.

Further treatment with bistrimate, as was suggested, was without benefit. Treatment with estrogen was started Nov. 13, 1945, consisting of injections of 5000 I.U. of estrone (equine).

Clinical course: The lesion was 50 per cent improved twenty-four hours after the first injection, and completely disappeared following the second injection. On Feb. 4, 1946, the patient returned with a recurrence of two small, but similar, lesions on her face of a few days' duration. She was in a highly emotional state. Three injections of 5000 I.U. of estrone and one of 2000 I.U. caused the complete disappearance of these lesions. The patient was not seen again until Sept. 15, 1948, at which time she complained of emotional disturbances which were accompanied by recurrences of the skin lesions. Each time the skin lesions could be controlled by estrogen therapy.

CASE 3.—Psoriasis-like eruption. Mrs. C. D. R., white woman, married, age 55.

History: The external auditory meati were the initial site of the eruption which was of five years' duration. The onset had coincided with her menopause which had been accompanied by metrorrhagia and severe hot flashes. The knees and elbows had been involved for three and a half years, and the palms for two, becoming badly involved in the last six months. Originally the eruption was worse in the winter, practically clearing in the summer.

Additional laboratory studies July 7, 1948: A biopsy was taken from the lesion on the right knee. The pathologic diagnosis was psoriasis. Microscopic description (Fig. 3): To a large extent the picture is that of psoriasis. All of the slightly thickened stratum corneum is parakeratotic, but the stratification is poorly developed. The high-grade acanthosis is beautifully regular in type. The tips of the papillae approach closely to the surface of the skin and many of them are edematous and club-shaped. Lymphocytic infiltration appears notably around the capillaries of the papillae and around the vessels in the subpapillary plexus. The

only shortcoming in respect to psoriasis as regards the corium is the relative inconspicuousness of the capillaries in the papillae; they are not as rigid appearing and congested as usual. Incidentally, one or two tiny hemorrhages appear in the tips of the papillae. The shortcomings of psoriasis are so few and minor that they cannot stand in the face of such a large assemblage of criteria in favor of it.

On July 9, 1948, a cervical biopsy showed chronic ulcerative endocervicitis with no suggestion of malignancy.

Clinical findings: Upon her first examination (June 8, 1948) there were patches of chronic, squamous dermatitis on the extensor surfaces of her forearms immediately below the elbows, extensor surfaces of the legs below the knees, and in the external auditory canals. There was also a dry, fissured eruption limited to the central portion of each palm and the interdigital webs of the forefingers and thumbs. The patient complained of a burning sensation in all the lesions, especially the palms.

Treatment was started immediately. An injection of 10,000 R.U. of estradiol benzoate was given, and about four grams of estrogen cream was applied to the involved areas twice daily.

Clinical course: One injection of 10,000 R.U. of estradiol benzoate caused a heavy vaginal discharge with macroscopic blood. Parenteral estrogenic therapy was discontinued. Topical application of estrogen cream was continued without much improvement in the eruption. On July 7 an injection of 10,000 R.U. of estradiol benzoate was given with the same result as before. The patient was then referred for pelvic examination. The findings on the cervical biopsy are reported under additional laboratory studies. The gynecologist advised continuing the estrogens. On July 12 an injection of 10,000 R.U. of estradiol benzoate, 1.25 mg. of conjugated estrogens (equine) daily orally, and the estrogen cream topically were ordered. On July 16 all skin lesions had improved and the burning sensation had disappeared. An injection of 10,000 R.U. of estradiol benzoate was given and the oral medication was increased to 1.25 mg. twice a day. Topical application of the estrogen cream was continued. On July 21 the fissuring of the palms had disappeared. Parenteral, oral, and topical doses of estrogen were continued.

On July 30 the patient complained of tenderness of the breasts and parenteral and oral estrogen were stopped. This was followed by uterine bleeding for six days. This was obviously associated with the discon-

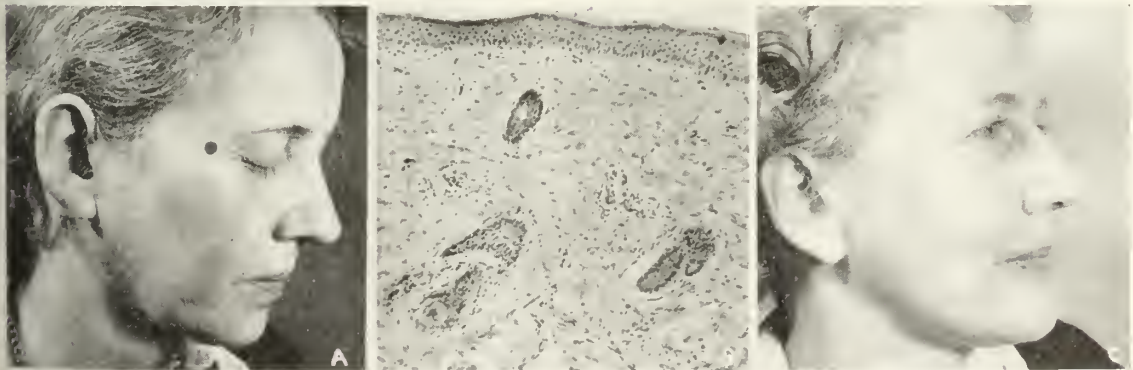


Fig. 2, Case 2. (A) Lupus erythematosus-like eruption due to estrogenic deficiency. (Black spot on temple is a photographic defect.) (B) Histologic section. Pathologic diagnosis—adenoma sebaceum (formes fruste?). (C) After estrogenic therapy.



Fig. 3, Case 3. Histologic section showing the pathology of psoriasis. Biopsy taken from a psoriasis-like eruption involving the knees, similar clinically to Case 10, Fig. 5-B.

tinuance of the internal estrogen therapy. Local application of the estrogen cream was continued. On Sept. 8, 1948, all the skin lesions were completely healed, but the patient was advised to continue the topical application of the estrogen cream for some time as maintenance therapy. NOTE: The patient had had five injections of 10,000 R.U. each of estradiol benzoate, 1.25 mg. of conjugated estrogens (equine) orally for four days, and twice a day for twelve days, and estrogen cream topically twice a day from June 8, 1948.

CASE 4.—Psoriasis-like eruption. Mrs. F. D., white woman, married, age 49.

History: This patient said that her skin lesions were of approximately three years' duration. The lesions on the elbows and knees had appeared first and had shortly been followed by a patch of neurodermatitis on the inner aspect of the right thigh, then by lesions on the dorsa of the hands and on the inner aspects of both ankles. Her menopause had occurred at the age of 44. The lesions on the elbows and knees had been treated for psoriasis without relief, and the lesions on the ankles for dermatophytosis and contact dermatitis likewise without relief.

Additional laboratory studies July 9, 1948: A biopsy was taken from a lesion below the right knee. The pathologic diagnosis was subacute diffuse dermatitis. Microscopic description: The epidermis is irregularly acanthotic. The stratum corneum is thick; for the most part from parakeratosis, with small "spots" of hyperkeratosis here and there. Much of the thickening is accounted for by an infiltration of serum between the layers, thus resulting in tiny, indefinitely outlined vesicles at some places. At the most, only a few polymorphonuclears are intermixed with the serum. The rest of the epidermis exhibits a uniform elongation of interpapillary pegs. The epithelial cells are surprisingly little infiltrated by edema, considering the changes in the stratum corneum. As to the corium, a conspicuous mantle of lymphocytes appears around the vessels of the subpapillary plexus; they consist almost exclusively of

lymphocytes. The papillae are abnormal only in that their connective tissue appears to be somewhat denser than normal. The picture is not diagnostic of any particular dermatologic entity. It is a subacute, diffuse dermatitis which features edema in the stratum corneum as the most promising lead for the separation of some entity. That is, a local irritant, whether traumatic or not, should be given first place in eliminating the clinical possibilities. After that, the eczematoid dermatitis could produce this reaction. Psoriasis can be excluded.

Clinical findings July 9: There were squamous, infiltrated, psoriasis-like lesions on the forearms, below the elbows, below the knees, and on the anterior aspect of the legs. There was a large patch of neurodermatitis on the inner aspect of the right thigh. On the anterior aspect of both insteps and extending upward appeared a subacute, moist, oozing dermatitis. Verrucous, keratotic lesions typical of keratoderma climactericum involved both heels. Pruritus was intense in all the lesions.

Treatment was started immediately and consisted of injections of 10,000 R.U. of estradiol benzoate at three-day intervals, 1.25 mg. of conjugated estrogens (equine) twice daily orally, and the topical application of approximately four grams of estrogen cream to the involved areas twice daily.

Clinical course: After two injections of 10,000 R.U. of estradiol benzoate and the oral and topical estrogen therapy as indicated, the lesions were regressing satisfactorily, but there was still some itching. On July 16, after three injections and the continued oral therapy and use of the estrogen cream, all the lesions except those over the insteps were practically healed and the itching had completely subsided. On Aug. 16, 1948, all skin lesions had healed. The patient was advised to resume oral and topical estrogen therapy if there was any recurrence of the skin lesions.

CASE 5.—Distorted growth of the nails. Mrs. M. E., white woman, married, age 52.

History: This patient said that her nails had been growing abnormally for an indefinite period of time



Fig. 4, Case 9. Deep vesicles in lichenified dermatitis. Limited to palms.

and that the condition had become progressively worse. She had been in her climacterium for about two years and had severe and frequent vasomotor disturbances.

Additional laboratory studies: The blood calcium was 9.4.

Clinical findings Jan. 18, 1946: When this patient was first seen, the nail plates were thin and brittle with a gouged-out appearance in the central portion, indicative of growth pathology in the matrix. All the nails were more or less symmetrically affected.

Treatment: This patient was referred for endocrinologic consultation, and treatment was started January 21. Her medication consisted of extract of desiccated thyroid 0.01 Gm. and calcium glycerophosphates 0.325 Gm. twice daily and 1.25 mg. of conjugated estrogens (equine) three times a day.

Clinical course: By March 4 the nails showed some improvement and the medication was continued. On September 13 the patient discontinued the prescribed endocrine therapy of her own volition because her nails had satisfactorily improved. On Jan. 10, 1947, the patient returned for treatment because her nails were regressing to the previous pathologic condition and she was having severe and frequent hot flashes. The original estrogen, thyroid, and calcium medication was resumed. On April 15 the nails were improved and had begun to thicken at the base. The endocrine medication was continued. On July 10, 1947, the nails were growing normally from the matrix. They were smooth and of the proper texture and consistency. The patient menstruated and all endocrine medication was discontinued.

CASE 6.—Squamous eruption limited to the palms. Mrs. J. B. G., white woman, married, age 56.

History: Upon her first examination a dermatitis of the palms was observed. This eruption had appeared shortly after a panhysterectomy in January, 1943. The operation had been followed by a considerable loss of weight, extreme nervous irritability, emotional instability, and insomnia.

Clinical findings Aug. 8, 1946: There was a chronic, erythematous, papular, highly pruritic eruption limited to the palms.

Treatment was begun immediately and consisted of injections of estradiol benzoate, 10,000 R.U. each, and the application of the estrogen cream twice daily. On August 12, after one injection of 10,000 R.U. of estradiol benzoate and the twice daily application of the estrogen cream, the palms were 50 per cent improved; the redness and scaling were gone and the papules had decreased in size. The "nervousness" had diminished. On August 30, after four injections of estradiol benzoate, 10,000 R.U. each, and one of estrone, 6000 I.U., the palms were healed. The patient was sleeping well and had a feeling of general well-being. At her request she was given three more injections of estrone, 6000 I.U. each, at weekly intervals and she continued the use of the estrogen cream for three weeks. On November 12 and December 31 the patient had slight recurrences of the papular dermatitis of the palms which were effectively controlled by application of the estrogen cream alone.

On July 7, 1947, the patient suddenly developed hot flashes, four to five a day, and her palms had broken out. This time the eruption was completely controlled by one injection of 10,000 R.U. of estradiol benzoate and the topical application of the estrogen cream. However, the patient was advised to take 1.25 mg. of conjugated estrogens (equine) daily orally for three weeks

of each month and to apply the estrogen cream as maintenance therapy, as she was highly emotional.

On July 6, 1948, the patient was again seen because the center of the left palm had broken out in a vesicular, erythematous eruption, and both hands were considerably swollen. She received three injections of estradiol benzoate and applied the estrogen cream from July 6 to July 13, 1948, and her palms were normal. The oral and topical continuance of estrogen was advised for an interval as maintenance therapy.

CASE 7.—Psoriasis-like eruption. Mrs. M. H., white woman, married, age 51.

History: This patient reported that the first skin lesion appeared on the outer aspect of her left leg in 1942 and she thought that its appearance coincided with her menopause. The lesions on her elbows, right thigh, knee, and vulva had appeared gradually thereafter.

Additional laboratory studies: Complete dental x-rays were negative.

Clinical findings May 6, 1947: Upon her first examination thick, infiltrated, scaly, psoriasis-like lesions were observed on the elbows, outer aspect of the left leg and knee, right thigh, and vulva. Bleeding points were evident when the scales were removed, which is supposedly characteristic of psoriasis. All the lesions were pruritic.

Treatment was started immediately and consisted of injections of estradiol benzoate, 10,000 R.U. each, and the topical application of the estrogen cream twice daily.

Clinical course: The progress was immediate and satisfactory. After the third injection of estradiol benzoate, my staff and the patient agreed that the lesions were 50 per cent improved. On Aug. 8, 1947, all the lesions were completely healed. The patient had received six injections of estradiol benzoate, 10,000 R.U. each, and had applied the estrogen cream regularly twice a day. All medication was discontinued at this time. On Sept. 15, 1948, there had been no recurrence of any skin lesions.

CASE 8.—Eczematoid eruption. Mrs. M. S., white woman, married, age 52.

History: This patient reported that a patch of "eczema" first appeared on the dorsum of the right instep in 1941 and that for two years it would "come and go." In 1944 the dorsa of the hands had broken out, and gradually other areas had become involved. In November, 1945, the face, ears, and almost the entire integument were affected. She had had a miscarriage in 1923 which had been followed by almost continuous metrorrhagia for eight or nine years, ending in a symptomless menopause at the age of 38. This patient had been exhaustively studied and treated at two medical centers without relief. In 1944 complete extraction of the teeth had been advised and carried out without amelioration of the dermatitis.

Clinical findings Feb. 12, 1946: Upon her first examination a dusky, violaceous, hyperpigmented, chronic, eczematoid dermatitis involved the dorsa of the feet, the legs, the vulva, extending onto the inguocrural areas, and the inframammary region. The eruption was highly pruritic. Her stature was typically hypoglandular and she weighed 270 pounds.

Treatment was started February 14 and consisted of injections of 10,000 R.U. each of estradiol benzoate every fifth day, 0.2 mg. thyroxin twice a day by mouth, and the topical application of the estrogen cream to all areas of dermatitis twice a day. Her diet was reduced to 1000 calories, as she was obese. After three injections

of estradiol benzoate, 10,000 R.U. each, thyroxin orally, and estrogen cream topically, there was substantial improvement in the dermatitis. Only very slight activity continued in two or three small areas. Her weight was 253 pounds, pulse 80, blood pressure 148/90. Estradiol benzoate was reduced to 6000 R.U. every fifth day. Thyroxin orally and estrogen cream topically were continued. On March 17 the dermatitis was completely healed; only residual pigmentation remained. The weight was 244½ pounds, blood pressure 142/90. On May 1, 1946, there was no return of the dermatitis. The estradiol benzoate was reduced to 6000 R.U. every ten days. Thyroxin orally and estrogen cream topically were continued.

On Aug. 1, 1947, the patient reported by telephone that she had stopped all medication, that she was eating everything and was well. On July 15, 1948, she reported that there had been no recurrence of the dermatitis and that she was enjoying good health.

CASE 9.—Squamous eruption limited to the palms (Fig. 4). Mrs. H. M. N., white woman, married, age 60.

History: The patient reported that the dermatitis began in the right palm in August, 1945, and had continued to be more severe on the right than on the left. Because of metrorrhagia a hysterectomy was performed in 1938. She did not experience any degree of menopausal reaction following this operation.

Clinical findings April 17, 1946: At this time there was an eruption confined to the central portion of the palms. It was characterized by vesicles, deeply seated in a dry, tenaciously squamous, lichenified skin. The lesions itched "like poison ivy." Her skin bruised easily without appreciable trauma. Body, extremity, and genital hair was absent. Obesity was most pronounced over the trochanters. The thyroid gland was atrophied. The skin did not perspire freely and the palms were especially dry.

Treatment was started on April 20 and consisted of extract of desiccated thyroid 0.03 Gm. three times daily and the application of about two grams of the estrogen cream to the palms twice daily. The patient's blood cholesterol was 348 mg.

Clinical course: By May 13 the palms were improved. Thyroid medication was discontinued because her blood cholesterol had fallen from 348 to 169 mg. On June 8 the dermatitis had practically disappeared except for a slight thickening and roughness of the right palm, which was the original lesion. The blood cholesterol had increased to 250 mg. and thyroid therapy was again instituted. Topical application of estro-

gen cream was continued. By Aug. 26, 1946, the skin on the palms was normal in texture and the general health was good. All treatment was discontinued. On August, 1947, there had been no recurrence of the dermatitis, and the general health continued good. On July, 1948, the same report was given.

CASE 10.—Psoriasis-like eruption (Fig. 5). Mrs. N. J., white woman, married, age 57.

History: This patient reported that her skin lesions had begun to appear between one and two years after her menopause. The menopause had occurred at 50 years of age and was associated with severe hot flashes and persistent emotional instability. The first lesions to appear were on the elbows, and these have persisted for at least five years. One year prior to her first visit, lesions appeared on her knees, and six months previously highly pruritic patches were first observed on the buttocks. The lesions have always been dry and scaly. Two years prior to her first visit an acute eruption appeared on the hands and extended up the arms, which persisted for a year or more before it regressed, leaving dry patches of dermatitis on the palms. These patches were particularly annoying and resistant in the interdigital spaces, and especially between the thumbs and forefingers. The patient's hands had been treated for fungus infection and contact dermatitis for more than a year without relief. Her other lesions had been treated for psoriasis without improvement.

Clinical findings April 15, 1947: Upon her first examination large, sharply defined, psoriasis-like eruptions were observed on her elbows, knees, and palms. These lesions were chronic, infiltrated, and squamous in type. Smaller and more recent lesions of a similar nature were observed on the inner and outer aspects of the left ankle and on each buttock. Examination of the scalp revealed five small patches of alopecia areata.

Treatment was begun April 22 and consisted of six injections of 10,000 R.U. each of estradiol benzoate given at approximately four-day intervals between April 22 and May 13, 1947. Estrogen cream was to be applied to the involved areas twice daily. The amount of estrogen cream per application was approximately four grams.

Clinical course: Improvement was immediate with amelioration of skin and climacteric symptoms within forty-eight hours. Her emotional improvement was dramatic; her sleep became restful and restoring. By May 13 the lesions on her buttocks and ankles were completely healed. The lesions on her elbows and knees had practically disappeared. One small area on the lateral aspect of the right knee remained. All other areas



Fig. 5, Case 10. (A) Psoriasis-like eruption of six years' duration. (B) Lesions on knees. (C) Histologic section from knee, showing a subacute diffuse dermatitis.

of infiltration had disappeared. The skin was smooth, but some pigmentation remained. Injections of estradiol benzoate were stopped and replaced by the oral administration of 1.25 mg. of conjugated estrogens (equine) three times daily. Topical application of estrogen cream was continued.

By June 24 all skin lesions were completely healed. On July 1 there had been no recurrence of skin lesions. Oral estrogen was discontinued because of soreness and heaviness of her breasts. This was followed by uterine bleeding for four days. Topical application of estrogen cream was continued. On July 29, 1947, the skin was still clear. All treatment was stopped. On June 15, 1948, the patient returned with a recurrence of the lesions on her elbows, knees, and right ankle of mild degree and of two weeks' duration. Oral and topical applications of estrogen were reinstituted and the lesions promptly disappeared.

Discussion of Therapy

From the results reported it appears that the chronic skin lesions which respond to estrogens require the preliminary administration of estrogen, either by injection or by mouth, before topical application of estrogen-containing cream will be effective. It is quite possible that the chronicity of the lesions is the reason why this preliminary systemic administration of estrogen is necessary. It might also be because the estrogen-containing cream was of a potency too weak to affect a chronic lesion or was not used in a sufficient amount. However, in the treatment of these chronic lesions an estrogen-containing cream is of great benefit and value as maintenance therapy. As will be recalled from the reported results, in all instances the improvement continued and the integrity of the skin was satisfactorily maintained by the cream alone. This is gratifying, as the systemic administration of estrogen in sufficient dosage to be effective has produced uterine bleeding in several instances in women who were past the menopause. Such a side effect is most undesirable. In no instance were general estrogen effects or bleeding produced by the topical application of the cream.

In many of these women, association was observed between skin lesions and emotional instability during the climacterium. The natural conjecture is that tapering off of estrogen production in the climacterium may be a causative factor in both, and the evidence furnished by the cases described herein seems to support the conjecture.

The cases presented are ten of a series of over one hundred and illustrate:

1. A number of chronic, recalcitrant eruptions, frequently psoriasis-like, in women in whom the estrogenic level might be inferred to be low, can be completely controlled by estrogens administered parenterally, orally, and topically.

2. The inference seems highly probable that these skin lesions are caused by estrogenic deficiency. That deficiency, it seems probable, is caused by some imbalance of physiologic processes during the climacteric. Therefore, it seems, such lesions will probably recur until the post-climacteric physiologic equilibrium has been successfully achieved.

3. Recurrences of cutaneous lesions, if treated at their inception, can be controlled by topical application of estrogens alone. However, if allowed to progress, they will require systemic treatment.

4. It appears advisable to continue the use of the estrogen cream as maintenance therapy for a time after the disappearance of the skin lesions.

5. The majority of these patients were menopausal. However, a few were in the early thirties, and there were no symptoms of the menopause. But even in these it may be inferred that the estrogen levels were low because they responded to estrogen therapy. This is analogous to the response observed with estrogen therapy in adolescent acne.

6. The integrity of the skin, as is well known, is maintained by estrogen. An interesting aside is that women who have a late climacterium have much younger-appearing skin than women in whom the menopause occurs early.

7. Some of these patients are women whose ovarian activity has been abruptly terminated by surgery or radiation.

The line of thought which supports the inferences drawn from the cases presented is as follows: a completely atrophied vagina can be brought to full cornification in seven days by adequate and individually accurate therapy. The skin lesions described in this paper improved swiftly and dramatically after estrogenic treatment. This suggests the accuracy of the original premise that these lesions, like vaginal atrophy, were caused or at least provoked by estrogenic deficiency and can be cured or controlled by supplying that deficiency.

Summary

1. Ten dermatologic cases responding to estrogen therapy have been presented. Two of these patients also received thyroid.

2. The estrogen was administered systemically by intramuscular injections and by mouth and was also given by topical application of an estrogen-containing cream.

3. The response in all instances was dramatically prompt and consistent.

4. It appears that in the treatment of these

chronic conditions systemic therapy must be given first. The reason for this has been discussed.

5. It appears that estrogen-containing creams have a definite role in the treatment of certain chronic skin conditions.

This is one phase of the study of the endocrine factor in dermatologic conditions in that it is limited to women near, at, or past the menopause. No doubt other studies will show new fields in which the endocrine approach may prove fruitful.

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ABSTRACT OF DISCUSSION

CHARLES WILLIAM DUNN (Philadelphia): It is a pleasure to discuss this brilliant paper by Dr. Drant. I can endorse practically every word she said as to caution and the excellent results. You may be a little concerned as to why these results can be produced, so I want to leave you with this explanatory thought: All the tissues affected by estrogen have the same basic embryonic derivation. The mucous membrane of the vagina or endometrium can be affected by estrogens. The skin is another developmental form of the same basic embryonic tissue. The other thing to bear in mind is that the endocrine glands exert a basic action upon skin development beginning from its early state in the embryo. All this has been well established in the cretin where there is a delay in the normal structural development. Atrophic changes in the skin are also common in the menopausal states, so that while these results may seem spectacular, there is a physiologic and embryonic reason for these tissues being affected both by thyroid and by the estrogens.

The history of these cases is very important. Dr. Drant did not have an opportunity to enlarge upon that, but you cannot look at a patient just as a dermatologic patient. You have to view the patient as a complex physiologic unit and determine the functional performances of the separate system and what reactions of the menopause are present. These cases do require more than the average clinical investigation in order to attain the results. Normal reactions to therapy will manifest themselves when the patient is brought up to a normal physiologic level by estrogenic therapy, namely, by breast and vaginal reaction. There are patients who have a certain differential in estrogenic response, thus the dose cannot always be standardized, and endocrine therapy of dermatologic disorders of this type becomes a matter of clinical experience. If you attempt to use therapies reported by Dr. Drant, do not be too discouraged by results which are not comparable, because it may be due to the fact that you are not using sufficient therapy.

POINTERS FOR BETTER VISION OF TELEVISION

These suggestions should help television fans see programs better and prevent eye fatigue, *The Journal of the American Medical Association* said in answer to a query.

1. In general, a large screen is considered better than a small one, because it allows clearer vision at a greater distance and gives a larger visual angle.
2. A distance of ten feet or more away from the screen would, in general, be better than a shorter distance, provided the size of the screen and of the room would permit.
3. The nearer perpendicularly the screen is viewed,

the better. Too much of an angle produces distortion and makes coordination of the two images received by the eyes difficult.

4. Although there is not a definite time limit for watching television, some discretion should be used, and it should not be persisted in beyond the point of fatigue.

5. Daylight screens, in general, are considered better than the ordinary ones because they are compatible with more light in the room, thus reducing the contrast between screen and surrounding objects.

Although television in itself does not produce eye strain, it requires all the important "components of the visual act," and patients often complain of fatigue after relatively short periods, *The Journal* said. People with eye defects are especially likely to notice fatigue.

Veterans Administration Medical Service

Fee Schedule

The following fee schedule for medical services as agreed upon by the Veterans Administration and The Medical Society of the State of Pennsylvania is applicable and in force up to and including June 30, 1949. Corrections to the fee schedule were made through the activities of our state medical society's Committee on Medical Economics and VA headquarters as late as February, 1949.

THE TWO PARTS OF THE FEE SCHEDULE

In order to achieve uniformity and to expedite negotiations between Veterans Administration and state medical associations or state medical service organizations concerning fee schedules, the Veterans Administration requests that such fee schedules be submitted on this prepared form in two parts:

PART I consists mostly of out-patient services to be rendered in the physician's office, veteran's home, or hospital.

PART II is made up principally of items relating to in-patient services.

The reason for the separation of the total schedule into parts is to permit the shorter, more frequently used and more urgently needed PART I to be quickly submitted, accepted, and put into operation while the longer and more difficult PART II is being negotiated.

NUMBERING OF ITEMS

For purposes of identification, all items of the fee schedule form are numbered. Some items are listed twice. This is done when items may be sought under more than one classification heading. Thus, "Blood Wassermann" may be found under both "Clinical Laboratory Tests" in Part I and under "Examinations-Blood" in Part II. However, it will be noted that to secure identification of the item as the same in both cases, the same number is assigned to each entry. For this reason the numbers are occasionally out of consecutive order.

AA

Minimum and maximum fees will be shown for each "AA" item. The fee for a given "AA" service will be determined by *arbitration and agreement* between Veterans Administration and the concerned state medical association or state medical service organization.

CONSULTATIONS AND EXAMINATIONS BY SPECIALISTS

Examinations by specialists are differentiated from normal consultations by specialists. Authorizations by Veterans Administration for fee basis physicians or specialists to furnish medical service to veterans are executed on either (old) VA Form 2639 (revised April, 1944) or VA Forms 10-2567 or 10-2568 (November, 1946). Each form shows a space for "Nature of Service Authorized (or Required)" and another for the "Fee Authorized" for the service in question. Fees for

formal consultation will be allowed only when consultation rather than examination by a specialist is specifically authorized. Consultations will be authorized only when previous efforts to arrive at a definite diagnosis have failed.

As a general policy, specialists will only be authorized to conduct examinations covering their particular specialty. If, however, a specialist is authorized to conduct a complete physical examination concurrently with an examination covering his specialty, his fee for the two concurrent procedures will be the greater fee plus one-half of the smaller fee.

EXAMPLE:

A cardiologist authorized to conduct an examination of the heart, including an electrocardiogram (Item 0026), and who is also authorized to conduct a complete physical examination (Item 0012), will be paid a fee of \$15.00 (Item 0026) plus \$3.75 (one-half of Item 0012), or a total fee of \$18.75.

NOTE:

The foregoing is not applicable to laboratory or x-ray services. Fees for these services will be in accordance with the actual number of services performed at prices listed in the Fee Schedule for each item.

PART I

Clinical Laboratory Tests

0001—Red, white, and differential blood counts including instrumental colorimetric hemoglobin estimation	\$5.00
0002—Blood smear for malaria	2.00
0003—Urinalysis, routine chemical and microscopic	2.00
0004—Blood Wassermann (complement-fixation)	3.00
0005—Blood Kahn (precipitation)	2.00
0007—Spinal fluid Wassermann (complement-fixation)	3.00
0008—Chemical examination of blood complete, including creatinin, urea, dextrose, nitrogen (or NPN), and uric acid	15.00
0009—Sputum examination for tuberculosis (plain smear)	3.00
0010—Determination of basal metabolic rate ..	10.00

Visits and Examinations

0011—Examination to determine need of hospitalization	3.00
0012—Complete general routine physical examination including routine urinalysis	7.50

Visits within City Limits

		First		Subsequent	
Day*	{ Office ..	0013	\$2.00	0014	\$2.00
	{ Home ..	0015	3.00	0016	3.00
	{ Hospital ..	0017	3.00	0018	3.00
Night*	{ Home ..	0019	6.00	0020	....
	{ Hospital ..	0021	6.00	0022	....

* Day: 8: 00 a.m.-7: 00 p.m.
Night: 7: 00 p.m.-8: 00 a.m.

0023—Charge for mileage one way for day or night visit outside city limits in addition to appropriate fee	\$0.75
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Examinations by Specialists

0024—General surgical	5.00
0025—Orthopedic	5.00
0026—Complete examination of heart, including electrocardiogram	15.00
0027—Electrocardiogram with interpretation ..	10.00
0028—Physical examination of lungs	5.00
0029—Roentgenologic study of chest	15.00
0030—Gastro-intestinal, including barium meal and enema, x-ray and fluoroscopy with preliminary KUB film	50.00
0031—Dermatologic	5.00
0032—Allergy investigation including history, physical examination, relevant laboratory procedures (skin tests, smears of sputum and nasal secretions, vital capacity, etc.) and report	25.00
0033—Diagnostic skin tests only, intradermal or scratch, 40 extracts	15.00
0034—Each additional intradermal or scratch test .....	....
0035—Genito-urinary examination without cystoscopy including prostatic smear and urinalysis	5.00
0036—Genito-urinary examination with cystoscopy	25.00
0037—Gynecologic	5.00
0038—Proctologic (rectal speculum)	5.00
0039—Psychiatric examination—one hour (50-60 minutes)	10.00
0039A—Each half hour (25-30 minutes) additional to original 60-minute hour ..	5.00
0040—Neurologic examination—one hour (50-60 minutes)	10.00
0040A—Each half hour (25-30 minutes) additional to original 60-minute hour ..	5.00
0041—Examination of ears, nose, and throat ..	5.00
0042—Special ear examination, including audiometric test with chart	10.00
0043—Special ear examination, including caloric or Bárány test with audiogram and report	10.00
0044—Examination of eyes with refraction, manifest or cycloplegic, to include either a copy of the prescription ordered or a report of the refractive error and fundus findings, as well as a report of abnormalities found	10.00
0045—Examination of eyes with refraction, manifest or cycloplegic, to include either a copy of the prescription ordered or a report of the refractive error and fundus findings, together with a report of the <i>visual field findings</i> (the latter by chart if the field is abnormal)	12.50
0046—Examination by internist to determine diagnosis	15.00

Out-patient Treatment by Specialists

0047—Dermatologic: first visit	5-10 AA
0048—Dermatologic: each subsequent visit ..	5.00
0049—Ear, nose, and throat: first visit	5.00
0050—Ear, nose, and throat: each subsequent visit	5.00

0051—Ophthalmologic: first visit	\$5.00
0052—Ophthalmologic: each subsequent visit ..	5.00
0053—Psychiatric treatment (psychotherapeutic conference)	10.00
One hour (50-60 minutes)	10.00
0053A—One-half hour (25-30 minutes)	5.00
0054—Neurologic treatment (treatment is understood to be the usual follow-up care and observation after diagnosis has been made at original neurologic examination)	10.00
One hour (50-60 minutes)	10.00
0054A—One-half hour (25-30 minutes)	5.00
0055—Other comparable specialties not listed above: first visit	5.00
0056—Other comparable specialties not listed above: each subsequent visit	5.00

PART II

NOTE: The fees for surgical services listed herein include fourteen (14) days' routine postoperative care but are exclusive of hospital charges, clinical laboratory, anesthesiologists', and x-ray fees. Fees for visits and dressings after fourteen (14) days' completed postoperative care are the same as those listed as hospital, home, and office visits in Part I of this fee schedule, Items 0013 to 0022 inclusive.

If two or more surgical procedures are performed *by the same physician* on the same patient concurrently or immediately successively (e.g., repair of unilateral indirect inguinal hernia and operation for varicocele), the fee for the two or more procedures will be the greater or greatest fee plus one-half each smaller fee or fees. The fee for two or more such concurrent operations will never exceed twice the greater or greatest fee.

If two surgical procedures are performed *by two different surgeons* on the same patient concurrently or immediately successively (e.g., intervertebral disk operation and vertebral fixation), the fee for each surgeon will be 75 per cent of the fee listed for each operative procedure.

Special Services

Detention with patient in critical condition at home or hospital .....	....
0100— Per hour—8 a.m.-7 p.m. ....	....
0101— Per hour—7 p.m.-8 a.m. ....	....
Formal consultation by specialists (in surgery, internal medicine, dermatology, ophthalmology, ear, nose and throat, radiology, anesthesiology and comparable specialties)	10.00
0102— <i>In office</i> , first visit	10.00
0103— Subsequent similar consultation or visit	5.00
Formal consultation by specialists (in surgery, internal medicine, dermatology, ophthalmology, ear, nose and throat, radiology, anesthesiology and comparable specialties)	10.00
0104— <i>In veteran's home or in hospital</i> , first visit	15.00
0105— Subsequent similar consultation or visit	10.00
0106—Surgical assistant's fee (allowed only in case of prior authorization by VA) ..	20% of surgical fees

*Examinations—special (for diagnostic purposes)**Allergy*

*0032—Allergy investigation including history, physical examination, relevant laboratory procedures (skin tests, smears of sputum and nasal secretions, vital capacity, etc.) and report	\$25.00
*0033—Diagnostic skin tests only, intradermal or scratch, 40 extracts	15.00
*0034—Each additional intradermal or scratch test	0.25
0200—Patch tests (for contact dermatitis), each test	0.50
0201—Tests with bacterial extracts, e.g., brucellergin, coccidioidin, Frei test, each	2.00
0202—Sputum examination, cytologic for eosinophils	2.00
0203—Nasal secretion examination, cytologic for eosinophils	2.00
0204—Measurement of vital capacity	1.00

Endoscopy

0210—Bronchoscopy, without biopsy	25.00
0211—Bronchoscopy, with biopsy	50.00
0212—Bronchoscopy, with removal of foreign body	50.00
0213—Bronchoscopy, subsequent to initial bronchoscopy	25.00
0214—Cystoscopy	25.00
0215—Cystoscopy, with ureteral catheterization or biopsy	35.00
0216—Esophagoscopy, with or without biopsy or dilatation	50.00
0217—Esophagoscopy, with removal of foreign body	50.00
0218—Esophagoscopy, subsequent to initial esophagoscopy with or without dilatation	50.00
0219—Gastroscopy	50.00
0221—Proctoscopy	10.00
0222—Sigmoidoscopy	10.00
0223—Thoracoscopy, diagnostic, with or without biopsy	50.00

Paracentesis

0230—Paracentesis, abdomen, diagnostic	15.00
0231—Paracentesis, joint, diagnostic	15.00
0232—Paracentesis, pericardium	25.00
0233—Paracentesis, tympanum, diagnostic	7.50
0234—Sternal puncture diagnostic	20.00
0235—Thoracentesis, diagnostic	15.00
†1421—Paracentesis, abdomen	15.00
‡5520—Paracentesis, joint, therapeutic	15.00
§4311—Paracentesis, pericardium, therapeutic	25.00
¶3407—Paracentesis, tympanum, therapeutic	7.50

Gastric Tests

0240—Gastric chemical, routine, including test meal and withdrawal of stomach contents	10.00
0241—Gastric contents for acidity, by histamine	5.00
0242—Gastric contents for pepsin	3.00

* Also listed in PART I.

† Also listed under "Surgery—Abdominal."

‡ Also listed under "Surgery—Orthopedic."

§ Also listed under "Surgery—Thoracic."

¶ Also listed under "Surgery—Otologic."

Tuberculosis

0250—Gastric wash for tubercle bacilli with smear (withdrawal of specimen by laboratory)	\$10.00
0251—Gastric wash for tubercle bacilli with smear (not including withdrawal of specimen)	5.00
0252—Gastric wash for tubercle bacilli with culture (withdrawal of specimen by laboratory)	7.00
0253—Gastric wash for tubercle bacilli with culture and virulence test	10.00
0254—Gastric wash for tubercle bacilli (withdrawal of specimen by laboratory) and with animal inoculation	12.00
*0009—Sputum examination for tuberculosis (plain smear)	3.00
0255—Sputum, smear for tubercle bacillus (concentration method)	5.00
0256—Sputum, culture for tubercle bacillus ..	5.00
0257—Sputum, culture for tubercle bacillus with virulence test	15.00
0258—Sputum, animal inoculation for diagnosis of tuberculosis with report of autopsy	10.00
0259—Tuberculin skin test (Mantoux)	3.00
0260—Urine, culture for tubercle bacillus	5.00
0261—Urine, animal inoculation for diagnosis of tuberculosis with report of autopsy ..	10.00

X-ray Preparation

0270—Arteriography or phlebography including injection of contrast medium but excluding x-ray fee	35.00
0271—Bronchography, including anesthesia and instillation of contrast medium but excluding x-ray fee	10.00
0272—Myelography, including operative preparation and removal of contrast medium but excluding x-ray fee	15.00
0273—Pneumo-encephalography, including operative preparation but excluding x-ray fee	15.00
0274—Pneumoperitoneum	25.00
0275—Ventriculography, including operative preparation but excluding x-ray fee ..	40.00

Autopsy and Biopsy

Autopsy, with report	
In VA hospital (histologic technique performed by hospital staff)	50.00
0300—Excluding central nervous system ...	25.00
0301—Including central nervous system ...	35.00
Outside VA hospital (report includes histologic preparation and examination)	
0302—Excluding central nervous system ..	50.00
0303—Including central nervous system ...	75.00
0304—Biopsy, with report of histologic examination	5.00

Miscellaneous

0310—Electrical examination of muscles	10.00
0311—Electro-encephalography with interpretation	30.00
0312—Intra-ocular tension	3.00
0313—Lumbar puncture, including local anesthesia and obtaining fluid	10.00

0314—Physical examination diagnostic for physical or occupational therapy . . .	\$7.50
*0045—Visual fields. Examination of eyes with refraction, manifest or cycloplegic, to include either a copy of the prescription ordered or a report of the refractive error and fundus findings, together with a report of the <i>visual field findings</i> (the latter by chart if the field is abnormal)	12.50

Examinations—Bacteriologic

0400—Animal inoculation for diagnosis, with report of autopsy	10.00
0401—Cultural examination for fungi	5.00
0402—Microscopic examination for fungi	2.00
0403—Pus or exudate (smear)	1.00
0404—Pus or exudate, cultural examination, classification	3.00
0405—Throat culture, classification of organism	5.00
0406—Throat smear	1.00
0407— <i>T. pallidum</i> (dark field), initial examination	5.00
0408— <i>T. pallidum</i> (dark field), subsequent examination	5.00

Examinations—Blood

0600—Agglutination test for typhoid, paratyphoid, or undulant fever	2.00
0601—Bleeding time	1.00
0602—Blood culture, including classification	5.00
0603—Blood typing (grouping)	1.00
0604—Rh factor	5.00
0605—Coagulation time	1.00
0606—Sedimentation rate	2.00
0607—Estimation of sugar tolerance	10.00
0608—Van den Bergh blood test for icterus	2.00
0609—Volume index	3.00
0610—Blood calcium	3.00
0611—Blood chlorides	3.00
0612—Carbon dioxide combining power of blood plasma	5.00
0613—Cholesterol	3.00
0614—Creatinin	3.00
0615—Dextrose	3.00
0616—Nonprotein nitrogen	3.00
0617—Blood phosphorus	3.00
0618—Urea nitrogen	3.00
0619—Uric acid	3.00
0620—Blood platelet count	1.00
0621—Total erythrocyte count	2.00
0622—Fragility test for erythrocytes	5.00
0623—Hemoglobin estimation, instrumental colorimetric	2.00
0624—Differential leukocyte count	2.00
0625—Total leukocyte count	2.00
0626—Reticulocyte count	2.00
*0001—Red, white and differential blood count including colorimetric hemoglobin estimation	5.00
*0002—Blood smear for malaria	2.00
*0004—Blood Wassermann (complement-fixation)	3.00
*0005—Blood Kahn (precipitation)	2.00
*0008—Chemical examination of blood complete, including creatinin, urea, dextrose, nitrogen (or NPN), and uric acid	15.00

* Also listed in PART I.

† Also listed under "Examinations—Special."

Examinations—Feces

0700—Cultural examination of feces for causative micro-organism (classification of organism)	\$7.50
0701—Fat in feces (qualitative)	1.00
0702—Parasites and ova (concentration method)	5.00
0703—Occult blood	3.00

Examinations—Spinal Fluid

0800—Examination of spinal fluid for causative organism (smear)	3.00
0801—Cell count	1.00
0802—Colloidal gold reaction	5.00
0803—Total protein (quantitative)	3.00
0804—Sugar and chlorides (quantitative)	3.00
*0007—Spinal fluid Wassermann (complement-fixation)	3.00
0805—Cultural examination of spinal fluid, including classification of causative micro-organism	5.00
0806—Globulin test	1.00
0807—Complete examination of spinal fluid, including complement-fixation test, colloidal gold, total protein, sugar and chlorides, globulin test, and cell count	10.00

Examinations—Urine

*0003—Urinalysis, routine chemical and microscopic	2.00
0900—Urinalysis, routine chemical	1.00
0901—Chlorides	3.00
0902—Creatinin	3.00
0903—Cultural examination including classification of micro-organism	5.00
0904—Hydrogen ion concentration	1.00
0905—Mosenthal test	1.00
0906—Total nitrogen (Kjeldahl)	3.00
0907—Renal function test (phenolsulfonphthalein)	3.00
0908—Urea nitrogen	3.00
0909—Uric acid	3.00
0910—Urobilin	1.00
†0200—Urine, culture for tubercle bacillus	5.00
†0261—Urine, animal inoculation for diagnosis of tuberculosis with report of autopsy	10.00

Surgery—Unclassified

1000—Abscess, deep (including ischiorectal)	50.00 AA
1002—Adenectomy, cervical or inguinal (minor)	20.00
1003—Adenectomy, cervical or inguinal (radical)	125.00
1004—Anal fissure, operation for	35.00
1005—Breast tumor, small, benign, excision	50.00
1006—Breast, resection of, simple	100.00
1007—Breast, resection of, radical, including axillary nodes	200.00
1008—Carbuncle	25.00-50.00 AA
1009—Cellulitis	25.00-50.00 AA
1010—Dupuytren's contracture	100.00
1011—Fistula-in-ano, operation for	75.00
1012—Hemorrhoidectomy	75.00
1014—Thyroidectomy	150.00
1015—Ulcer, varicose, excision with skin graft	100.00
1016—Varicose veins, injection treatment, each injection	5.00

1017—Varicose veins, one leg, operation for ..	\$60.00
1018—Varicose veins, both legs, operation for	100.00

Surgery—Abdominal

1400—Abscess, liver, operation for	150.00
1401—Appendectomy	100.00
1402—Cholecystectomy, with or without choledochostomy	150.00
1403—Cholecystostomy	125.00
1404—Choledochostomy (secondary operation)	150.00
1405—Colostomy	100.00
1406—Fecal fistula, abdominal, operation for	125.00 AA
1407—Gastrectomy (partial) (or subtotal) ...	200.00
1408—Gastro-enterostomy	150.00
1409—Gastrostomy	100.00
1410—Herniotomy, diaphragmatic	175.00
1411—Herniotomy, ventral	100.00
1412—Herniotomy, inguinal or femoral, unilat- eral	100.00
1413—Herniotomy, inguinal or femoral, bi- lateral	150.00
1415—Intestinal obstruction, operation for, without resection	150.00
1416—Intestinal obstruction, operation for, with resection	200.00
1417—Large bowel carcinoma, resection with or without preliminary colostomy	200.00
1418—Laparotomy, exploratory	100.00
1419—Laparotomy and drainage, general peri- tonitis	150.00
1420—Meckel's diverticulum, operation for ...	125.00
1421—Paracentesis, abdomen, therapeutic	15.00
1422—Pyloroplasty	150.00
1423—Splenectomy	150.00
1424—Ulcer, gastric or duodenal, operation for	125.00
1425—Vagotomy, abdominal	125.00
1426—Vagotomy, abdominal and gastro-enter- ostomy	175.00

*Surgery—Burns and Traumatic Wounds**Burns*

1800—First degree, less than 10% body sur- face	On a
Second degree	basis of
1801— Less than 25% of body surface	dressing
1802— More than 25% of body surface	time
1803—Third degree burns, depending on the area involved	required

Traumatic Wounds

1900—Incised, minor procedure (office type) ..	10.00
1901—Lacerated	10.00
1902—Punctured	10.00
1903—Foreign body removal	10.00-50.00 AA

Surgery—Gynecologic

2000—Bartholin's gland, excision	50.00
2001—Bartholin's gland, incision	10.00
2002—Cervical polyp, curettage	50.00
2003—Cervix, amputation of	75.00
2004—Cervix, cauterization	15.00
2005—Cervix, conization	20.00
2006—Cervix, repair of tear	50.00
2007—Colporrhaphy, combined, including peri- neorrhaphy	125.00
2008—Cul-de-sac, drainage	30.00
2009—Cystocele, repair of	75.00
2010—Dilatation and curettage	50.00
2011—Fistula, recto-vaginal	125.00

2012—Fistula, vesico-vaginal	\$150.00
2013—Hysterectomy, simple (supracervical) .	150.00
2014—Hysterectomy, vaginal, including plastic repair	175.00
2015—Panhysterectomy	175.00
2016—Hysterectomy, with adnexa	150.00
2017—Labial tumors or cysts, removal of	40.00
2018—Laparotomy, exploratory	100.00
2019—Myomectomy, vaginal operation (intra- uterine)	75.00
2020—Myomectomy, with laparotomy	100.00
2021—Oophorectomy, unilateral or bilateral ..	125.00
2022—Perineorrhaphy	100.00
2023—Perineorrhaphy, repair of cystocele or rectocele and trachelorrhaphy	150.00
2024—Rectocele, repair of	75.00
2025—Salpingectomy, unilateral or bilateral, with or without oophorectomy	125.00
2026—Tubal inflation	15.00
2027—Urethral caruncle, removal of	15.00
2028—Uterine displacement, correction (lap- arotomy for suspension)	125.00
2029—Uterine polypi, removal with curettage .	50.00
2030—Uterine prolapse, operation for, includ- ing perineal repair	150.00

Surgery—Neurosurgery

2300—Aneurysm, intracranial, operation for ..	200.00
2301—Auditory nerve section	150.00
2302—Brain abscess, excision of	150.00
2303—Brain abscess, primary tapping of	100.00
2304—Brain abscess, subsequent tapping of ...	....
2305—Brain tumor, operation for	200.00
2306—Carotid ligation for intracranial arterio- venous fistula or aneurysm	100.00
2307—Chordotomy	150.00
2308—Craniotomy, exploratory, bilateral (burr holes)	75.00
2309—Craniotomy, operative, unilateral	150.00
2311—Gasserian ganglion, injection of alcohol	50.00
2312—Hematoma, extradural, operation for ..	150.00
2313—Hematoma, subdural, operation for	150.00
2314—Laminectomy	150.00
2315—Neuroma, superficial, resection of	50.00
2316—Nucleus pulposus or intervertebral disk, ruptured, extruded or crushed, oper- ation for	175.00
2317—Osteomyelitis of skull, excision of	150.00
2318—Peripheral nerve, suture or lysis of	100.00
2320—Scalenus anterior syndrome, operation for	75.00
2321—Supra-orbital nerve, evulsion of	50.00
2321A—Supra-orbital nerve, injection of	15.00

Sympathetic Nervous System, Operations

2322— Unilateral resection	100.00
2323— Bilateral resection	150.00
2324— Presacral plexus resection	100.00
*0313—Lumbar puncture, including local anes- thesia and obtaining fluid	10.00
*0272—Myelography, including operative prepa- ration and removal of contrast me- dium but excluding x-ray fee	15.00
*0273—Pneumo-encephalography, including op- erative preparation but excluding x-ray fee	15.00
*0275—Ventriculography, including operative preparation but excluding x-ray fee ..	40.00

* Also listed under "Examinations—Special."

Surgery—Nose and Throat

2700—Abscess, oral (not to include dental or periodental)	\$10.00
2701—Abscess, pharyngomaxillary space, external drainage of .....	.....
2702—Abscess, peritonsillar	20.00
2703—Abscess, retropharyngeal	20.00
*0210—Bronchoscopy, without biopsy	25.00
*0211—Bronchoscopy, with biopsy	50.00
*0212—Bronchoscopy, with removal of foreign body	50.00
*0213—Bronchoscopy, subsequent to initial bronchoscopy	25.00
*0216—Esophagoscopy, with or without biopsy or dilatation	50.00
*0217—Esophagoscopy, with removal of foreign body	50.00
*0218—Esophagoscopy, subsequent to initial esophagoscopy	50.00
2704—Esophagus, dilatation of by means of bougies or sounds—office procedure, no anesthesia	5.00
2705—Fulguration or electrocoagulation of minor tumor of trachea or esophagus	50.00
2706—Laryngectomy (total)	175.00
2708—Laryngoscopy, direct, with biopsy of tumor	50.00 AA
2710—Tracheotomy	50.00
2711—Ligation of jugular vein or carotid artery	75.00-100.00 AA
2712—Nasal bones, fracture, reduction of	10.00
2713—Nasal polypus, removal of	10.00
2714—Nasal septum, submucous resection of ..	50.00
2715—Sinus, ethmoid, radical operation for, external or intranasal	50.00
2716—Radical external fronto-spheno-ethmoid operation .....	.....
2717—Sinus, frontal, trephination	50.00
2718—Sinus, maxillary, intranasal anthrotomy (antrum window)	50.00
2719—Sinus, maxillary, radical operation for	125.00
2720—Sinus, sphenoid, intranasal drainage of (sphenoidectomy)	50.00
2721—Sinuses, accessory nasal, irrigation of ..	10.00
2722—Tonsillectomy, with adenoidectomy if indicated	50.00
2723—Adenoidectomy	20.00
2724—Turbinate bone, galvano-cauterization of ..	10.00
2725—Turbinectomy	25.00

Surgery—Obstetric

NOTE: Complete maternity care, including prenatal and postpartum care, is not provided by Veterans Administration.

Surgery—Ophthalmologic

3000—Cataract, needling operation for	50.00
3001—Cataract, operation for	150.00
3002—Chalazion, operation for	10.00
3003—Corneal ulcer, cauterization	5.00
3005—Ectropion, operation for	50.00
3006—Entropion, operation for	50.00
3007—Entropion, cautery puncture or Snelling sutures	30.00
3008—Enucleation of eye, simple	75.00
3009—Enucleation of eye with implantation for restoration of orbit	100.00
3010—Evisceration of eye	100.00
3011—Foreign body, removal from conjunctiva ..	10.00

* Also listed under "Examinations—Special."

3012—Foreign body, removal from cornea, simple	\$5.00
3013—Foreign body, removal from cornea requiring dissection or curettage	25.00
3014—Foreign body, intra-ocular, removal with or without magnet	100.00
3015—Glaucoma, corneal paracentesis for	50.00
3016—Glaucoma, operations of all types for attempted permanent cure	150.00
3017—Hordeolum, operation for	5.00
3018—Iridectomy, non-glaucomatous	75.00
3019—Laceration of lid, suture of	25.00
3020—Laceration of globe, suture of	75.00
3021—Lacrimal duct, dilatation of	10.00
3022—Lacrimal sac, excision of	75.00
3023—Lacrimal sac, dacryocystorhinostomy ..	125.00
3024—Orbit, reconstruction of	100.00
3025—Pterygium, operation for	30.00
3026—Ptosis, operation for	75.00
3027—Retina, detached, operation for	125.00
3028—Strabismus, operation for	75.00

Surgery—Otologic

3400—Aural polypus, removal of	15.00
3401—Fenestration operation for clinical otosclerosis	300.00
3402—Mastoid, acute, operation for	125.00
3403—Mastoid, radical operation for	150.00
3404—Mastoidectomy, with lateral sinus drainage and with or without juglar ligation	250.00
3405—Mastoidectomy with facial nerve decompression, suture or graft	300.00
3406—Lateral sinus, secondary drainage of ...	150.00
3407—Paracentesis, tympanum, therapeutic ...	7.50

Surgery—Thoracic

4300—Decortication for chronic empyema	150.00
4301—Decortication for hemothorax	100.00
4302—Esophagogastrostomy	250.00
4304—Foreign body, removal from lungs	75.00
4305—Foreign body, removal from heart	200.00
4306—Gastrectomy, transthoracic	250.00
4308—Lobectomy	150.00
4309—Mediastinotomy	100.00
4311—Paracentesis, pericardium, therapeutic ..	25.00
4312—Pericardectomy	200.00
4313—Pericardotomy (open drainage of pericardium)	100.00
4314—Phrenic nerve operation	75.00
4315—Pneumolysis, extrapleural	100.00
4316—Pneumolysis, intrapleural	100.00
4317—Pneumonectomy	200.00
4318—Pneumonotomy	100.00
4319—Pneumothorax, artificial, first induction ..	15.00
4320—Pneumothorax, artificial, refill	10.00
4321—Pneumothorax, extrapleural	75.00
4322—Scaleniotomy	75.00
4324—Subphrenic abscess, drainage	150.00
4325—Thoracentesis, therapeutic	15.00
4326—Thoracoscopy, cutting pleural adhesions	75.00
4327—Thoracoplasty, each stage	125.00
4329—Thoracostomy, without rib resection ...	50.00
4330—Thoracostomy, with rib resection	75.00
4331—Thoracotomy, exploratory	50.00
4332—Tumor, thoracic wall, transpleural removal	150.00
4333—Tumor, mediastinal, removal of	150.00
4334—Vagotomy, transthoracic	125.00

*Surgery—Tumors**Aspiration*

4700—Cyst, superficial \$25.00

Fulguration or Electrocoagulation

4701—Tumor, superficial 10.00

4702—Tumor (minor) of trachea, esophagus,
or bladder 50.00*Exploration with Biopsy*

4703—Tumor, requiring a major operative approach including exploration, verification of existence, location, and biopsy. This item applies particularly to major operative approach to chest, abdomen, head or brain when only biopsy is taken, but is also relevant to such major operation terminating in biopsy (rather than resection) in any location 100.00

Removal, Excision, Resection or Operation for

4704—Tumor or cyst, small, benign 10.00

4705—Cyst or sinus, pilonidal 75.00

4706—Cyst, sebaceous, small 5.00

4707—Cyst, sebaceous, large 10.00

4708—Cyst, thyroglossal 100.00

4709—Epithelioma, lip, tongue, or face 50.00-150.00 AA

4710—Epulis 25.00

4711—Papilloma, bladder 100.00

4712—Papilloma, external 25.00

4713—Tumor, abdominal wall 100.00

Surgery—Urologic

5000—Circumcision, adult 25.00

5002—Cystectomy, partial 150.00

*0214—Cystoscopy 25.00

*0215—Cystoscopy with ureteral catheterization
or biopsy 35.00

5004—Cystotomy, suprapubic 75.00

5005—Epididymectomy 75.00

5006—Hydrocele, aspiration of 5.00

5007—Hydrocele, operation for 50.00

5008—Litholapaxy 50.00

5009—Nephrectomy 150.00

5010—Nephrotomy 150.00

5011—Orchidectomy 50.00

5012—Prostatectomy, perineal 150.00

5013—Prostatectomy, suprapubic, two-stage .. 150.00

5014—Prostatic resection, transurethral 125.00-175.00 AA

5015—Prostatic abscess, incision and drainage 75.00

5016—Pyelotomy with removal of calculus ... 150.00

5017—Ureteral stone, removal of (non-operative) 125.00

5020—Ureterolithotomy 150.00

5021—Urethral fistula, operation for 75.00-150.00 AA

5022—Urethrotomy, external 75.00

5023—Urethrotomy, internal 50.00

5024—Varicocele, operation for 50.00

Surgery—Orthopedic

5500—Arthroplasty, major joint 150.00-250.00 AA

5501—Application of plaster cast, chest 15.00

5502—Application of plaster cast, thighs and
hips 25.00

5503—Application of plaster cast, thigh and leg 10.00

5504—Application of plaster cast, torso \$25.00

5505—Application of plaster cast, torso and
hips 30.00

5506—Application of plaster cast, entire body 45.00

5507—Bone graft (long bone), including plaster cast 150.00

5508—Bone plate, removal of 35.00

5509—Bone tumor, extensive, removal of 150.00

5510—Bone tumor, small, removal of 50.00

5511—Cartilage of condyle of femur, removal
of 75.00

5512—Cartilage, semilunar, removal from joint 100.00

5513—Claw foot, operation for 100.00

5514—Coccyx, excision of 75.00

5515—Hallux valgus, unilateral, operation for 75.00

5516—Hallux valgus, bilateral, operation for .. 100.00

5517—Hammer toe, operation for 50.00

5518—Osteomyelitis, operation for, small bones 75.00

5519—Osteomyelitis, operation for, large bones
(tibia, fibula, femur, humerus, radius,
ulna, spine, pelvis) 125.00

†2317—Osteomyelitis of skull, excision of 150.00

5520—Paracentesis, joint 15.00

5521—Sequestrum, removal of (deep) 100.00

5522—Sequestrum, removal of (superficial) .. 25.00

5523—Tenorrhaphy, one 50.00

5524—Tenorrhaphy, each additional 25.00

5525—Tenotomy, closed 35.00

5526—Torticollis, spasmodic, operation for ... 75.00

5527—Vertebral fixation (Albee or Hibbs) .. 150.00

Fractures and Dislocations

NOTE: The fees stated for fractures and dislocations include reduction, fixation, and fourteen days' postoperative care but are exclusive of hospital charges, anesthesiologist's and x-ray fees. (See note at beginning of Part II of this fee schedule). Fees for visits after fourteen days' completed postoperative care will be the applicable ones of those listed as hospital, home, or office visits in Part I of this fee schedule—Items 0013-0022 inclusive.

Plaster casts applied or reapplied for fractures or dislocations during the period covered by the fourteen days' after-care are considered a part of the treatment and no additional fees for application of casts for these conditions will be authorized. The fee for application or reapplication of plaster casts after fourteen days' completed postoperative care will be 50 per cent of the appropriate fee listed under Items 5501-5506 inclusive. One hundred per cent of these items will be charged only when disability other than fracture or dislocation is being treated.

The cost of plaster of paris used for casts in contract or private hospitals will be listed as a part of the hospital charges.

Compound fractures. The fee for care of compound fracture is that for care of simple fracture plus 50 per cent, except when otherwise specified.

Open operation for fracture or dislocation. The fee for open operation when this procedure is necessary for reduction and fixation of a fracture or dislocation is that for care of simple fracture or dislocation plus 50 per cent, except when differently specified.

Multiple fractures. When more than one bone is fractured, the fee will be that for the major fracture plus 50 per cent of the fee listed for each other fracture.

Fracture involving dislocation. When a fracture involves dislocation, the fee will be that for the fracture plus 50 per cent of the fee for treatment of the dislocation.

* Also listed under "Examinations—Special."

† Also listed under "Surgery—Neurosurgery."

Surgery—Orthopedic (Compound and Simple Fractures)

	Simple	Compound
Carpal bone, one	6000—\$50.00	6500—\$75.00
Carpal bones, each additional	6001— 5.00	6501— 15.00
Clavicle	6002— 50.00	6502— 75.00
Coccyx (on basis of hospital visits)	6003—	6503— 75.00
Femur	6004—150.00	6504—150.00
Femur, suturing, plating, or nailing	6005—150.00	6505—150.00
Fibula, including Pott's fracture	6006— 35.00	6506— 75.00
Fibula, including Pott's fracture, suturing or plating	6007— 75.00	6507—100.00
Finger, one	6008— 25.00	6508— 25.00
Fingers, each additional	6009— 5.00	6509— 10.00
Humerus	6010— 75.00	6510—125.00
Humerus, suturing or plating	6011—150.00	6511—150.00
Metacarpal bone, one	6012— 40.00	6512— 50.00
Metacarpal bones, each additional	6013— 5.00	6513— 10.00
Metatarsal bone, one	6014—40.00AA	6514— 50.00
Metatarsal bones, each additional	6015— 5.00	6515— 10.00
Patella	6016— 50.00	6516—100.00
Patella, suturing or plating or excision	6017—125.00	6517—125.00
Pelvis	6018— 75.00	6518—100.00
Radius, or ulna, or both, including Colles' fracture	6019— 50.00	6519— 75.00
Radius, or ulna, or both, including Colles' fracture, suturing or plating	6020—100.00	6520—125.00
Rib, one	6021—Hospital, home, or	
Ribs, each additional	6022—office call basis same.	
Sacrum	6023— Call basis	6523— 75.00
Scapula	6024— 40.00	6524— 50.00
Sternum	6025— 50.00	6525— 75.00
Tarsal bone, one	6026— 50.00	6526— 75.00
Tarsal bones, each additional	6027— 5.00	6527— 15.00
Tibia, including Pott's fracture	6028— 75.00	6528—112.50
Tibia, including Pott's fracture, suturing or plating	6029—150.00	6529—150.00
Tibia and fibula	6030— 75.00	6530—125.00
Tibia and fibula, suturing or plating	6031—150.00	6531—150.00
Toe, one	6032— 25.00	6532— 25.00
Toes, each additional	6033— 5.00	6533— 10.00
Vertebrae, one or more ..	6034—100.00	6534—150.00
Vertebra, transverse process only	6035— Hospital call basis	6535—

Surgery—Orthopedic (Dislocations)

7000—Carpal bone, one	40.00
7001—Carpal bones, each additional	10.00
7002—Clavicle (closed)	40.00
7003—Elbow	50.00
7004—Finger, one	10.00
7005—Fingers, each additional	5.00

7006—Hip	\$75.00
7007—Knee	60.00
7008—Mandible	25.00
7009—Metacarpal bone, one	25.00
7010—Metacarpal bones, each additional	10.00
7011—Metatarsal bone, one	25.00
7012—Metatarsal bones, each additional	10.00
7013—Patella	50.00
7014—Pelvis	75.00
7015—Rib	(Home or hospital call basis)
7016—Shoulder	50.00
7017—Shoulder, recurrent or habitual, reduction only	40.00
7018—Shoulder, recurrent or habitual, correcting operation	150.00
7019—Tarsal bones, one	25.00
7020—Tarsal bones, each additional	10.00
7021—Thumb	15.00
7022—Toe, one	15.00
7023—Toes, each additional	10.00
7024—Vertebrae, one or more	100.00

NOTE: The fee for open reduction of a dislocation will be the appropriate fee listed above plus 50 per cent.

Surgery—Orthopedic (Joint Resections or Arthrodeses)

7400—Ankle joint	150.00
7401—Elbow joint	150.00
7402—Hip joint	200.00
7403—Knee joint	150.00
7404—Shoulder joint	160.00
7405—Wrist joint	150.00

Surgery—Orthopedic (Amputations)

7800—Forequarter amputation (interscapulo-thoracic amputation)	200.00
7801—Disarticulation at shoulder	150.00
7802—Arm	125.00
7803—Forearm	125.00
7804—Hand	100.00
7805—Metacarpal, one	50.00
7806—Metacarpals, each additional	10.00
7807—Finger, one	25.00
7808—Fingers, each additional	10.00
7809—Hindquarter amputation (interminomino-abdominal amputation)	200.00
7810—Disarticulation at hip	150.00
7811—Thigh	150.00
7812—Leg	125.00
7813—Foot	125.00
7814—Metatarsal, one	50.00
7815—Metatarsals, each additional	10.00
7816—Toe, one	25.00
7817—Toes, each additional	10.00

Anesthesia

Any type

8000—First half-hour or fraction thereof	10.00-15.00
8001—Each subsequent half-hour or fraction thereof	5.00-10.00

(No additional fee is approved for local anesthesia used in connection with usual treatments in office or home. Time is to be calculated from beginning of anesthesia to delivery of patient to hospital bed.)

Miscellaneous Medical Treatment

NOTE: A physician who dispenses drugs or biologicals will consider this service included in his established visit fee when the drugs are routine non-expensive items. When an expensive drug is required, it is suggested that the physician prescribe (it is understood that a physician may prescribe all drugs—expensive and non-expensive) and the prescription be filled at a V.A. pharmacy or by a pharmacy participating in a state pharmaceutical plan.

Allergic desensitization to hay fever (preseasonal or perennial)	
*8100— For tree, grass or weed season	\$40.00
*8101— For two of these seasons	50.00
*8102— For all three seasons	65.00
*8103—Desensitization to dust alone or in combination with other allergens	75.00
8104—Vaccine therapy for asthma, course of treatment	
8105—Blood transfusion, not including cost of blood	25.00
8107—Blood for transfusion, supply by donor of blood per 100 cc.	10.00
8108—Colonic irrigation	3.00
8109—Hypodermoclysis	15.00
8110—Injections: subcutaneous or intramuscular, exclusive of cost of drug, biological, or other medication	5.00
8111—Injection, intravenous, exclusive of cost of drug, biological, or other medication	5.00
8113—Preparation of autogenous vaccine including original culture	10.00
8114—Spinal medication, any type, as with meningococcus serum, exclusive of cost of drug or biological	15.00
8115—Therapy, histamine, per treatment	3.00
8116—Therapy, electroshock or metrazol, per treatment, to include medication, curare, etc., as employed	15.00
8117—Therapy, insulin shock, per treatment, to include medication	10.00
8118—Therapy, fever (mechanical), per treatment, to include medication and parenteral administration of fluids if required	10.00

Occupational Therapy and Physiotherapy

NOTE: Physical therapy and occupational therapy are understood to be treatment rendered by physicians practicing in the field of physical medicine or by physical therapists or occupational therapists who render such treatment on a prescription basis under the direction of physicians. Authorization for physical therapy and occupational therapy will be issued only to physicians who will in relevant cases pay the physical or occupational therapists.

Occupational Therapy

8800—Occupational therapy per patient per hour (the fee per patient per day not to exceed \$5.00)	2.00
Occupational therapy in groups (the fee per group per day not to exceed \$10.00 and groups not to exceed five in number)	
8801— Two patients, per hour	4.00

* Including cost of extracts.
† Also listed PART I.

8802— Group of 3 to 5 patients, per hour ..	\$5.00
Supplies are to be furnished by the occupational therapist whenever necessary.	

Physical Therapy

8803—Infra-red lamp	}	2.00
8804—Baker		
8805—Ultraviolet ray	}	2.00
8806—Whirlpool		
8807—Contrast baths		
8808—Paraffin baths		
8809—Hot fomentations	}	2.00
8810—Short or long wave		
8811—Galvanism		2.00
8812—Sinusoidal		2.00
8813—Ionization		3.00
8814—Hydrotherapy		2.00
8815—Local massage and infra-red or baker .		3.00
8816—Local muscle re-education and infra-red or baker		3.00
8817—Suction pressure		2.00
8818—Electrical muscle test		5.00
8819—Any combination of treatment to one extremity or back		3.00
8820—General massage		4.00
8821—General exercises, postural or corrective		3.00
8822—General underwater exercises		2.00
8823—Gait training	}	5.00
8824—General manual muscle test (anterior poliomyelitis)		
8825—Muscle re-education (anterior poliomyelitis)		2.00
8826—Any combination of treatment to two or more extremities including back		5.00
8827—Above listed treatment in home plus the applicable fee shown for items 8803 to 8826 inclusive		3.00

Roentgenology with Interpretation

Bones and Joints of Extremities	
9000—Shoulder joint	10.00
9001—Hip joint	15.00
9002—Films of bones or joints distal to shoulder or hip	10.00
9004—Maximum fee for other than shoulder or hip joint	10.00

General

NOTE: Preparation of the patient for radiography in procedures requiring barium meals or enemas, intravenous injection (as in the Graham technique for gallbladder or intravenous pyelography), will be included by the radiologist as a part of the service for the fees listed below. In arteriography, phlebography, bronchography, myelography, pneumo-encephalography, ventriculography, retrograde pyelography and uterosalpingography, the fees listed below are for x-ray only; the fees for preparation for x-ray in these procedures are listed under Examinations—Special and Surgery—Gynecologic. The total fee for retrograde pyelography is cystoscopy with ureteral catheterization plus the x-ray fee shown below.

9100—Abdomen (KUB)	10.00
9101—Arteriography or phlebography	15.00
9102—Bronchography	25.00
†0029—Chest, roentgenologic study of	15.00
9103—Colon, barium enema	20.00
9104—Cystography	15.00

9105—Esophagus (only)	\$15.00
9106—Eye, localization of foreign body, Sweet method or equivalent	25.00
9107—Fistulae, contrast study	15.00
9108—Cholecystography	20.00
*0030—Gastro-intestinal, including barium meal and enema, x-ray and fluoroscopy with preliminary KUB film	50.00
9109—Kymography	10.00
9110—Laminagraphy	15.00
9111—Mandibles	10.00
9112—Mastoids, including petrous pyramids ..	15.00
9113—Maxilla and facial bones	15.00
9114—Myelography	20.00
9115—Nasal bones	10.00
9116—Optic foramina, both for comparison ..	15.00
9117—Pelvis	15.00
9118—Pneumo-encephalography	20.00
9119—Pyelography, intravenous, including cost of dye	25.00
9120—Pyelography, retrograde	20.00
9121—Sacro-iliac joint	15.00
9122—Sialography	10.00
9123—Sinuses, paranasal	15.00
9124—Skull	20.00
9125—Small intestinal series	25.00
9126—Smith-Petersen nail	30.00
9127—Spine, cervical	15.00
9128—Spine, dorsal	15.00
9129—Spine, lumbosacral with coccyx	15.00
9130—Spine, entire	35.00
9131—Stomach and duodenum only with barium meal	25.00
9132—Thorax, ribs	7.50
9133—Urethrocystography	15.00
9134—Uterosalingography	30.00
9135—Ventriculography including preliminary films	30.00
9136—Fluoroscopy service	5.00
9150—Special examinations requiring additional time or unusual procedure. The fee shall be that for the examination in question plus an additional	25%
9151— <i>Interpretation of Roentgenograms</i> per case \$5.00 except foreign bodies in esophagus or the respiratory tract ... Not to exceed \$6,000 per annum per radiologist	10.00

* Also listed in PART I.

X-ray Therapy, Deep and Superficial

9500—Original consultation	\$10.00
9501—Superficial therapy, benign lesion, per treatment, one to three fields	5.00
9502—Superficial therapy, benign lesion, per treatment, more than three fields	10.00
9503—Superficial therapy for skin cancer, per treatment	15.00
9504—Maximum fee for superficial x-ray therapy for skin cancer	50.00 AA
9505—Deep x-ray therapy, per treatment	10.00
9506—Maximum fee for deep x-ray therapy (unless greater amount is approved by the Branch Medical Director in consultation with the Branch Office Section Chief)	250.00
9507—Each follow-up visit	5.00

Radium and Radon Therapy

9600—Original consultation	10.00
9601—Office radium treatment	10.00-25.00 AA
9602—Operative radium insertion or intracavity implantation	75.00-150.00 AA
9603—Interstitial radon therapy, office	25.00
9604—Interstitial radon therapy, hospital, operative	100.00

Total Fees for Certain X-ray Procedures

	Preparation		X-ray		Total
	Item No.	Fee	Item No.	Fee	
Arteriography, phlebography ...	0270	\$35.00	9101	\$15.00	\$50.00
Bronehography	0271	10.00	9102	25.00	35.00
Colon, barium enema			9103	12.00	12.00
Cystography			9104	15.00	15.00
Gallbladder, Graham technique ..			9108	20.00	20.00
Gastro-intestinal, barium meal and enema			0030	35.00	35.00
Myelography	0272	15.00	9114	20.00	35.00
Pneumo-encephalography	0273	15.00	9118	20.00	35.00
Pyelography, intravenous			9119	20.00	20.00
Pyelography, retrograde	0215	35.00	9120	15.00	50.00
Small intestinal series			9125	20.00	20.00
Stomach and duodenum, barium meal			9131	15.00	15.00
Urethroecystography			9133	12.00	12.00
Uterosalingography	2026	15.00	9134	25.00	40.00
Ventriculography	0275	50.00	9135	20.00	70.00

THE INSTALLATION MEETING

On Tuesday evening, September 27, in beautiful Carnegie Music Hall, Pittsburgh, President Engel will install President-elect Samuel as his successor in office. Dr. Samuel's address will be followed (promised but not confirmed) by an account of the British nationalized health service as observed by Dr. Ralph Gampell of England. The Pittsburgh Little Symphony Orchestra consisting of 25 pieces, with choice vocalists, will provide a ninety-minute concert of good music from the light classics and popular operettas.

THE PENNSYLVANIA MEDICAL JOURNAL

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EDITORIALS

EQUIVOCATION PER SE

A publication reaching the editor's desk on June 2, 1949, captioned "Restrictions on Free Enterprise in Medicine" was issued in April, 1949, by the Committee on Research in Medical Economics, of which Michael M. Davis, Ph.D., is chairman and Channing Frothingham, M.D., is a member.

The introductory paragraph to this 25-page pamphlet, mailed to each member of the 1948 House of Delegates of the A.M.A., reads as follows:

"Only 3½ million Americans are covered by comprehensive medical service insurance plans. Many more millions want such plans but their development has been blocked by restrictions imposed by special interests. This report reveals those restrictions and the forces responsible for them."

On the next to the last page appears the following, also in black-faced type:

"Organized medicine, by trying to suppress voluntary medical insurance plans except those which conform to its own patterns, has said to the American public, in effect:

"We, your doctors, will decide how you must pay us your doctor bills, whether by fee-for-service or by insurance.

"Medical insurance is good, but you may have it only on our terms.

"You do not have to join our medical insurance plans, but you shall not have any others unless we approve them.

"We who receive your medical insurance money shall determine the way in which it shall be spent.

"We shall decide what benefits you may receive, whether for catastrophic illness only or for comprehensive medical care; whether in the form of cash payments or of medical service.

"We shall not permit doctors of your choice to serve you in any medical insurance plan unless we like your plan.

"These policies have been expressed in practice by the restrictive laws and the oppressive medical society actions which have been described in this report."

The few JOURNAL readers who may not know the socio-politico-economic reputations of Messrs. Davis and Frothingham in support of compulsory forms of government-controlled insured medical services and hospital care will surely be surprised at being told by this committee that the organized medical profession has ever been opposed to the sale of accident, sickness, or hospitalization insurance to individuals, families, or groups by commercial insurance companies. Most doctors have personally carried such insurance throughout the years.

Furthermore, the pages of the official publications of scores of medical societies have expressed sentiments such as the following:

While the physician's first interest may be in behalf of non-profit voluntary insured medical service and hospital care—Blue Shield and Blue Cross—they nevertheless owe allegiance to the field of general insurance which provides such protection in a satisfactory manner on a profit basis to many millions of persons.

Too few practitioners display interest or activity in the direction of acquiring or extending information about the amazing growth of voluntary systems of prepayment hospitalization and medical insurance, both profit and non-profit.

Knowledge of the misinformation existing in the Davis, Frothingham, et al. committee report referred to above, which will no doubt be widely distributed, should stimulate those who know the true position of the profession in support of all forms of voluntary sickness insurance to refute the committee's statements quoted above. And they might at the same time express satisfaction in the knowledge that opposition from commercial insurance interests to the enactment of enabling legislation for Blue Shield non-profit insured service was not a problem in the legislature of most of the forty-eight states of the Union. As a matter of fact, several programs outlined by the medical profession have been underwritten by commercial insurance companies. One of the first of such plans was Community Surgical and Medical Care Plan of Toledo, Ohio. Other examples are the Wisconsin Plan, South Dakota Injury-Illness Expense Plan, and the Rhode Island Plan.

REDUCE RESIDENCIES IN MOST SPECIALTIES

"The present great volume of residency training should appreciably decrease in many fields."

"The hospital staff mount their professional horses and ride in so many directions at the same time that it is difficult for the young doctor to gain perspective as to what properly balanced medical care really is."

The first quotation above is from the pen of Victor Johnson, M.D., for many years secretary and currently a member of the Council on Medical Education and Hospitals of the American Medical Association, while the second quotation is from the pen of M. B. Casebolt, M.D., chairman of the Section on General Practice, Missouri State Medical Association.

The latter estimates that "30 per cent of young physicians should be directed in special fields and 70 per cent in the general."

Dr. Johnson points out that "residency training must decrease appreciably" or "90 per cent of future medical graduates will take three years of residency work in specialties." The latter declares: "From the opinions of over a hundred members of the various American specialty boards it has been estimated that there are about

52,800 specialists in all fields possibly required for the best medical service to the people of this country."

This estimate is not far afield from the above estimate by Dr. Casebolt if it is agreed that there are about 165,000 active physicians in the United States of America.

We print in this issue with due credit the very interesting articles from which we have above quoted briefly.

FROM THE DISTAFF SIDE

"Men have sight; women insight."—(Victor Hugo).

Probably for the first time in the history of THE PENNSYLVANIA MEDICAL JOURNAL and The Medical Society of the State of Pennsylvania, the distaff side of the latter organization—its Woman's Auxiliary—has been invited and through its president has spoken plainly, without repression, and yet in words characteristically tender toward helping man to do his duty.

All the above is but an invitation to all JOURNAL readers of either sex to carefully peruse the message captioned "What Does the Woman's Auxiliary Expect from the County Medical Society?" appearing in this issue, page 996.

MODERN TREATMENT OF EARLY SYPHILIS

(EDITOR'S NOTE: This is the fourth of a series of guest editorials prepared by members of the Pittsburgh Syphilis and Venereal Disease Control Program, which is sponsored by the Venereal Disease Division of the Pennsylvania Department of Health, and the Department of Dermatology and Syphilology, University of Pittsburgh School of Medicine. They should refresh the minds of practicing physicians on the procedures necessary to establish a diagnosis of syphilis, the modern therapy, the follow-up of treated cases, and certain public health aspects.)

Today, after four years of clinical experimentation and use, the schedules for the treatment of syphilis with penicillin continue to be provisional. This should not be surprising or disappointing, however, because of the fact that the first penicillins which were used were amorphous and crude, and were a composite of several different penicillin fractions, some of which were therapeutically effective, some inert. Because of the variation in the penicillin fractions, the therapeutic responses of the patients in many instances were inconstant and unsatisfactory, and as a consequence our early statistics now have very little value. Now that standardized crystalline penicillin G is being used generally, the com-

position and potency of the drug are definitely known and our results both clinically and statistically, since 1946, should be fairly constant and reliable.

Once a positive diagnosis of primary or secondary syphilis is made, penicillin therapy should be started immediately. If the patient is to be hospitalized, penicillin G in saline solution is injected every two hours around the clock. The total dosage now used for primary and secondary syphilis in our Rapid Treatment Center is four million units divided into 100 doses of 40,000 units each. No other antisyphilitic medication is used in the treatment, because arsenicals and heavy metals are considered to be non-essentials in present-day therapy. With this treatment all surface lesions on the skin and mucous membranes become non-infectious and darkfield-negative within eight to twenty-four hours after the first penicillin injection.

A small chancre, or a macular or a maculopapular eruption will usually be completely healed by the time that the injections are finished. A large indurated chancre or a florid papular or papulopustular eruption may not be healed when treatment has been finished, but one can confidently expect that all of these lesions will continue to clear up and heal completely within a short period of time.

Failure of a chancre to completely heal within a few weeks after completion of treatment suggests the probability that a mixed venereal infection is present. This might possibly be syphilis plus chancroid, or granuloma inguinale, or lymphogranuloma venereum. If a mixed infection is found to be present on subsequent examination, additional medication other than penicillin must be used, because these other venereal diseases just mentioned are not benefited by penicillin therapy.

Early latent syphilis is that phase of the disease which follows immediately after the disappearance of all of the signs of the secondary stage and which extends for an arbitrary period of time up to four years after the initial infection. The criteria for the diagnosis of early latent syphilis are: (1) usually a positive history of syphilitic infection of four years' or less duration; (2) absolutely no clinical evidence of syphilis on physical examination; (3) positive serologic tests; (4) negative spinal fluid findings. The diagnosis of early latent syphilis is made on all treated or untreated patients who fulfill these requirements.

Once the diagnosis of early latent syphilis is made and reconfirmed by repeated strongly positive quantitative serologic tests, treatment with

penicillin should be started, usually in dosages higher than those used for the primary and secondary stages. In the Rapid Treatment Center these patients are given an intramuscular injection of 50,000 units of penicillin G in saline solution every two hours, around the clock, for 100 doses totaling five million units of penicillin.

For the treatment of ambulatory patients and also for the treatment of hospitalized patients if desired, intramuscular injections of either penicillin in oil and beeswax or procaine penicillin G in oil, or procaine penicillin G for aqueous injection can be used. There is no unanimity of opinion as to the frequency of the injections or the total dosage which should be used. Some clinicians have injected 300,000 units twice a day for ten days for a total of six million units. We have found that 300,000 units daily for twenty days is very satisfactory and it has the advantage of prolonging the treatment period over a longer period of time. By using the procaine penicillin G aqueous or in oil, the patient experiences no local discomfort from the repeated injections.

For the treatment of clinical or serologic relapse, the same schedules of treatment may be used, only it is advisable to increase the total dosage of penicillin. Recommended dosages will range between five and ten million units of penicillin.

The reactions to penicillin therapy for syphilis can be classified as immediate and delayed. The immediate reaction is the Herxheimer reaction in which the patient develops a fever within twenty-four hours after the onset of treatment. The temperature may range from 100 to 104° F. and may persist for eight to sixteen hours and then promptly return to normal. The patient may also complain of headache, malaise, and loss of appetite, and the chancre or the secondary eruption might become more prominent during this period. Penicillin therapy is continued without interruption during this time.

Urticarial reactions occur in less than 5 per cent of the patients who are treated with penicillin. The urticarial reactions can develop from four to eight days after the treatment is started, or their appearance may be delayed until two or three weeks after the treatment has been completed. The penicillin injections should be continued unless the reaction becomes very severe. Usually the urticarial reaction ranges from mild to moderately severe and can be modified with injections of adrenalin in oil, 1 cc. given once daily, and/or a combination of $\frac{3}{8}$ grain ephedrine sulfate and a sedative, given orally several times a day. Calamine lotion with 1 per cent phenol will also help to control local pruritic

areas. The oral antihistaminic preparations are of little value and usually will not prevent or control the urticaria or the pruritis which is caused by the penicillin. Cautious use of the antihistaminics intravenously, however, is reported to relieve the urticaria and the accompanying pruritis. TOWNSEND W. BAER, M.D.

TO RECESS WOULD BE DISASTROUS

Little comfort can be taken from the May 24 Associated Press dispatch from Washington to the effect that "the hotly contested health insurance proposal has been stripped from the Administration *must* program for this session of Congress."

More time is thus provided for every doctor to pay and play his share in the two-year A.M.A. national education program for which the \$25 assessment is collected; however, Messrs. Ewing, Falk, and Altnyer will not be on vacation and another compulsory bill replete with sophistry and subterfuge will doubtless be forthcoming next January.

Maintain all your summer educational contacts with your patients and neighbors.

Contact your county or state medical society officers for additional campaign material.

LICENSURE OF FOREIGN MEDICAL GRADUATES

The Committee on Foreign Medical Credentials, an unofficial body sponsored by the Council on Medical Education and Hospitals of the American Medical Association and composed of invited individuals from organizations interested in the problem of foreign physicians, has issued a summary of the problems involved in the licensing of foreign medical graduates and its recommendations for their solution, from which we quote freely.

The membership of the committee includes individuals from organizations such as the Advisory Board for Medical Specialties, Association of American Medical Colleges, Department of State, Federation of State Medical Boards, National Board of Medical Examiners, Pan-American Sanitary Bureau, Rockefeller Foundation, United States Office of Education, World Health Organization, and World Medical Association.

A Growing Problem

The licensure of physicians who have received their medical degrees from foreign institutions seems certain to present a growing problem for the licensing bodies of the forty-eight states, the District of Columbia, and the territories and outlying possessions of the United States, and for the National Board of Medical Examiners. The unsettled economic and political conditions in many parts of the world have already stimulated many physicians to migrate to the United States, and it may be predicted that the number seeking to migrate will increase in the years ahead. In addition, each year a number of Americans enter foreign medical schools with the expectation of returning to the United States to practice. Some of these students study abroad because they are unable to gain admission to an American medical college, while others do so from choice.

The problem of the physician who has graduated from a foreign medical school promises to confront the public, various legislative bodies, and the licensing boards with increasing frequency during the next several years. The problem has important and far-reaching implications for the health and safety of the people of the United States.

Two basic principles are involved in the licensure of physicians whether they be graduates of domestic or foreign schools. One that has long been recognized by all states and nations is the requirement that a physician satisfy a licensing body representing the public as to his competency before he is permitted to practice. Without this requirement, the people of a community cannot distinguish those physicians who are competent to provide medical care from those who are not.

Examination System Not Infallible

The training a man has undergone in preparing to enter a profession is a paramount factor in determining the quality of his professional practice. To allow an inadequately trained physician to attempt to perfect himself through the mistakes of years of practice is to permit unwarranted and unnecessary abuse of patients who entrust their health and lives to him.

The best assurance of the quality of the training that a physician has received is an intimate knowledge of the faculty, facilities, curriculum, and standards of the medical school from which he has graduated. Only when the results of such examinations are limited by considerations of practicality and are coupled with an evaluation of the quality of training that a physician has re-

ceived can a licensing board be reasonably confident that a physician is adequately prepared to assume the responsibilities that are an inevitable part of his practice.

In licensing graduates of American and Canadian schools, the various state licensing boards have for many years had the benefit of the findings of periodic thorough surveys of these schools carried out by the two accrediting bodies—the Council on Medical Education and Hospitals of the American Medical Association and the Association of American Medical Colleges.

Rate Character of Physician and His School Equally

It should be pointed out that the present high standards of medical practice in the United States have been the direct result of the recognition by the licensing boards that evaluation of the school from which a physician graduates is equally important as evaluation of the physician himself. Before this principle was generally recognized, the country was overrun with physicians who, armed with a degree from a low-grade school or outright diploma mill, succeeded in one way or another in passing the examinations for licensure. The needless suffering and injury perpetrated by the incompetent and at times fraudulent practices of many of these inadequately trained men constitute a dark chapter in the history of medicine.

While it has been possible for the two accrediting agencies referred to above to maintain current appraisals of the quality of education offered by American and Canadian medical schools, it has been beyond their resources to attempt to maintain a similar inventory of the three hundred or more medical schools in other parts of the world. For many years this was not important because the number of physicians migrating to the United States was small and most of the foreign-trained physicians came from medical schools that were well known in America.

Between 1930 and 1939 two developments occurred that entirely changed the situation. Unsettled and unfavorable conditions abroad prompted large numbers of physicians to migrate to this country. At the same time, internal developments in many countries led to a rapid deterioration in the quality of medical education. This change, which was readily apparent to American physicians traveling abroad in the years immediately prior to the war, was greatly accelerated when these countries became involved in World War II. The pressures of the war reduced the quality of medical education in all countries, including the United States, but in

many countries the effect was catastrophic. Faculties were decimated, buildings, libraries, and equipment were destroyed or badly damaged, all contact with scientific developments in other countries was interrupted, and standards were lowered in an effort to turn out large numbers of physicians to serve the armies of the warring nations.

By the end of the war, medical education in other countries, with few exceptions, had degenerated to a degree that was shocking to those who had known these countries in the period up to 1930. While medical education in the United States recovered quickly from the war and is now at the highest point in its development, unsettled political and economic conditions in many foreign countries have prevented any similar recovery. Even more disturbing is the fact that some foreign countries appear to be committed to educational policies that are so unsound and so inferior that there is serious doubt that satisfactory standards of medical education will be re-established at any time in the foreseeable future.

It is against this background that the problem of the foreign-trained physicians must be studied. Their complete exclusion from the United States cannot be reconciled with the traditional role of this country as the land of opportunity. The fact that few foreign countries will admit the graduates of American medical schools to practice should not be accepted as a valid reason for pursuing a reciprocal policy. It is well, however, for the people to know that the United States is the most liberal of all countries in licensing physicians who have not graduated from their own schools.

It is clear that until more information can be obtained about the present quality of medical schools abroad, the licensing boards would fail in their responsibility to the public if they did not use the greatest care and discretion in admitting foreign-trained physicians to their examinations.

Detailed current knowledge of foreign medical schools is indispensable for the guidance of state licensing boards in determining which foreign physicians have had sound training. It will not be an easy task and it is improbable that well-documented evaluations can be made of all foreign schools in the same manner as is done for American and Canadian schools. International relations will undoubtedly also limit the extent to which such a study can be carried out.

It should be possible to derive a list of foreign medical schools which have maintained during specific periods, or are now maintaining, educational programs sufficiently comparable to the

training offered by the medical schools of this country to warrant the admission of their graduates to the examinations of the licensing boards of the forty-eight states, as well as the examinations of the National Board of Medical Examiners.

As an added safeguard it would seem entirely reasonable that whenever a candidate cannot present evidence to a state licensing board that he is sufficiently familiar with recent scientific advances in medicine, with the practices and customs of American medicine, and with the English language, that he be required to take additional training in this country before being permitted to appear for examination.

It is to be hoped that the American people will continue to have confidence that these licensing bodies are acting for their best interests according to well-established principles.

The licensing bodies and the governments to which they are responsible have a heavy obligation to continue their efforts to maintain high standards of medical practice. They must also recognize that the spirit and tradition of America place upon them an obligation not to deny the opportunity to practice his profession to any citizen or prospective citizen who can demonstrate satisfactory qualifications as to his professional competence and character.

If the problem of the foreign medical graduate is approached in this spirit, the Committee on Foreign Medical Credentials is confident that it will be solved without lowering the standards of American medicine and in a manner consistent with our national ideals of justice and humanitarianism.

MEDICAL EDUCATION—THE PAST CENTURY AND THE FUTURE

Victor Johnson, M.D., Director, Mayo Foundation for Medical Education and Research, Rochester, Minn.

From the very outset the history of organized medicine has been in large measure the history of medical education. There are few if any cities in the United States like Philadelphia with such a rich heritage of medicine. In the sphere of science and medicine this city can record a distinguished past. At the time of the organization of the County Medical Society in 1849 and the American Medical Association in 1848 medical education in this country was at a very low state. However, through the efforts of the American Medical As-

sociation by means of discussions and recommendations this situation was soon remedied. Early medical education took the form of medical schools and the apprentice training in physicians' offices. In addition, there arose diploma mills in all sections of the country which resulted in low standards of medical training.

The period from 1904 to 1914 saw a revolution in medical education through a transformation probably unequaled in any area of learning. It began in the formation of the Council on Medical Education of the American Medical Association and ended with the entire scene of medical education redrawn. This council established standards for admission and for a four-year medical course to be followed by a year of internship. This resulted in the ensuing decade in a considerable reduction in the number of medical schools caused by the closing of many weak schools and the merger of others into institutions much stronger than the component parts. The role of the *Journal of the A.M.A.* in establishing the wide influence of the council should be emphasized.

In the twenty years from 1922 to 1942 the number of medical schools still further decreased to 77, but the number of graduates steadily increased, so that the number graduating in 1944 (5163) was about double the number for 1922.

For two decades the number of physicians has increased more rapidly than the population of the country. This is expected to continue with the establishment of new colleges. The current rate of general population increase is about six persons per 1000 of the population per year. The present rate of physician increase is about 10 physicians per 1000 per year. Responsible medical educators will continue to encourage the formation of any new medical school which promises success but will resist efforts at sudden ill-conceived expansion based upon alarmist pronouncements of existing and impending dire shortages of physicians. The unquestioned demonstration of high competence by physicians in adjusting to the health needs of the nation in the past warrants the people of the country resting great confidence in today's efforts by medicine to reach a solution to the extremely difficult problems now pressing upon our honored profession today.

Graduate Training

Today internship and residency problems employ far more funds and professional time of the American Medical Association than do the varied activities in the field of undergraduate medical education. The development of residency training programs and the American boards in the specialties of medicine is relatively recent history familiar to all. Specialty training has expanded at a staggering rate in the past few years. In 1941 there were 5256 approved residency positions. Today there are 15,172 or three times the pre-war number. This brings up the question, "How many specialists in the various fields do we need in this country?" The apparent simplicity of this question is misleading since the complications are numerous. For example, what is the proper sphere of practice of the specialist in pediatrics, internal medicine, or obstetrics, as related to the general practitioner of medicine? Or, to what extent should anesthetics be given by physicians or specialists rather than by qualified nurses? Furthermore, some specialists practice in more than one field.

From the opinions of over a hundred members of the various American specialty boards it has been estimated that there are about 52,800 specialists in all fields pos-

Abstract of talk delivered before the joint meeting of the Philadelphia County Medical Society and the College of Physicians of Philadelphia, March 9, 1949, at the County Medical Society Building, 21st and Spruce Streets.

sibly required for the best medical service to the people of this country. Our present total specialist population approaches or equals the optimum number for the best medical care. Thus it would appear that the present great volume of residency training should appreciably decrease in many fields. Indeed it must decrease unless 90 per cent of future medical graduates take three years of residency work in specialties. We must also consider the quality of residency training and the competence of the specialists as well as the numbers involved. Our efforts should be directed toward improved quality of training while reducing the number of residency programs except in certain special fields like anesthesiology and psychiatry, where manifest shortages of specialists exist.

Medical School Finances

All education is suffering from inadequate financial support, but the plight of the medical schools is particularly acute because undergraduate medical education is more expensive than that in any other field. The budgets of all medical and basic science schools in this country for the current academic year total about 51 million dollars excluding research grants, special teaching grants, and major costs of operating hospitals closely affiliated with medical schools. Just one-fourth of this sum (12.8 million dollars) is derived from tuition. The remainder is derived from endowment income, gifts, grants and appropriations from states and municipalities. These sources cannot continue to supply such sums. Increased legislative appropriations are negated by rising costs, and endowment income is decreasing. There is a universal and well-founded fear that the financial support of medical schools generally will become inadequate to maintain the existing high quality of undergraduate medical education, which is the foundation upon which our whole structure of superior medical care rests.

It has been estimated that the combined medical schools of the country need 15 million dollars annually from new sources merely to maintain the status quo. The new source most frequently mentioned is the Federal government. Most medical schools and medical educators are concerned lest such aid would be secured only by a gradual but progressive relinquishing of that independence which has contributed so importantly to the achievement of a quality of medical education and research unequalled anywhere in the world.

There are two alternatives to Federal aid. First, allow medical education to deteriorate, which alternative can only be rejected. Second, secure additional funds from other sources. Tuition increases cannot meet the needs unless we frankly admit that medical schools are open only to the well-to-do. Greatly augmented support

from state appropriations does not seem likely. Increased private giving still remains as a source of the required funds. Considerable thought is being given at present toward a thorough exploration of this possibility.

Conclusion

Physicians of this country have demonstrated that they could transform undergraduate medical education from the worst in the world to the best in the world mainly within one decade. They evolved a program of graduate medical education unexcelled anywhere and tripled its size in an emergency. They provided for the armed forces, essentially through their own organization, 60,000 doctors to give the best medical care received by any military establishment in history. This was accomplished while still maintaining and even improving the good health of the workers at home.—*Philadelphia Medicine*, April 16, 1949.

1700 GUESTS ATTEND CENTENNIAL BANQUET

The turnout for the centennial banquet of the Wayne County Medical Society was literally overwhelming—overflowing the Fountain Ballroom where accommodations had been made for an expected crowd of 1500.

Following the parade of a Century of Fashions staged by the Detroit Historical Society, Dr. Clarence Candler, toastmaster, introduced the speaker, Hon. Walter H. Judd, M.D.

Some Excerpts from the Speech

"America's health status is like a glass of water that is three-fourths full. Some people look at the three-fourths and say the whole thing is good. Some look at the one-fourth and say the whole thing is bad. Neither is right. We must do all we can to fill the empty one-fourth at the same time that we preserve the full three-fourths. *Let's not throw away what we have just because we do not have everything.*"

"The purpose of our government is not to do everything for the citizen, but to give the citizen the right to do for himself. . . . The primary impetus should not come from the *top* down, but from the *bottom* up."

"The Bill of Rights, on which our individual freedoms rest, *are not guarantees that the government shall do certain things; they are guarantees that the government shall not do certain things.*"—*Detroit Medical News*, Michigan.

Plan now to attend The Religious Hour at the State Meeting, in Pittsburgh, Sunday, September 25.

PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division, American Cancer Society, in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

Cancer Society Financially Unable to Care for Indigent Patients

Restricted by lack of funds to a three-pronged program of education, service, and research, the American Cancer Society renders only limited case service among the needy or medically indigent cancer patients.

While other health organizations make limited funds available for individual case care, the Pennsylvania Division, like other state divisions of the American Cancer Society, cannot follow this policy because of the heavy incidence and death rate from cancer. To cover all cases, sufficient funds would not be available. Thus the Society's funds used in this manner would weaken the organization's broader functions such as education and the subsidy of detection, diagnosis, and treatment facilities.

A simple comparison indicates why funds for indigent cancer patients are not available. During an epidemic year of poliomyelitis—the National Foundation for Infantile Paralysis provides funds for direct case service—about seven hundred persons are stricken, and the death rate is small. During the past several years, nearly 15,000 persons died annually of cancer in Pennsylvania and thousands more have been suffering.

Cancer is a costly disease because many patients will live for several months after being declared "incurable" by their physicians. If the Society were to supply funds for the care of the indigent and medically indigent cancer patients, the amount of money involved would reach staggering proportions. Funds for this purpose should be obtained through local or state governments. Data released by the National Cancer Institute indicates that thirty-two states are making no effort to obtain funds available from the Institute for financial payment through grants-in-aid or case-by-case arrangement to local hospitals accepting cancer patients.

The American Cancer Society is convinced that the most important aspect of cancer control today lies in the research problem. In an effort

to find the cause and a cure for cancer, 25 per cent of all funds received by the Society goes into research grants and fellowships.

Realizing that something must be done to control cancer until medical science solves the age-old problem, the Society is conducting an intensive educational program. It is necessary to keep both the lay public and the medical profession ever aware of the importance of early suspicion, accurate diagnosis, and effective treatment in order to reduce the delay factor, because early cancer is curable.

In addition to financial support of coordinated research efforts and the expanded educational program now underway, American Cancer Society funds are expended in service to the cancer patient through transportation to and from treatment centers, provision of cancer dressings made for distribution by members of the volunteer Field Army, loan and gift closet items, home nursing care, provision of sedatives or medication and other specialized services applicable to specific needs.

The Society's funds would be exhausted virtually overnight if the organization would embark upon a cancer program of individual care, and as a result the research and educational programs would suffer. Therefore, the problem of individual care is one that must be assumed by existing local welfare agencies. The magnitude of the problem makes it a public welfare responsibility to take care of these needy cases.

Philadelphia's Program

The Philadelphia Division of the American Cancer Society is subsidizing five fellowships in four of the city's medical schools and the Philadelphia General Hospital. Each fellowship carries a yearly grant of \$2,400 and is designed to develop liaison clinical relationship between the various departments of the medical schools and the hospital with respect to training in early diagnosis of malignancy and proper application of x-ray and radium treatment.

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*

8104 Jenkins Arcade

Pittsburgh 22, Pa.

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

CALL TO THE 1949 MEETING

The first meeting of the House of Delegates of The Medical Society of the State of Pennsylvania will be called to order in the Pittsburgh Room, Hotel William Penn, Pittsburgh, at 10 a.m. on Monday, Sept. 26, 1949. Subsequent sessions will be held as decided by the House except the session for the election of officers on Wednesday morning.

Notice relative to parliamentary requirements for consideration of proposed amendments to the constitution and by-laws was published in the May JOURNAL.

Proposed Amendments to Constitution and By-laws

Eligibility for Active Membership

The following resolution embodying an amendment to Article IV, Section 1, of the Constitution of The Medical Society of the State of Pennsylvania, and an amendment to Chapter VIII, Section 2, of the By-laws, was adopted by the Erie County Medical Society at its May 3, 1949 meeting, and is respectfully submitted for consideration and action by the 1949 House of Delegates of The Medical Society of the State of Pennsylvania.

(NOTE: These two proposed amendments involve only deletion of the words "citizens of the United States" and substitution of the words "Doctors of Medicine" in the requirement for eligibility for membership.)

Resolution

WHEREAS, The laws of the Commonwealth of Pennsylvania permit otherwise qualified Doctors of Medicine to be licensed to practice medicine and surgery on the strength of holding first papers for United States citizenship, and

WHEREAS, A number of Doctors of Medicine who are foreign-born but who hold such first papers are duly licensed in the Commonwealth of Pennsylvania and are practicing medicine therein, and

WHEREAS, The Constitution of The Medical Society of the State of Pennsylvania requires full United States citizenship as a prerequisite for membership, thereby denying component county societies the opportunity to accept those legally qualified fellow-practitioners into Society membership with its corollary rights and privileges and mutual advantages; therefore, be it

Resolved, That the Erie County Medical Society proposes that Article IV, Section 1, of the Constitution of The Medical Society of the State of Pennsylvania be amended to read as follows: "The active members of this Society shall be *Doctors of Medicine* licensed to practice medicine in the Commonwealth of Pennsylvania, members in good standing in the component coun-

ty medical societies, and whose annual assessments in this Society have been paid"; and be it further

Resolved, That Chapter VIII, Section 2, of the By-laws of The Medical Society of the State of Pennsylvania be amended by deletion of the phrase "*citizens of the United States.*"

The following proposed amendments to the By-laws are submitted by the Board of Trustees:

CHAPTER II, SECTION 1.—The House of Delegates shall meet on the morning of the day *before that* fixed as the first day of the annual session . . . (amendment involves only omission of the words in italics).

CHAPTER V, SECTION 2.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the morning of the *third* (second) day of the annual session . . . (amendment involves only substitution of the word *third* for the word "second.")

CHAPTER VII, SECTION 11, now reads: The Advisory Committee to the Woman's Auxiliary shall consist of three members. They shall act in an advisory capacity to the Woman's Auxiliary, and shall hold meetings whenever it is necessary to furnish advice to the Woman's Auxiliary on any debatable question regarding the change in their constitution or other functions.

Amend by changing last sentence to read: They shall act in an advisory capacity to the Woman's Auxiliary *whenever called upon by the Woman's Auxiliary regarding its functions or changes in its constitution and by-laws.*

THE MEDICAL SPECIALTIES IN THE SCIENTIFIC PROGRAM

It was recognized by many members of our State Society and then brought into acute focus by President Engel that we, as a group, had become so highly specialized that we were losing sight of our primary purpose—to provide a general training program for our members. In many instances the scientific program of our annual convention provided the only graduate training that some of us received. To overcome this fault, the scientific sections of the Society were reduced to two parts, viz., Medicine and Surgery, with the absorption into each of its related sub-specialty groups.

In some instances in the new setup there is overlapping, such as with radiology and pathology being applicable to both sections, but each of the two groups has felt free to call upon any of the sub-groups to take part in this 1949 program of education.

This arbitrary division early met with some disfavor from representatives of the former specialty sections on the grounds that their identity would be lost. However, this did not prove to be so, since we were able to use the officers of the former respective sections in an advisory capacity, and in so doing have developed what we believe will be the best annual session program evolved in the history of the Society.

One has only to scan the preliminary program now nearing completion to appreciate the coordination made possible by this change. For instance, our opening Symposium on Silicosis includes two clinicians, a physiologist, a pathologist, a roentgenologist, and an attorney. Internists and surgeons comprise the personnel of the second Symposium on Cardiac Surgery. Absorbed into the Section on Medicine are specialists in pediatrics, dermatology, neurology and psychiatry, preventive medicine and public health, and general practice of medicine. Both the Section on Medicine and the Section on Surgery are presenting papers from the Section on Pathology and Radiology. Much more space on the medical side of the program is being given to pediatrics than to any other section except the current Section on Medicine. This was deemed advisable because pediatrics comprises so much of the work of the doctors in general practice.

The pediatricians will present a Symposium on Endocrinology and one on Problems of the Newborn. The dermatologists will present newer work on dermatitis and psoriasis, while specialists in nervous and mental diseases will present papers on sex deviates, psychosurgery, and neuritis. Nine guest speakers of national reputation in their respective specialties will be presented by the medical section.

The Section on Preventive Medicine and Public Health has as its speakers Drs. Perrin Long, Thomas Parran, and Pascal F. Lucchesi, all of whom are well known in their respective fields.

As one reads the completed program, he becomes filled with a feeling of pardonable pride at the accomplishments of the entire committee in arranging such a varied and integrated program on medicine and the medical specialties. Furthermore, the list of names of the essayists reads like the faculty of a medical school. It is our sincere hope that all the members of The Medical Society of the State of Pennsylvania will

avail themselves of the opportunity to be present at this fine course in postgraduate medicine.

RALPH L. SHANNO, M.D., *Chairman*
JOHN H. WILLARD, M.D., *Secretary*
Section on Medicine

LETTER FROM AMERICAN MEDICAL ASSOCIATION

To the Members of the Congress:

It has come to our attention that misstatements have been made before Congressional committees recently concerning the purposes, objectives, and methods of the National Education Campaign of the American Medical Association on the issue of health insurance.

References have been made to the plan of the campaign developed by the A.M.A. and Whitaker & Baxter, the directors of our program, for the guidance of doctors and others who are carrying the case for the American medical system to the American people—and there has been an attempt to make it appear that the campaign program is devious and unethical.

There is nothing devious or unethical about our campaign program, nor the methods which we are using. We are going directly to the people on this issue, because the people's health is involved—and we believe the people should be given the facts.

This is a grass roots campaign in the best American tradition. The facts as we see them are being placed before the people in every community in the Nation—just as the proponents of compulsory health insurance, including the President and the Federal Security Administration, long have been stating their own views. We are confident that the majority of the members of Congress believe in public discussion of public issues and will defend our right of petition.

So that you may have the facts, we are sending you herewith a copy of our plan of campaign against compulsory health insurance—and in behalf of voluntary health insurance. Copies also are being sent to all other members of the Congress. This plan of campaign has been distributed to state and county medical societies throughout the country. It has been published in scores of medical journals and has been quoted extensively in newspapers and national magazines. The best indication that the medical profession is doing its work on this issue openly and honestly is that nearly 14,000 copies of this plan of campaign have been distributed, without any restrictions on the use of material which it contains.

To enable you to know the type of campaign and educational material which we are using in getting medicine's story to the people, we are also enclosing with this letter a copy of a question and answer pamphlet entitled "The Voluntary Way Is the American Way!" We believe the people have many questions in their minds concerning this whole problem of health insurance, and we believe that they are entitled to have them answered. The Federal Security Administration and many other government agencies, as you undoubtedly know, have been propagandizing in favor of compulsory health insurance for many years past. A committee of your Congress has investigated the propaganda activ-

ities of some of these government agencies on this issue and has strongly condemned this misuse of government funds for propaganda purposes. In view of this condition, if the people of America are to hear both sides of this issue, American medicine must conduct a campaign; it not only has the right to do so, as I am sure you will agree, but it has a public obligation to do so.

There has been criticism of the American Medical Association because we asked doctors to discuss this issue with their Congressmen. In common fairness, we ask: Who should discuss a vital health issue with a Congressman, if not a doctor? And who is better able to do that than a Congressman's own doctor, in whose medical knowledge and integrity he presumably has confidence?

If there is any other material that we have issued which you would like to have, please feel free to ask for it. Comment has been occasioned by the fact that the American Medical Association voted an assessment of \$25 per member at its Mid-Winter Meeting for this educational work and for the general support of the Association's activities.

You should know, in that connection, that the Association does not collect dues from its members, and that this assessment was in lieu of dues. Every dollar expended by our association in connection with this issue is being reported to the House of Representatives and the Senate, under Public Law 601, even though at least half of this fund is being used to acquaint the people with the advantages and the availability of prepaid medical care under the many splendid voluntary health insurance systems now operating in the country.

We will be happy to hear from you if you have any comment to make on this letter, or if you desire any further information.

Sincerely,

ELMER L. HENDERSON, M.D.,
Chairman of the Board of Trustees.
(President-elect since June 9, 1949)

May 23, 1949

RESOLUTION PASSED UNANIMOUSLY BY LEHIGH COUNTY MEDICAL SOCIETY *

WHEREAS, Under a system of free enterprise the American medical profession has established the world's highest standard of medical care, thereby helping the United States to become the healthiest major nation in the world; and

WHEREAS, The benefits of American medicine are now available to the majority of the people of this country and can be extended to every American through budget-basis, *voluntary* health insurance; and

WHEREAS, The experience of all countries where government has assumed control of medical services has shown that there has been a

* Resolutions of similar import have also been received from the following component societies: Allegheny, Cumberland, Elk, and Jefferson. However, to be most effective, the wording and arrangement of paragraphs should be dissimilar.

gradual erosion of free enterprise and a progressive deterioration of medical standards and medical care to the detriment of the health of the people; therefore, be it

Resolved, That the Lehigh County Medical Society does hereby go on record against any form of compulsory health insurance or any system of political medicine designed for bureaucratic control; and be it further

Resolved, That the Lehigh County Medical Society endorses and urges the rapid expansion of Blue Cross and Blue Shield (Medical Service Association of Pennsylvania) plans in Pennsylvania; and that a copy of this resolution be forwarded to the President of the United States, to our Senators and Representatives now in the Congress of the United States, and that said Senators and Representatives be and are hereby respectfully requested to use every effort at their command to prevent the enactment of legislation advocating compulsory health insurance or any system of political medicine designed for bureaucratic control.

ROWLAND W. BACHMAN, M.D., *President*,
J. FREDERIC DREYER, M.D., *Secretary*,
Allentown, Pa.

Dated this 20th day of May, 1949.

CONTRIBUTIONS TO MEDICAL BENEVOLENCE FUND

The Committee on Medical Benevolence makes grateful acknowledgment of the following contributions to the fund. These have also been previously acknowledged individually.

Woman's Auxiliary, Luzerne County	\$200.00
Woman's Auxiliary, Blair County	100.00
Woman's Auxiliary, Allegheny County	373.00
Woman's Auxiliary, Montour-Columbia County	38.50
Previously reported	3,887.68

Total contributions since 1949 report\$4,599.18

RECENT APPOINTMENTS

1. President Engel appointed to the subcommittee of Governor Duff's *Highway Safety Advisory Committee* —Drs. Rufus M. Bierly, Pittston; James A. Lehman, Philadelphia; and Max H. Weinberg, Pittsburgh.
2. To the Subcommittee to Study the Problem of the Automobile Driver Suffering from a Heart Ailment: Drs. Constantine P. Faller, Harrisburg, chairman; Luther I. Fisher, Bethlehem; William Lehman, Phila-

delphia; William L. Mullins, Pittsburgh; and Wilfred H. Winey, Johnstown.

3. To the *Committee to Nominate Delegates and Alternates to the A.M.A.*—Drs. I. S. Ravdin, Philadelphia, chairman; Harold B. Gardner, Pittsburgh; Louis W. Jones, Wilkes-Barre; Harry B. Thomas, York; and W. Blair Mosser, Kane.

4. To represent the Society at the *Sesquicentennial Celebration of the Medical and Chirurgical Faculty of Maryland* held in Baltimore—First Vice-president Harold B. Gardner, Pittsburgh.

5. To the *Centennial Celebration of the Medical Association of Georgia*, held in Savannah—Dr. Catharine Macfarlane, Philadelphia. In the name of our society Dr. Macfarlane presented a hand-engraved, handsomely framed scroll which bears the following message:

TO

The Medical Association of Georgia

In recognition of the laudable devotion of the Medical Association of Georgia to the high ideals of the profession of medicine throughout the last century—1849-1949.

The Medical Society of the State of Pennsylvania extends greetings and good wishes for a second century of distinguished service to the people of the Empire State of the South—Georgia—which, with Pennsylvania, the Keystone State, is one of the thirteen original states of the Union. May your contributions to progress in the science and art of medicine long continue.

President

Chairman, Board of Trustees

Secretary-Treasurer

WHAT DOES THE WOMAN'S AUXILIARY EXPECT FROM THE COUNTY MEDICAL SOCIETY?

MRS. PAUL C. CRAIG
READING, PA.

The invitation to speak before this conference presented an excellent opportunity for me to clarify my own thinking about Medical Society-Auxiliary relationships. For preparation I wrote 150 letters to county officers and members of our State Executive Board, asking them about their problems, the present situation, and what the ideal of cooperation would be. From their replies I wrote this paper. So my presentation is really a summary of the thinking in the counties.

One of your officers said that I "should speak

without inhibitions and talk frankly." The people I really would like to talk to are not here—those who tolerate, belittle, ignore, show hostility, or say "I don't want my wife to belong to that organization." So I can't hurt the feelings of those who are present, you who came to help improve the county medical society program, if I point out the deficiencies in the present Medical Society-Auxiliary relationships, and suggest possible changes to make the Auxiliary more useful to the Medical Society.

I think there must be positive value in a crisis—and in this crisis you have discovered that it is a woman's world, that women do influence thinking, and that we can be of service to you now. Benjamin Franklin discovered electricity after he was married. He knew that one can be burned by misuse of this power but that its service potential is great. So it is with the Auxiliary.

What does the Woman's Auxiliary expect from the county medical society? The same kind of intelligent, tactful supervision, cooperation, and criticism with fine personal working relationships as exist now, at the state level and in some counties, between the Medical Society and the Woman's Auxiliary. The only flaw in our relationship is some slight difficulty in timing due to the pressure of current activity.

These things we can offer you: loyalty, interpretation, and detail work—if you'll let us feel that we are in this thing together. We are not ready for a full-scale program, but the stimulation of recent recognition and cooperation has resulted in a revitalized program in several counties. The essential ingredient is the intangible of understanding, of working wholeheartedly for the profession which means so much to us all.

Speaking to the House of Delegates in October, 1948, Dr. Elmer Hess had this to say of us:

"During the past year our Society has contributed substantially to the work of the Woman's Auxiliary. This work should be continued. These splendid women wish to make their organization an effective weapon in our public relations program and they should receive both our active and financial support. They are peculiarly fitted to sense public opinion long before we, as individuals, appreciate what is going on."

And Dr. Gilson Colby Engel in his inaugural address in October, 1948, said:

"Their (Woman's Auxiliary) key task in organized medicine, I believe, is that most important role of public relations. Through their connections with women's clubs and other organizations, they are in a position to spread news of what medicine is doing in the way of research and legislation to improve health standards in America. Theirs is the task of crystallizing public opinion to force the improvement of health standards in this country."

Delivered Before the thirty-seventh annual Conference of Secretaries and Editors of Component Societies of The Medical Society of the State of Pennsylvania, March 3-4, 1949, in Harrisburg. Mrs. Craig is president of the Woman's Auxiliary to the MSSP.

Before we can meet this challenge it is necessary to understand the make-up and history of the Auxiliary. Started almost twenty-five years ago, it developed to almost its present organization within a few years. Its objectives were: increased friendliness among physicians' families, assisting in the solution of the doctors' community problems when called upon, conventions, and helping to spread knowledge about preventive medicine and health legislation to the public. Each county auxiliary for the most part carries out its own program ideas in helping hospitals and health or welfare agencies locally. The only state-wide programs have been the sale of subscriptions to *Hygeia*, at the request of the American Medical Association, and providing contributions to the Medical Benevolence Fund at the request of the State Society. There have been repeated expressions of appreciation for our accomplishments in both of these endeavors.

Health institutes in larger counties have had varying degrees of success through the years, but in all cases have failed to attract increasing attendance or more diversified types of audiences. Some auxiliary activities are entirely social, but even in counties where this exists they do contribute to the Medical Benevolence Fund.

Thirty-two of our county auxiliaries have less than fifty members, twelve have less than twenty. With a state membership of 3600 we have not attracted the wives of several thousand members of the Medical Society, which has 10,700 on its membership list. There are many doctors' wives who give their time and talents to community service and ignore the Auxiliary because its program has not been clear-cut enough to interest them.

We are not a closely knit organization. We are loosely basted together, with some of the threads not holding. I say this with chagrin and regret, but it is a fact to be faced.

On the more pleasant side of the picture, this year with specific direction from the Medical Society and a program geared to immediate needs a definite interest in the importance of Auxiliary services has developed. It has been an exceedingly thrilling and stimulating year to work with the men of the Medical Society at the state level. We could not ask for more cooperation or more understanding. It has been an immensely fruitful period, and the year is not yet over. Briefly, this is what has happened during the past ten months:

1. The chairman of your Committee on Public Relations has been made chairman of our Advisory Committee and works in-

defatigably with us. He wrote to the county advisory committees and asked them to cooperate with us.

2. State Auxiliary chairmen sit in at meetings of the Medical Society's Committees on Public Relations and Public Health Legislation.
3. During the 1948 convention Drs. Palmer and Petry met with a group of our women to begin training as public speakers.
4. The State Society office force has done a great deal of our typing and mimeographing.
5. We have assumed responsibility for the 1949 Health Poster Contest and are actively at work on it in fifteen counties.
6. We circulate petitions and publicize defense of medical research under Dr. Palmer's direction.
7. The Auxiliary News has been compiled for us, with a mailing list of over 700, to keep our county officers and chairmen informed.
8. We have called upon Mr. Leo E. Brown continuously and have received help and advice from him. We are happy now to have on the public relations staff Miss Suzanne Treadwell, who will assist more specifically with our program.
9. We are awaiting the release of a 16-page, two-color pamphlet entitled "Your Family's Future Health" which puts the problem of compulsory sickness insurance versus voluntary sickness insurance on a personal basis. This factual, non-emotional pamphlet, geared to the thinking woman, will be distributed at public meetings and to lay groups. At the request of the Auxiliary, the pamphlet was written and produced by an advertising agency in order to achieve an objective approach. It was paid for by the Medical Society.
10. In connection with the ten graduate study courses, the women have done clerical work, telephoning, and served meals where necessary.

The response to my request for problems of relationship in the counties brought the following comment:

1. Too often the men have looked upon the Auxiliary as a purely social group.
2. There has been toleration, indifference, and even hostility toward Auxiliary activities.

3. "The men are too busy to think about us. They think the Auxiliary just came along for the ride."
4. Some small counties feel a sense of isolation; they do not realize that they are part of a state and national organization and their members never attend a convention. "The men are indifferent—their wives are bound to be the same."
5. Rural societies plan meetings without telling the women. "It would be a very great help if we could find out when and where the men are meeting. By the time we know, it is too late to get reservations. It is little wonder there is such apathy. The wonder to me is that we bother at all."
6. There is a lack of consultation on important subjects. The men plan community-wide matters without referring to the Auxiliary. This sometimes causes conflicting dates which inconvenience the women and handicap publicity possibilities.
7. The men show ignorance of Auxiliary activities and of our potential power and capacity for work. "They did not know of requests to the Auxiliary from the State Society on petitions for medical research, poster contest, or even that we contribute generously to the Medical Benevolence Fund."
8. They do not want to have anything to do with *Hygeia*.
9. "Why should we try to put medical information across when the doctors themselves refuse to help us?"
10. There are personality clashes, jealousies, and hospital conflicts which cannot be solved by the women, and which make good community relationships and Auxiliary unity impossible. One auxiliary member expressed it this way:

"Since the county medical society has seldom expected much from us or from itself, the auxiliary expects and gets less. The society is poorly organized and its active membership is small. . . . For the most part the men fail to realize that in their county organization lies a small measure, an all-important measure, of the great strength of a national organization that is striving to keep them 'free men.' They go on treating colds, setting bones, and delivering babies as though they lived in some far distant land apart from the immediate and approaching threats that beset the medical profession.

"They seem consumed by petty jealousies and misunderstandings within their own small compound. In brief, these men seem to need a missionary from the outside world. The few among them who are farsighted and interested in solving the problem have made very

little progress. How can wives of these men find the Auxiliary very interesting? *There must be a complete re-evaluation of the county medical society and auxiliary.* I want to help. My husband wants to help. We have made little progress this year, but there is still time. . . . We hope to prove to the public that private medicine can make strides. We hope to push Blue Shield and Blue Cross and really put the spotlight on their countless advantages."

In those letters to me from the counties the following points of cooperation were listed:

1. Advisers—to keep us out of trouble.
2. Occasional joint meetings—usually social.
3. Auxiliary notices included with those of the medical society.
4. Use of county bulletin space.
5. Occasional speakers supplied for Auxiliary meetings and lay groups.
6. Joint planning for councilor district meetings.
7. Assistance with postgraduate courses.
8. Health poster contest.
9. Medical research publicity.
10. Petitions signed.
11. Publicity on Blue Shield.
12. Circulation of motion pictures.
13. Assistance with radio programs.

On the basis of the foregoing comments, may we ask the county medical societies to:

1. Evaluate the field of service in which they desire the assistance and cooperation of the auxiliary, in the light of current needs.
2. Appoint advisers with vision and insight into the program of the State Medical Society and the Auxiliary's potential part in it—advisers who are willing to take time to work with the women and to interpret the Auxiliary's services to the general membership of the county medical society.
3. Plan jointly with the women. "The men came to us—a great psychologic advantage." Many women in smaller counties are too timid to go to the medical society and suggest activities even when asked to do so by their state officers.

May we request the county medical society:

TO URGE the wives of all members to join the Auxiliary.

TO PERMIT the Auxiliary's president to present her program to the county medical society once a year, to answer questions and hear suggestions.

TO INVITE the Auxiliary's chairmen to sit in at meetings of the public relations and public health legislation committees of the county medical societies.

TO SOLICIT the interchange of reports about programs and policy of both organizations by consultation with officers following each meeting.

TO ARRANGE at least one joint meeting a year—social, but with a speaker using a topic of concern to both men and women.

TO DEVELOP a plan which the women could also follow in training speakers through study groups.

TO ESTABLISH definite rules on publicity—a close liaison between county society and woman's auxiliary on handling and releasing information to the press; the opportunity to report auxiliary activities in county medical society bulletins, not just social write-ups.

TO FOSTER a positive attitude on the part of the individual physician which would help immeasurably in putting across all types of public relations.

"It's hard to apologize for the doctors' indifference all the time" was one comment we received. When physicians ignore Blue Shield, criticize the rheumatic fever program as unnecessary and the Cancer Detection Clinics as socialized medicine, when they criticize their confreres who give of their time to speak to lay groups and call them "publicity seekers"—one wonders what can be done. We would like to see doctors discuss fees with patients to avoid misunderstanding. We feel that neglected night calls also cause bad public relations.

"Where women associate with men in serious matters, both will grow stronger and the world's work will be better done." As we plan for the future, these are the things Auxiliary members would like from the Medical Society:

1. *Recognition* of the Auxiliary as an ally. "They should know what their Auxiliary is doing."
2. *Appreciation* of the Auxiliary program so that the men will not say, "I don't want my wife to belong."
3. *Cooperation* in periodic joint meetings and joint planning of local activities.
4. *Coordination*. "We should know about their community projects."

5. *Faith* in our ability to do the jobs that need to be done. "When we feel useful, we are busy as beavers."

Mrs. Drury Hinton, our president-elect, has had excellent results in organizing counties this year. She has reported: "We showed the women there was a job to do for the Medical Society and they enthusiastically organized to carry on. There is a new outlook and, in the younger women, a new pattern of thinking."

One letter to me said, "We are willing to work and we do not like to be suggesting plans all the time. We might be considered hecklers or nagging wives."

We miss a tremendous chance if we do not capitalize on the present interest of the public in health and sickness problems. The urgency of the issues will attract the younger women who are willing to study and work. We can do for the busy doctor what he is too busy to do for himself. We can't speak for you and about you unless we know what you are doing. It has been of immense help to me personally to gain insight into the functioning of the State Medical Society by attending the meetings of the Public Relations and Health Legislation Committees and by consulting frequently with the chairman of our Advisory Committee. Multiply this kind of co-operation 55 times and we will have a firm foundation at the county level for proceeding with an effective public relations program.

Women like to be noticed. A few will plug along despite indifference, but we know that a little flattery will go a long way towards stirring interest and willingness to work.

Robert Oppenheimer, of atomic energy fame, believes that "the best way to send an idea is to wrap it up in a person." Please take this idea back to your counties. We want to live up to our name—*Auxiliary*—that which helps.

As our immediate past president, Mrs. Rufus M. Bierly, said, "We have enough women with loyalty, intelligence, and concern for medical problems who can be trained to help. I know of no doctor's wife who would change places with anyone for a less hectic life. We will do the jobs you give us, faithfully and loyally."

Gentlemen, here is the potential of Benjamin Franklin's electric force. You need only give us direction.

To serve you is our responsibility.

To help you is our pleasure.

CHANGES IN MEMBERSHIP OF COUNTY SOCIETIES

New (35) and Reinstated (4) Members

ALLEGHENY COUNTY: Frank Concilus, Charles C. Custer, Robert J. Hudson, and Frances L. Selye, Pittsburgh; William N. Pigozzi, McKeesport. (Reinstated) Grosvenor B. Pearson, Pittsburgh.

BERKS COUNTY: Stanley J. Rozansk, Reading.

BRADFORD COUNTY: Albert L. Hunter, Jr., Sayre.

BUTLER COUNTY: Charles Morrow and Ralph Wymer, Butler.

FAYETTE COUNTY: Marion F. Magalotti, Masontown.

GREENE COUNTY: W. B. Birch, Carmichaels.

LANCASTER COUNTY: Frank T. Moran, Lancaster; Thomas W. O'Connor, Mount Joy.

LEBANON COUNTY: Charles G. H. Menges and Suzanne H. WorriLOW, Lebanon.

LEHIGH COUNTY: Alexander J. Filip and Jean Salines, Allentown.

LUZERNE COUNTY: Martin J. Walsh, Pittston.

MERCER COUNTY: (R) Harold A. Daugherty, Grove City; Hugh M. Crumay, Philadelphia.

MONTOUR COUNTY: Ellsworth B. Harris, Danville.

PHILADELPHIA COUNTY: Marvin A. Gershenfeld, John F. Leedom, Jr., J. G. Lockhart, C. K. McGeorge, Joseph T. Marconis, James D. Maxwell, Joseph Pasceri, Seymour Schotz, and Herman A. Spivack, Philadelphia; Mortimer S. Falk, Drexel Hill; Charles B. Hanes, Ambler; Herbert A. Luscombe, Havertown; Joseph H. Walton, Chatham, N. J.; Louis A. Wesolowski, Lafayette Hill. (R) Matthew T. Moorehead, Philadelphia.

WAYNE-PIKE COUNTY: Henry C. Benzenberg, Milford.

YORK COUNTY: Arthur N. Barr, Felton.

Resignations (16), Transfers (13), Deaths (13)

ALLEGHENY: *Transfer*—Joseph P. Dobo, South Mountain, to Franklin County Society. *Resignations*—Henry J. Gowaty, Pittsburgh; Joseph W. McMeans, Florence, S. C.; Richard E. Rosenfield, New York City; William C. Schaefer, Silver Spring, Md.; Charles R. Stewart, Melrose, Mass. *Death*—Shaul George, Pittsburgh (Northwestern Med. Coll. '04), April 15, aged 76.

BERKS: *Death*—James R. Gerhard, Reading (Univ. Pa. '01), March 30, aged 75.

BLAIR: *Death*—Carl Henry Metzgar, Altoona (Jeff. Med. Coll. '08), March 29, aged 70.

BRADFORD: *Transfer*—George A. Truckenmiller, Wilkes-Barre, to Luzerne County Society.

CAMBRIA: *Death*—Ancrum Waring, Jr., Sanford, Mich. (Med. Coll., S. C. '42), March 7, aged 32.

CHESTER: *Death*—Joseph Scattergood, Sr., West Chester (Univ. Pa. '94), March 18, aged 79.

CRAWFORD: *Transfer*—Ulysses S. Wharton, Pittsburgh, to Allegheny County Society.

DELAWARE: *Deaths*—John M. Hutchings, Clifton Heights (Hahn. Med. Coll. '11), April 26, aged 64;

Charles H. Sanderson, Lansdowne (Univ. Pa. '09), April 12, aged 64.

FAYETTE: *Death*—Joseph Brain, Isabella (Univ. Pgh. '27), March 19, aged 46.

INDIANA: *Death*—Joseph C. Lee, Indiana (West. Res. Univ. '29), April 8, aged 45.

LACKAWANNA: *Death*—Thomas P. Martin, Carbon-dale (Med.-Chi. Coll. '05), March 13, aged 72.

MONTGOMERY: *Transfer*—John N. Negry, Ardmore, to Philadelphia County Society.

MONTOUR: *Transfer*—John Pfromm, Allentown, to Lehigh County Society.

NORTHAMPTON: *Transfers*—Alexandria McL. Kates and William A. Kates, Jr., Shoemakersville, to Berks County Society. *Death*—Harry F. Leibert, Bethlehem (Med.-Chi. Coll. '04), April 12, aged 66.

PHILADELPHIA: *Transfers*—William L. Hoon, Pittsburgh, to Allegheny County Society; J. Arthur Horneff, Chester, to Delaware County Society; W. P. Stelmach, Reading, to Berks County Society. *Resignations*—Balduin Lucke, William S. Carter, Jr., Joseph R. Fox, Philadelphia; Rudolph H. Beckert, Bridgeville, Del.; Dale E. York, Pensacola, Fla.; George A. Silver, Baltimore, Md.; Paul L. Johnson, Iowa City, Ia.; Richard W. Rooker, Niagara Falls, N. Y.; Hoke Wammond and Virgene Wammond, Augusta, Ga.; Maurice T. Fliegelman, Louisville, Ky. *Deaths*—Frank M. Coyne, Philadelphia (Md. Med. Coll. '07), April 13, aged 66; Albert F. Garton, Philadelphia (Med.-Chi. Coll. '04), April 15, aged 69; Charles Carter Hamilton, Philadelphia (Iowa Univ. '23), March 28, aged 52; Edward Horgan, Philadelphia (Univ. Pa. '93), April 10, aged 80; James H. McKee, Philadelphia (Univ. Pa. '92), March 24, aged 78; Samuel Wolf, Philadelphia (Med.-Chi. Coll. '09), March 22, aged 77.

SCHUYLKILL: *Transfer*—Joseph J. Mullen, Pottstown, to Montgomery County Society.

WARREN: *Transfer*—Richard H. Parks, McKeesport, to Allegheny County Society.

WASHINGTON: *Death*—David L. McCarrell, Hickory (Univ. Pgh. '99), March 31, aged 77.

WESTMORELAND: *Transfer*—Harry E. Shaw, Glen-shaw, to Allegheny County Society.

YORK: *Death*—George N. Yaglc, Red Lion (Coll. Phys. & Surg., Balt. '95), April 23, aged 81.

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since March 31. Figures in first column indicate county society numbers; second column, State Society numbers.

Apr. 1 Mercer	91	9749	\$15.00
Mercer (1948 dues)		10524	15.00
Adams	27	9750	15.00
2 Butler	70-71	9751-9752	30.00
4 Beaver	136	9753	15.00
Washington	143-144	9754-9755	30.00
5 Bedford	15	9756	15.00
Northumb'land	75	9757	15.00

Apr. 6	McKean	53	9758	\$15.00
	Armstrong	41	9759	15.00
	Montour	36-37	9760-9761	30.00
7	Westmoreland	206	9762	15.00
	Jefferson	52-53	9763-9764	30.00
	Indiana	40	9765	15.00
	Dauphin	253-254	9766-9767	30.00
8	Centre	32	9768	15.00
	Schuylkill	134-143	9769-9778	150.00
9	Indiana	39-40	9779-9780	30.00
	Lebanon	64-65	9781-9782	30.00
	Lackawanna	259-261	9783-9785	45.00
	Somerset	21	9786	15.00
11	Philadelphia	2654-2971	9787-10104	4,770.00
	Lancaster	223-228	10105-10110	90.00
	Montgomery	329-333	10111-10115	75.00
	Delaware	288-291	10116-10119	60.00
	Lawrence	78-79	10120-10121	30.00
12	Cambria	162	10122	15.00
	Luzerne	319-349	10123-10153	465.00
15	Greene	24-26	10154-10156	45.00
	Mercer	92	10157	15.00
18	Huntingdon	27	10158	15.00
	Fayette	114-115	10159-10160	30.00
	Lehigh	187-220	10161-10194	510.00
	Clearfield	49	10195	15.00
19	Cambria	163-164	10196-10197	30.00
20	York	165-167	10198-10200	45.00
21	Washington	146	10201	15.00
25	Lancaster	225	10202	15.00
26	Butler	72	10203	15.00
27	Berks	254-255	10204-10205	30.00
	Allegheny	1611-1627	10206-10222	255.00

IMPRESSIONS OF THE AMERICAN
ACADEMY OF GENERAL PRACTICE
CONVENTIONS

Milton B. Casebolt, M.D., Chairman, A.M.A.
Section on General Practice

For thirty-five years medical education has revolved around specialized training. Gradually, the practical clinical professor in teaching centers has been replaced by the full-time research type of instructor. Medical knowledge has been divided into a multitude of departments, with overlapping of corresponding fields, to the extent that the student is bewildered and confused as to just what he is supposed to know when he graduates from his four-year exposure to numerous research problems.

He is informed that he will have to get all the practical applications in his hospital internship. Here again he meets with neurosurgical, orthopedic, urologic, laboratory, and medical procedures designed for the rare type of disease. With pen in hand he prescribes x-rays, intravenous fluids, complete laboratory work-up and antibiotics, many times before a complete history and physical examination. The hospital staff mount their professional horses and ride in so many directions at the same time that it is difficult for the young doctor to gain perspective as to what properly balanced medical care really is.

It is not the purpose of your reporter to discredit the educators or to cast reflection on the integrity of med-

ical teaching in our schools, but rather to call attention to the fact that an undue amount of subject matter is crowded into the curriculum, in the name of science, which is not related to the practical. It is little wonder that medical values become distorted and lost.

All problems which appear highly complicated are usually due to the lack of grasp of the fundamentals or are due to incomplete information. The correct diagnosis involves simple mental processes. The things one can *hear, feel, and see*, if correctly interpreted, will lead to the right conclusion most of the time.

It is the belief of many general practitioners that the correlation and integration of medical knowledge may be as important as mastery of isolated facts. Each part of the whole must be evaluated and assigned to its proper place and assembled to give a complete picture of any educational project.

Those who are well informed in things medical state that approximately 30 per cent of the young physicians should be directed in special fields, and 70 per cent in the general. If this be the proper proportion, the general practitioners should consider the general applications in their field and bring into play related facts in diagnosis and care of the sick. When the need arises, the proper specialist can be made available for both practitioner and patient.

New techniques and procedures may have to be developed to maintain the proper balance and equilibrium in medical practice. Certainly a re-emphasis must be placed on the role of the family doctor in medical care and teaching. If the student does not *hear, see, or feel* the idealism of the general practitioner in his undergraduate years, how can he be expected to be one? How much weight will a surgeon, eye, ear, nose and throat or other specialist carry when he advises his admirers of the student level to become general practitioners? The answer would seem to be that qualified successful men in this field must be permitted to develop a program which will appeal to the students within the curriculum of the teaching centers.

In pursuance of this thought, the Congress of Delegates went on record at the 1949 American Academy of General Practice convention as recommending a department of general practice in all medical schools.

The logical question arises—how can this be accomplished without disrupting the present educational system? Will there be two programs of instruction—one for the young physician preparing for a specialty, and another for the general practitioner? We are now on one of the frontiers of medical thought, and the best minds of the profession are exploring the field. There is no doubt that an answer will be found.

The American Academy of General Practice, with ten thousand members, and so rapidly receiving applicants that it cannot keep up with its enrollment, also speaks for thousands of other doctors who believe this project is of vital concern and relates to the future of medicine. The ways and means are not entirely clear, but the 70 per cent have found a voice and feel they have a just cause.

Medical centers all over the country report that their refresher and postgraduate courses are well filled with general practitioners eager to keep abreast of the newer developments. Is this a renaissance? The spirit, attendance, and atmosphere of the Cincinnati convention seemed to indicate a *crusade*—a movement by family physicians for equality of opportunity and action.—*Jackson County Medical Society Weekly Bulletin*, Kansas City, Mo., April 16, 1949.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the co-operation of the Pennsylvania Tuberculosis Society
and The Medical Society of the State of Pennsylvania

EVERY argument used to encourage the examination of apparently healthy persons for the purpose of finding unsuspected tuberculosis gains added force when applied to college students. If tuberculosis is found among them in the early stage when it is more easily cured, future and potentially valuable citizens are saved for productive lives.

TUBERCULOSIS AMONG COLLEGE STUDENTS

Modern tuberculosis case-finding techniques applied to groups of apparently healthy people are productive of important, instructive, and often startling results. Active and communicable cases of tuberculosis are not infrequently found where there is no other evidence that anything is amiss. Fortunately, the majority of cases so discovered are in an early or a minimal stage of the disease, when the chances for rapid, complete recovery are best.

To no other population group are the above statements of more importance than to college students. These young men and women are at the highest level of health, strength, and vigor and from their ranks are recruited leaders for the various fields of human endeavor. From their ranks are also recruited many cases of tuberculosis.

For seventeen years the Tuberculosis Committee of the American Student Health Association has been promoting interest in tuberculosis among the institutions of learning in the United States. For more than ten of these years, all colleges have repeatedly been urged to develop a tuberculosis control program, and many have, although in some colleges tuberculosis still is not recognized as a serious threat to students.

The curve of college participation has shown an almost constant upward trend. For reasons that are not entirely clear, the 1947 returns show fewer programs reported. Each of the 885 institutions to which a questionnaire was sent was asked to return the questionnaire, but only 311 replies were received, of which 259 reported a program.

In spite of lessened returns, many cases of

tuberculosis were discovered among college students. The total number of cases, presumably of the "re-infection" type, reported for 1946-47 was 630, and all but nine were found at colleges having anti-tuberculosis programs. In 1946-47, 590 arrested cases of tuberculosis were again permitted to resume their college work. They emphasize the fact that "they *do* come back."

Programs Employing the Tuberculin Test and X-ray of Reactors

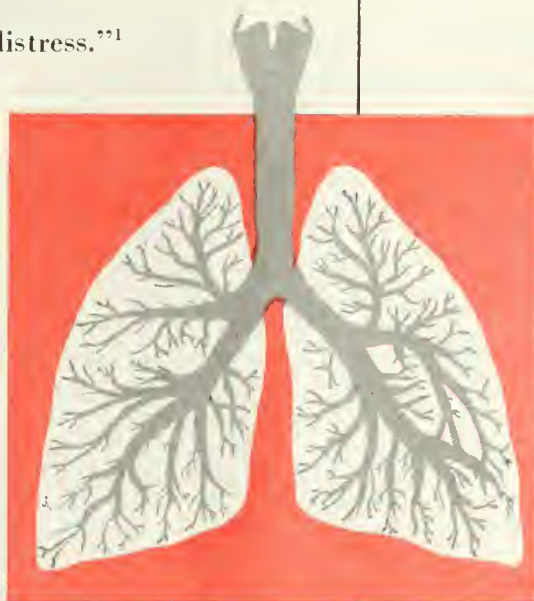
Colleges depending primarily upon the tuberculin test as their initial screening method numbered 105. Based on adequacy of data submitted, apparent proportion of student body tested, and number of reactors x-rayed, 24 programs were roughly classified as "excellent," 34 as "good," 33 as "fair," and 14 as "poor." A college has an "excellent" program when entering students are tuberculin-tested and reactors among them x-rayed, and when, each year, upper classmen, non-reactors are retested and reactors re-x-rayed.

In recent years an increasing number of colleges have reported the use of both the tuberculin test and the chest x-ray for all entering students. It is recommended that this combined procedure be employed wherever facilities permit.

For better results, and to insure greater uniformity, tuberculin testing should be done intradermally (Mantoux), using Purified Protein Derivative of tuberculin (P.P.D.) in two strengths. The first dose, prepared according to directions, is 0.00002 milligram. If no reaction occurs after 72 hours, a second dose of 0.005 milligram is given. Equally dependable results

paroxysmal dyspnea...

"When an acute attack of paroxysmal dyspnea sets in, Aminophyllin administered intravenously is generally sufficient to relieve the distress."¹



In paroxysmal dyspnea, bronchial asthma, selected cardiac cases and Cheyne-Stokes respiration,

SEARLE ^{*}AMINOPHYLLIN

acts by relaxing the bronchial musculature, encouraging resumption of a more normal type of respiration and reducing the load placed upon the heart.

Searle Aminophyllin is available in tablet, ampul, powder and suppository forms.

**Searle Aminophyllin contains at least 80% of anhydrous theophylline.*
G. D. Searle & Co., Chicago 80, Illinois

SEARLE RESEARCH IN THE SERVICE OF MEDICINE



1. Murphy, F. D.: Treatment of Cardiovascular Emergencies in the Home, Wisconsin M. J. 42:769 (Aug.) 1943

may be obtained if Old Tuberculin (O.T.) is used. The first dose, injected intradermally, is 0.1 milligram. When no reaction occurs after 72 hours, a second dose of 1.0 milligram is given. Failure to react to the second dose of either P.P.D. or O.T. may be taken as evidence of freedom from tuberculous infection.

Programs Using X-ray Alone as a Screen

The main criterion for an excellent program was that all students were x-rayed annually. When this is done, most of the significant cases of tuberculosis will be found in a relatively short time.

Forty-seven colleges, distributed over 23 states, indicated that part or all of their x-ray program had been conducted by either the local tuberculosis society or one of the official health departments. One of the limitations of the x-ray is that it gives no certain proof either of tuberculous infection or tuberculous disease. Diagnosis may be made only after careful clinical study of a suspected case. Calcifications noted on chest films are not proof of previous tuberculous infection. Diagnoses have undoubtedly been ascribed to "healed childhood tuberculosis" when

the true cause was *Histoplasma capsulatum*. One who reacts to tuberculin should have regular examinations, including chest x-ray, for evidence of active tuberculosis. Conversely, except in a few well-recognized instances, the non-reactor does not have tuberculosis.

Program Participation by Non-Students

Students come in daily contact with other members of the college community which includes all of the college staff, the administration, the faculty, and other employees. Any one of these may have tuberculosis. Students would have added protection if all college employees were examined.

Student health services are in the best possible position to inform vast numbers of young people about tuberculosis, and must be prepared to meet this challenge.

Tuberculosis Among College Students, Seventeenth Annual Report of the Tuberculosis Committee, Chairman, Max L. Durfee, M.D., American Student Health Association, for the Academic Year, 1946-1947, The Journal-Lancet, November, 1948.

THE DOCTOR'S OBLIGATION TO HIMSELF

The doctor as an individual is faced with the necessity of offering objective evidence that he is aware of his relation to a changing social order. More than that, he must show a desire to participate actively and positively in directing this change. He is deterred from assuming this role not only by reluctance and perhaps inertia, but, more important, by an actual inability springing directly from his all-consuming interest in professional pursuits.

In the 19th century it became impossible for any man to encompass even in general knowledge the whole field of science. Therefore, most scientists withdrew first from the non-scientific world. In this mental monastery departmentalization began and developed until today in medicine alone there are numerous relatively isolated divisions. Rationalized monomania has meant much to the advance of science, but is reacting to the disadvantage of scientists.

In the evolution of animal species there are numerous illustrations of the principle that extreme specialization has led to disaster as environment has changed. It is true that man himself is not a highly specialized animal. His hand is less specialized than that of the monkey. His brain by its very broad development and synaptic variation is versatile but not specialized. Only in psychoses does stereotypy of cerebration resemble the

specialization characteristic of insect nervous response.

An analogy may be drawn between the proven hazard of physical specialization in species evolution and the specialism which is the outgrowth of a proper functional specialization in science. This "specialism" causes a group of specialists to see the rest of the world in the narrow terms of their own group requirement.

The social differences even among non-scientific groups must be among the basic considerations influencing the doctor's relation to them.

The doctor no longer can content himself with doing only his scientific job. The implications of science in today's world are such that its power must be used for social good lest its evil potential destroy us all. The doctor's new social role must be positive, but it must also be convincing to the several groups involved. It must be mutually helpful and mutually determined with these groups.

Therefore, the energies of the individual must not be dissipated in fighting his brother as to method. There must be concerted teamwork to do the job. Thus it is that today's doctor is obligated over and above his professional duties to understand his relation to the rest of the social order, to take real pains to educate himself in these broad fields where he must also work. To fail in this duty as individuals is to insure failure of the profession to do its best job and therefore to insure its degradation.—D. S. writing in the *Medical Annals of the District of Columbia*.

CONSTANT INSPECTION for BABY'S PROTECTION



Our cows don't come to an inspector for examination; inspectors come to them! Herds are examined regularly by inspectors to make sure they are in the best of health.

These and many other controls, at every step of production, from herd inspection to examination of the filled cans, assure the safety and quality of Nestlé's Evaporated Milk.

Nestlé was the first to add 400 U.S.P. units of genuine vitamin D₃ to each pint of evaporated milk. This fortification provides the antirachitic protection which every infant needs.

DOCTORS EVERYWHERE KNOW **NESTLÉ'S**

THROAT SPECIALISTS PROVE CAMEL MILDNESS IN --- 30-DAY SMOKING TEST



● In a recent coast-to-coast test, hundreds of men and women smoked Camels—and only Camels—for thirty consecutive days: They smoked on the average of one to two packages of Camels a day. Each week during the entire test period, the throats of these Camel smokers were examined by throat specialists. A total of 2,470 careful examinations were made. And after correlating these case histories, the throat specialists reported

“NOT ONE SINGLE CASE OF THROAT IRRITATION due to smoking CAMELS.”

MONEY-BACK GUARANTEE!

Try Camels and test them as you smoke them. If, at any time, you are not convinced that Camels are the best cigarette you've ever smoked, return the package with the unused Camels and you will receive its full purchase price, plus postage. (Signed) R. J. Reynolds Tobacco Co., Winston-Salem, N. C.



According to a Nationwide survey:

MORE DOCTORS SMOKE CAMELS
than any other cigarette

When three leading independent research organizations asked 113,597 doctors what cigarette they smoked, the brand named most was Camel.

THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

547 Water Street

Indiana, Pa.

ANY DOCTOR'S WIFE



It is a long time ago (1935-1936), long in time, longer in terms of changed thinking in so many areas of our lives. At that time I was president of my county auxiliary—eager, interested, a little naive and idealistic. News of the national Auxiliary in those days appeared in the American Medical Association *Bulletin*, and some time during that year I clipped articles from the pages of the *Bulletin*—articles now yellow with age and dog-eared from use. Through the years I have been reminded of certain passages from them which are as valid today as when they were written. They have been my guide.

Mrs. Robert W. Tomlinson wrote this at the close of her year as president of the Auxiliary to the American Medical Association almost fifteen years ago:

"We as an organization have come into existence in a generation when much of this accomplishment is apt to be taken for granted or belittled, and perhaps we are prone to become accustomed to that point of view ourselves. It is because of this that our opportunity is so great.

"If you have become weary of those three words that I have repeated so many times this year, let me tell you that we must keep them ever before us. To be true to its name an auxiliary must always be *that which helps*. That is what individually as doctors' wives we strive to be. That is what we must be collectively if we are to justify our existence. We must never in the least way act in any fashion that might cause the slightest embarrassment to the medical profession.

"I suppose that there never has been a time when our men have needed the understanding of us as their help-mates as they do under the present changing conditions. I hope that we will all appreciate this and try to do our part."

From Mrs. David S. Long, then national public relations chairman, came these paragraphs:

"Is it any wonder that at long last through the long ages of work and striving the doctor is set aside as one who walks the high road? What should be the reaction of the doctor's wife to this elevated status that has been given her husband? Does she think of it as something to satisfy ambition for social prestige as expressed in a too full social calendar and with values based on

snobbery of things that money can buy, or does this classification make her justly humble with the weight of her responsibility? Men cannot rise to their highest and best capabilities unless their wives, too, possess the idealism of their profession. Yes, the wives of doctors need training also—training in character, training in intellectual poise, and training to live this role of doctor's wife. . . . How can she mold public opinion unless she has the imagination to understand the minds of other people? . . . Our pioneer mothers developed noble characters by overcoming hardships. There is need for the women of today, particularly in our profession, to hold fast to the beauty and idealism of the traditions of our profession.

"In the crisis which the medical profession faces today, in the economic struggle which confronts all of our husbands, we are needed to show courage, fortitude, and patience and above all things else to be cheerful and happy 'though a thousand rivers of grief pour o'er our heads.' For most of us not only need to hold high the ideals of the profession for our husbands; we also have sons and nephews and their friends. The purity of the ideals of the medical profession must come through this crisis unstained at any cost.

". . . How can we interpret the medical profession to the laity unless we ourselves are informed and intelligent? Study not only the present problems and trends but steep yourselves in the history and traditions of the profession of the past. In order to accomplish the best public relations work, this period of intense reading and discussion is necessary, and where else can it be had except at Auxiliary meetings? I fear I am not quite sympathetic with the auxiliaries that have to have contract bridge and book reviews to keep up interest. I have no opposition to either, but one can get contract bridge and book reviews anywhere, while there is only one place where one can have the true presentation of medical problems with free discussion and that is at the Auxiliary meeting.

"After we have educated ourselves, we aim at educating the laity. Many problems arise that vitally affect the welfare of human beings . . . and the trained doctor's wife alone has the background needed to meet the problem with wisdom and with judgment."

Mrs. Long is at present on the board of the Woman's Auxiliary to the American Medical Association as a director. She continues to tie in her medical interest with other organizations. She is active in the American Cancer Society and is the author of a pamphlet on cancer which is circulated by the United Council of Church Women, with whom she is associated. This kind of participation exemplifies the value of individual effort. Hers is the activity of one who has concern for community fields of service.

So I present to you some of the things which any doctor's wife can do alone, in her own locality among her own associates. She can be an active Auxiliary member without ever attending a meeting—though we hope there will always be an enjoyable and congenial group near enough for her to meet with conveniently. In carrying out any program that you believe in, there is no substitute for the use of gray matter and elbow grease. We remind you that "the worst foe of the medical profession is Dr. Inertia."

ANY DOCTOR'S WIFE CAN:

1. Contribute to the Medical Benevolence Fund.
2. Buy *Hygeia* for her husband's waiting room table and as gifts.
3. Serve her community as a "resource on health material"—supply movies, exhibits, and pamphlets to meet local needs.
4. Clip newspaper articles about the profession and send them to the Harrisburg office.
5. See that unwarranted criticism of the profession is answered in "letters to the editor."
6. Thank editors for good medical editorials. (They are human, too.)
7. Be intelligent about the need for medical research and talk about it.
8. Have petitions signed at the request of the medical society.
9. Circulate pamphlets on government medicine.
10. Assist the medical society with a school poster contest.
11. Read and discuss with her husband articles about medical care.
12. See that her family is covered by Blue Cross and Blue Shield and be informed about its advantages.
13. Refrain from sitting on the side lines and criticizing, but rather explain and try to understand—know where to go for the answers to questions which puzzle her.
14. Keep up-to-date material in the doctor's waiting room.
15. Sense the opportunity for speakers and arrange to have someone present the following subjects at clubs to which she belongs:

- a. Medical Research.
 - b. Voluntary Insured Medical and Hospital Care Plans.
 - c. Government Medicine.
16. Check what is in the public and high school libraries on the subject of government-controlled medicine. Keep their supply up to date with sufficient information and literature which presents our side of the question.
 17. Check on quacks who rent public auditorium space. Obtain their credentials from the A.M.A. (especially food faddists and biochemists.)
 18. See that resolutions against compulsory government medicine and favoring the expansion of voluntary insured service plans are presented to and adopted by all organizations to which she belongs. (Sample resolutions are available from 230 State St., Harrisburg, Pa.)

ANY DOCTOR'S WIFE CAN URGE AND AID HER HUSBAND TO:

1. Have a positive attitude of cooperation with Blue Cross and Blue Shield.
2. Discuss fees with patients to avoid misunderstanding and ill feeling.
3. Provide factual information about politically controlled medicine and talk about it to patients whenever the opportunity arises.
4. Talk to local editors and write to Congressmen.
5. Attend his medical society meetings and help to make the group an articulate one.
6. Check with his office assistants. Are they considerate of and polite to patients? Do they know about Blue Shield Service so that they can explain it?
7. Be willing to speak before lay groups.
8. Help to find 100-year-old citizens of Pennsylvania for the State Society centenarian awards.

"One soldier in action is worth three standing still."

(MRS. PAUL C.) CATHARINE PALMER CRAIG,
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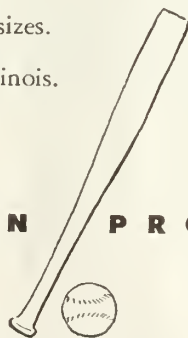
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MID-WINTER CONFERENCE

Minutes

The third annual Conference of County Auxiliary Presidents and Presidents-elect opened at a dinner held at the Penn-Harris Hotel, Harrisburg, Thursday, March 17, 1949. Mrs. Paul C. Craig, president of the Woman's Auxiliary to the MSSP, presided. Ninety-eight were in attendance at the dinner. Mrs. David B. Allman, president-elect of the Woman's Auxiliary to the American Medical Association, was a guest of honor and spoke briefly. Mrs. Roger Murray, president of the Woman's Auxiliary to the Medical Society of the State of Delaware, was also a guest.

The theme of the conference was "The New Outlook in Auxiliary Plans."



Left to right: Mrs. Paul C. Craig, president, Woman's Auxiliary to The Medical Society of the State of Pennsylvania; William F. Doscher, assistant director of public relations, American Medical Association; Mrs. David B. Allman, president-elect, Woman's Auxiliary to the American Medical Association; James H. Duff, governor of the Commonwealth of Pennsylvania; Mrs. Drury Hinton, president-elect, Woman's Auxiliary to The Medical Society of the State of Pennsylvania.

Third annual conference of the Woman's Auxiliary to the MSSP, Harrisburg, March 17-18, 1949.

Dr. Gilson Colby Engel, president of the MSSP, speaking on the subject "It Is Not Too Late," explained the provisions of his ten-point medical service plan, which has been drafted into a bill and introduced by Senator Lester Hill of Alabama in the United States Senate (S. 1456). Dr. Engel urged the members of the conference to study the various bills on health insurance and to be able to explain them intelligently.

Mrs. Drury Hinton, president-elect of the Woman's Auxiliary to the MSSP, presided at the first regular session of the conference which followed the dinner. Dr. Marjorie G. Morrison showed a film for youth, "Human Growth," and explained its phases.

A panel discussion "What's Puzzling You?", with Mrs. Hinton as moderator, brought out points suggested by a questionnaire previously sent to county presidents. The questions covered phases of public relations, legislation, program, publicity, benevolence, membership, and *Hygeia*. The points brought out were answered in an entertaining yet very practical fashion by the various state chairmen. Mrs. F. Earle Magee gave the details and plans of a special health month in Venango County. Mrs. J. Frederic Dreyer explained her questionnaire which gave an insight into Lehigh County's understanding of and desire to further auxiliary aims. Mrs. Edmund C. Boots gave suggestions to county treasurers on

what to do and what not to do in paying per capita dues and in filing membership lists. Two presidents gave the procedures for different approaches in awarding nursing scholarships as an auxiliary project.

Mrs. Paul C. Craig reported on her participation in the 1949 Secretaries-Editors Conference of the MSSP. She listed the many cooperative endeavors of the medical society officers and the staff assistants in behalf of the Auxiliary. Miss Suzanne Treadwell, a new member of the public relations staff of the MSSP, assigned to the Auxiliary, was introduced. Mrs. Craig listed nine projects that she as president had pledged the Auxiliary to undertake for the State Society. She recounted eight suggestions made to the Medical Society from the Auxiliary viewpoint, as requested by the State Society.

The second session of the conference opened at nine o'clock, Friday morning, March 18, 1949. "We Look Ahead" was the topic of Mrs. Allman's remarks. Mrs. Roger Murray, Delaware, and Mrs. William J. Lavelle, president-elect of the Woman's Auxiliary to the Medical Society of the State of New York, were introduced. Mr. Lester H. Perry explained Blue Shield insured medical service and its ramifications as "Pennsylvania's Answer to Oscar Ewing." Conference members asked Mr. Perry many questions which he and other members of his staff answered.

"The National Outlook in Auxiliary Public Relations" was presented by Mr. William F. Doscher of the American Medical Association staff. Dr. Howard K. Petry introduced the speaker. Mr. Doscher stressed the value of public opinion and its force for progress or failure in any program. He outlined various public relations projects carried out by state auxiliary groups. He gave suggestions for continued auxiliary efforts at the community level.

Mr. Leo E. Brown of the MSSP office gave suggestions for using packet material provided at the conference to be distributed in county lay groups. He reminded the women of the force behind their ideas and ideals and asked for some of this educational pressure to be exerted on their doctor husbands.

The conference met again at luncheon with Mrs. Howard A. Power presiding. The Governor of the Commonwealth of Pennsylvania and his wife, the Hon. and Mrs. James H. Duff, were guests of honor. Governor Duff spoke on "The Need for an Informed Public." He stressed the necessity for the public to be aware of their stake in the issues of the day, as part of their own safety and prosperity. He explained the general welfare program so dear to his heart as planned for Pennsylvania.

The conference adjourned at 2:30 p.m. The final registration was one hundred nineteen.

(MRS. FRANK P.) MARY DWYER, *Secretary*,
(MRS. DRURY) ELIZABETH HINTON, *Chairman*.

Jottings

Councilor and state board member reports at a pre-conference meeting were most interesting and beneficial.

Information and enlightenment were gained from the panel discussion.

Bridge playing and pink teas have ceased to hold membership in the auxiliaries.

Be informed of the issues of the day.

Auxiliary members can do a great service to the public by applying the brakes to the social planners with political ambitions who are racing ahead with plans for compulsory, tax-supported medical care.

We wonder how many ladies at the conference wrote to their respective State Senators favoring S. 278, their first letter of this type.

We are sure to hear more from our charming and capable Miss Suzanne Treadwell.

Gilson Colby Engel, M.D., is a medical statesman.

Will anyone forget Mrs. Edmund C. Boots' remarks about the treasurers' reports?

Mrs. Edgar S. Buyers, our honorary member, kept us "in time."

No stores, no Capitol, no theater—we attended a workshop and inspirational conference. We must admit that we were exhausted, but enthusiastic to go home informed and carry out more auxiliary aims.

Those who missed the conference were the losers. A "return engagement" is hoped for by those who attended this year and it will be a "must" on everyone's calendar.

(MRS. ROBERT S.) SARA M. LUCAS, *Director*.

THE NATIONAL OUTLOOK IN AUXILIARY PUBLIC RELATIONS

Public opinion, our state medical auxiliaries are discovering in this eventful year, is the mightiest force on earth.

It can create or destroy governments, elect or defeat presidential candidates, win or lose wars, bring success or failure to an enterprise, change the development of medical care from voluntary to compulsory patterns, and conquer any other human force that opposes it.

The Woman's Auxiliary to the American Medical Association is discovering that public opinion represents the thinking of the majority of the people—your next-door neighbor, the grocer down the street, the druggist on the corner, and most of the other people in your county and beyond it.

State woman's auxiliaries from California to Florida and north to Minnesota are learning a great public relations lesson this year. They are learning that the progress and success of an organization may be decided by what people know and think about it.

Auxiliary members in the past twelve months have come to take a far more serious view of their membership and its implications in the light of the threat to voluntary medical care in the United States.

We know that the Pennsylvania Auxiliary pioneers in the realization that the women of all state auxiliaries can no longer shun their definite responsibilities to become thoroughly informed on the subject of compulsory versus voluntary medical insurance. More than that, you Pennsylvania women leaders realize that from no group can more such information and interest reasonably be expected than from the Woman's Auxiliary.

Your state president has asked you to devote a part of each of your meetings to the acquisition of authentic information on the subject. You have received a list of reference materials based on facts. You and your public relations leaders agree on the merits of the "doctors' plan" and you are to be congratulated on your promotion of it.

What are a few of the implications we find in them and in similar activities in most of the active state auxiliaries? I list a few of them which I consider most significant.

Every member can be a student of politics.

If politics is to be the primary social science of to-

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morrow, we all can study it. Politics can be a rewarding hobby.

We can take a page out of the book of the CIO political action committee and study up on how to make friends and influence Congressmen.

We can learn what the A.M.A. has done and is doing to aid your state society to do its job.

We can organize ways to promote the prepayment voluntary health care plans, after thoroughly studying them.

We can participate in a carefully trained speakers' bureau in each county for regular and emergency use, because there are at least two or more of busy years ahead.

Nurses, doctors, office secretaries, and other medical personnel like technicians and medical students need briefing on the compulsory health threat. Auxiliary members can organize and help the busy doctors give it at least to the technicians and secretaries. These people are in constant contact with the public and can make a strong impression on them.

Let us all remember that medicine, in the past as well as in the future, does not prosper half-slave and half-free.

Now, you might rightly ask, how about the latest activities at the A.M.A. itself in the face of present threats?

You leaders here for this meeting today, and the many active and interested members of your Pennsylvania Auxiliary, will be pleased by the broadened activities in medical public relations at the A.M.A. since the new national education program was announced. In a

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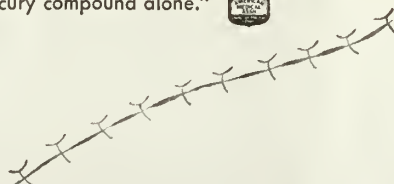
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Council on Pharmacy and Chemistry, A.M.A.
J. A. M. A. 137:789 (June 26) 1948.

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GYNECOLOGY—Intensive Course, two weeks, starting June 20, September 26. Vaginal Approach to Pelvic Surgery, one week, starting June 13, September 19.

OBSTETRICS—Intensive Course, two weeks, starting September 12.

MEDICINE—Intensive General Course, two weeks, starting June 13. Gastroenterology, two weeks, starting June 27. Gastroscopy, two weeks, starting June 13, July 18. Electrocardiography and Heart Disease, two weeks, starting July 18.

PEDIATRICS—Diagnosis and Treatment of Congenital Malformations of the Heart, two weeks, starting June 13. Personal Course in Cerebral Palsy, two weeks, starting August 1.

DERMATOLOGY—Formal Course, two weeks, starting June 13. Informal Clinical Course every two weeks.

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nutshell we are like Clancy in the popular song; the A.M.A. is "lowering the boom."

Repeatedly, the A.M.A. is bringing down the sledgehammer with powerful blows against the already-crumbling foundation which Oscar Ewing has tried to erect in support of compulsory health care by government.

I could enumerate case after case of the activation of the twelve-point program. The Board of Trustees of the A.M.A. is now making available \$25,000 to set up a Commission on Chronic Illness, drawing the sum from the national education campaign budget. The purpose of this commission will be to promote programs for the control of chronic illness among the 2,000,000 persons currently afflicted in the United States. The permanent commission will include representatives of the general public, education, churches, hospitals and medicine, agriculture, labor, management, public health, psychiatry, journalism, nutrition, economics, and sociology. This is just one further illustration of the A.M.A.'s determination to bring about constructive co-operation between the lay public, public and private agencies in the task of meeting a common health problem.

The A.M.A. will very shortly make a film which will portray and dramatize the contribution to America's health of one day's activities of the members of this organization. I believe that even many doctors will be amazed at the number of scientific and social health care activities in which the A.M.A. engages for the benefit of the average citizen.

Our Bureau of Health Education, working through coast-to-coast radio networks and recorded health series, is broadening its coverage in the pioneer work of edu-



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cating the public in basic principles of public and personal hygiene.

These are deeds, not words, and if all of us cooperate, more and more news of these great contributions of the medical profession will appear in your local newspapers.

We count upon your continued labors on the state, county, and community levels to bring the truth home to the individual American citizen. We know that, at the sides of your doctor husbands, you want to help carry the torch for medical liberty.

Said Dorothy Thompson in the *New York Mirror*, December 26, 1948, in her column "On the Record": "Before Congress passes any bill for universal sickness insurance—falsely called health insurance—it owes it to the American people to tell them exactly what a person with, say, an income from \$2,000 to \$3,000 a year is going to have to pay over a working life of forty years to take care of his illnesses, and just what services the government positively guarantees him in return for his money. Will it, for instance, sign on the dotted line that if his wife is in labor, the government guarantees a bed and a physician at the critical moment?"

"Do not make me laugh. I have lived under these schemes."—Excerpts from an address delivered by William F. Doscher, formerly Assistant Director of Public Relations of the A.M.A., at the Mid-winter Conference, Harrisburg, March 17-18, 1949.

COUNCIL ON PHARMACY AND CHEMISTRY

SULFADIAZINE-SULFAMERAZINE COMBINED. — Mer-Diazine-McNeil. — A mixture of equal parts of sulfadiazine and sulfamerazine to which there may or may not be added a suitable compatible agent to increase the pH of the urine.

Actions and Uses.—The combination of equal parts of sulfamerazine and sulfadiazine has been shown to provide approximately the same therapeutic activity that is obtained when either drug is administered singly in doses equal to the sum of the two. Comparable total sulfonamide blood levels are thus produced with the same doses of the mixture as for either drug given alone. Because each of the component sulfonamides has its own distinct urinary solubility, the combination which contains only half the usual therapeutic dose of each drug is also potentially less toxic and less liable to be accompanied by crystal deposition from the urine. It has been demonstrated that the incidence of renal crystalluria is reduced to about the same extent as it would be by the administration of 12 Gm. of sodium bicarbonate per day with therapeutic doses of either sulfonamide alone. The simultaneous administration of a urinary alkali with the mixture of sulfonamides still further reduces the tendency of the drug to crystallize out and form deposits in the kidney, although less alkali is required than when the drugs are given singly. It should be emphasized, however, that because of the closely similar chemical structure of the two drugs, the incidence of drug sensitivity and other toxic manifestations of sulfonamide therapy is considered to be about the same for the mixture as for either drug alone.

Dosage.—The dosage of total sulfonamides represented by the mixture should be not less nor more than is recommended for the therapeutic use of the constit-

uent sulfonamides singly. See statements under Sulfadiazine and Sulfamerazine. The use of a lower total sulfonamide dose than the single recommended dose would not be therapeutically effective; the use of a higher total dose than customary for the drug given singly would defeat the purpose of the mixture.

Tests and Standards.—

The sulfadiazine and sulfamerazine used in the manufacture of Sulfadiazine-Sulfamerazine Combined respond to the tests and assays given for these substances in the U. S. Pharmacopoeia.

SULFADIAZINE-SULFAMERAZINE COMBINED, LIQUID SUSPENSION: This preparation is a thick, creamy, stable, liquid suspension.

Determine the total sulfonamides present in a 5 cc. aliquot of the suspension by the diazotization-titration described in the assay for Sulfadiazine in *U. S. P. XIII*, p 526. Each cc. of tenth-normal sodium nitrite is equivalent to 0.02573 Gm. of sulfadiazine-sulfamerazine combined; the total sulfonamides present should not be less than 95.0 nor more than 105.0 per cent of the labeled amount.

McNEIL LABORATORIES, INC., PHILADELPHIA 32

Liquoid Mer-Diazine: 120 cc. and 480 cc. bottles. A suspension containing 1.5 Gm. sulfamerazine and 1.5 Gm. sulfadiazine per 30 cc. solution.—*Journal of the American Medical Association*, May 7, 1949.

MONAGHAN PORTABLE RESPIRATOR ACCEPTABLE

Manufacturer: J. J. Monaghan Company, Inc., 4401 Morrison Road, Denver 3.

The Monaghan portable respirator is a respirator of the cuirass type. It is designed to give artificial respiration somewhat after the manner of the tank type respi-

rator but without enclosing all of the trunk and extremities. The essential feature is a plastic dome, cuirass, or shell that fits only over the chest and abdomen. An electrically driven pump supplies negative pressure at regular intervals to produce breathing.

A storage battery powerful enough to operate the pump for four hours is automatically thrown into action by a special switch in the event of failure of the regular power supply. In addition, a simple provision for hand operation is made.

The apparatus submitted to the Council included one set of plastic cuirass shells (six different sizes), one power unit, one portable self-charging battery unit, four leather straps (for suspending power unit and batteries), two corrugated rubber hoses, six flexible shell straps, and one inflating bulb. The total weight is given as 20 Kg. (45 pounds). The shipping weight is 32 Kg. (71 pounds). The power unit is designed to operate either on 110 volts alternating current or 12 volts alternating or direct current with no changes or adjustments. The weight of the battery unit is 18 Kg. (39 pounds).

The power consumption is stated to be 100 watts (1 ampere at 110 volts or approximately 8 amperes at 12 volts). The frequency can be adjusted from 14 to 30 strokes per minute.

The need for the variety of sizes and shapes of shells arises from the fact that leaks between the shell and the patient's body greatly reduce the effectiveness of any cuirass type of respirator. The volume of the space between the cuirass and the patient's body is remarkably small as compared with the corresponding space in the tank type of respirator. This means that any inequality between the volume of air aspirated by the pump and the volume of air that can be inhaled by the patient must result in much greater fluctuations of pressure in



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its quality

the chamber. An inequality that would pass unnoticed in the tank type is intolerable in the cuirass type, and it is easy to show that the smaller the volume of space between the patient and the walls of the respirator chamber, the more important it is that the volume of air aspirated by the pump should be nearly equal to the tidal air that one intends to produce in the patient.

The Monaghan portable respirator has been found to conform to the "Requirements for Acceptance of Cuirass Type Respirators" described in *The Journal*, Nov. 15, 1947, page 715. It has a limited use in applying emergency artificial respiration. Its usefulness in acute poliomyelitis, according to the evidence that has been reviewed by the Council, is confined to transporting the victim from a remote place to a center where a tank type of respirator is available. The Monaghan portable respirator does not take the place of a tank type of respirator and is accepted only as supplemental equipment.

This appliance does not adequately equip a medical organization or clinic for sustained artificial respiration to patients with acute poliomyelitis and respiratory failure. The device is not accepted for emergency artificial respiration by life-saving crews such as those of the police and fire departments. In chronic poliomyelitis, the device is recommended for "weaning" the patient from his dependency on prolonged artificial respiration. The Monaghan portable respirator is also useful for temporary artificial respiration when nursing care and physical therapy are given to a patient who is otherwise confined to a tank type of respirator.

The Council on Physical Medicine voted to include the Monaghan portable respirator in its list of accepted devices.—*Report of the A.M.A. Council on Physical Medicine.*

"They (compulsory health insurance plans) result in two sorts of medicine—good medicine for the well-to-do; and bad medicine for the masses, at high cost to those who can least afford it."—DOROTHY THOMPSON in *The Cleveland Plain Dealer*.

RHEUMATIC FEVER

The diagnosis of rheumatic fever in its early and latent phase can be only suspected and may be arrived at by frequent and careful search for minimal changes in cardiac size or function. The classical and textbook manifestations of rheumatic fever such as polyarthritis and chorea are well known. On the other hand, the most common and most damaging manifestation of rheumatic disease, the manifestation which is responsible for heart disease, is carditis. This manifestation has thus far evaded clear diagnostic criteria.—LEO M. TARAN, M.D., Roslyn, Long Island, N. Y.

BLUE SHIELD RECOGNIZES TEN MILLIONTH MEMBER

A scroll, certifying Orval G. Stuhr, of Daytona Beach, Fla., as the ten millionth Blue Shield member, was presented to Mr. Stuhr and his family in April by L. Howard Schriver, M.D., president of the Blue Shield Commission, and Leigh Robinson, M.D., president of Blue Shield in Florida. Assisting in the presentation, which marked the closing event of the 1949 annual conferences of both Blue Shield and Blue Cross plans, were Paul R. Hawley, M.D., chief executive officer of the Blue Cross and Blue Shield Commission, and H. A. Schroder, executive director of both Blue Cross and Blue Shield in Florida.

The total net growth in 1948 for all non-profit medical care plans reporting to Associated Medical Care Plans totaled 3,130,038, including enrollment figures from 71 plans. This was 84.9 per cent of the net growth for 90 Blue Cross plans, totaling 3,686,879 for the same period.

The total membership for the 71 plans reporting to Blue Shield was 10,368,464 at the end of 1948, which was 31.42 per cent of the 32,997,161 enrolled by the 90 Blue Cross plans.



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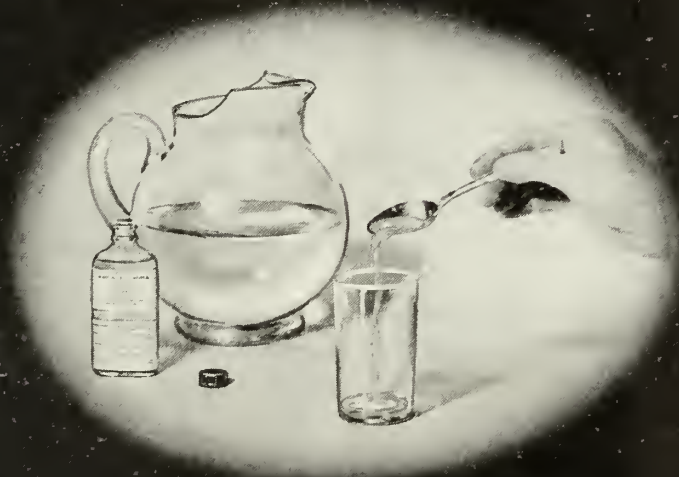
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MEDICAL NEWS

Births

To DR. AND MRS. ALBERT R. HUNT, of Devon, a son, Philip St. George Hunt, April 23.

To DR. AND MRS. ALFRED STENGEL, JR., of St. Davids, a daughter, Susan Stengel, May 16.

To DR. AND MRS. HUGH WILSON HEIM, of Nanticoke, a son, Hugh Wilson Heim, Jr., April 23.

To DR. AND MRS. J. WALLACE DAVIS, of Wynnewood, a son, John Wallace Davis, 3d, April 14.

To DR. AND MRS. HERBERT S. GASKILL, of Philadelphia, a son, Daniel Willis Gaskill, May 18.

To DR. AND MRS. ARTHUR M. ROGERS, of Philadelphia, a daughter, Holly Morris Rogers, April 21.

To DR. AND MRS. E. KIRBY LAWSON, JR., of Harrisburg, a daughter, Pamela Elizabeth Lawson, May 9.

Engagements

MISS CATHERINE ELIZABETH PIERSON, of Philadelphia, to Morris L. Yoder, Jr., M.D., of Glenolden.

MISS VIVIAN GLORIA PARKS, of Buffalo, N. Y., to Mr. Ernest H. Beutner, son of Dr. and Mrs. Reinhard Beutner, of Philadelphia.

MISS LOIS JANE MEHRING, daughter of Dr. and Mrs. Percy L. Mehring, of Springfield, to Mr. Donald Mulford, of Ocean City, N. J.

MISS SARAH ELIZABETH HENSYL, daughter of Dr. and Mrs. William C. Hensyl, of Berwick, to Mr. Frank A. Schute, of Philadelphia.

MISS JEANETTE WARNER HENNY, daughter of Dr. and Mrs. George C. Henny, of Philadelphia, to Mr. Thomas Raymond Conway, Jr., of Portland, Ore.

Marriages

MISS ANNE ELIZABETH READ, of Bryn Mawr, to John Joyce Sayen, M.D., of Wynnewood, May 21.

MISS HELEN ELIZABETH CASEY, daughter of Dr. and Mrs. Arthur E. S. Casey, of Philadelphia, to Ensign John Raymond O'Rourke.

MISS GLORIA PAULINE SCHWARZ, daughter of Dr. and Mrs. Paul E. Schwarz, of Easton, to Mr. John Leslie Milne, of Glenolden, April 30.

MISS EDITH DOROTHEA LAMPE, daughter of Dr. and Mrs. Albert V. Lampe, of Philadelphia, to Mr. S. Kirk Knott, of Gloversville, N. Y., May 15.

MISS KATHRYNE ELIZABETH MCKEOWN, of Narberth, to Lawrence Thomas Smyth, M.D., son of Dr. and Mrs. Thomas L. Smyth, of Allentown, May 7.

MISS HARRIET JUNE PERKINS, daughter of Dr. and Mrs. William Harvey Perkins, of Philadelphia, to Mr. Robert Lochridge Anderson, of Savannah, Ga., May 21.

Deaths

☉ Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

☉ Daniel C. Longaker, Philadelphia; University of Pennsylvania School of Medicine, 1881; aged 91, died April 30, 1949, after a long illness. A pioneer in obstetrics, Dr. Longaker practiced for fifty-six years and delivered more than 5000 babies. He retired in 1937. He is credited with being one of the first physicians in Philadelphia to perform a cesarean section in

a patient's home. Dr. Longaker was graduated from the Philadelphia College of Pharmacy in 1879, and was the last surviving member of his class at the University of Pennsylvania. He was a member of the College of Physicians of Philadelphia and a Fellow of the American College of Surgeons. He served on the staffs of Lying-In Hospital and Jewish Maternity Hospital, and for several years was chief of obstetrics at the Kensington Hospital for Women. He was a past president of the Philadelphia Obstetric Society. A son, Edwin Longaker, of Ardmore, two grandsons, a son-in-law, and a grandson-in-law are practicing physicians. Dr. Longaker is survived by two sons, four daughters, and a brother.

☉ Raymond M. Krepps, Philadelphia; Tufts College Medical School, Boston, Mass., 1917; aged 59; died May 12, 1949. Prior to World War II, Dr. Krepps practiced medicine in Lewistown and was industrial physician for the American Viscose Corporation there. He was associated with Sharp & Dohme, pharmaceutical manufacturers, for four years before retiring because of illness. During World War I, he served as a lieutenant with the Navy Medical Corps. He is survived by his widow, a daughter, and a son.

☉ Christian G. Yaeger, Philadelphia; University of Pennsylvania School of Medicine, 1895; aged 77; died May 4, 1949, after a short illness. He had practiced medicine fifty-two years. His wife died last September. Dr. Yaeger bequeathed \$50,000 to the University of Pennsylvania for cancer study, research, and teaching. His probated will revealed that his purpose in creating the fund was "to do something to support the great work of the medical profession in lessening human suffering and prolonging human life."

☉ Frederick E. Ward, Easton; Medico-Chirurgical College of Philadelphia, 1906; aged 66; died May 4, 1949, after an illness of two months. Dr. Ward was chief of the Pennsylvania Tuberculosis Clinic in Easton for fifteen years, and a medical examiner for the Easton school district for more than thirty years. He is survived by his widow, two sons, one of whom, Frederick W. Ward, is a practicing physician in Easton, and two daughters.

☉ W. Hess Lefevre, Lancaster; Medical College of Virginia, Richmond, 1913; aged 59; died suddenly April 30, 1949, of a heart condition. An eye specialist, Dr. Lefevre studied in France and Germany after graduating from schools in the United States. He was a former president of the Lancaster Board of Health. Surviving are his widow, a daughter, and one brother, Robert G. Lefevre, M.D., of Lancaster.

A. Frank Ziegenfus, Philadelphia; Hahnemann Medical College and Hospital of Philadelphia, 1879; aged 93; died May 7, 1949. Dr. Ziegenfus was the oldest surviving graduate of Hahnemann Medical college and had practiced medicine in Philadelphia for fifty years prior to his retirement in 1929. He is survived by two sisters.

☉ Medus Monroe Davis, Indiana; Jefferson Medical College of Philadelphia, 1893; aged 81; died May 9, 1949. Dr. Davis was a past president of the Indiana County Medical Society and a member of the original staff of the Indiana County Memorial Hospital from the time of its creation. He served during World War I aboard an Army transport.

☉ Joseph C. Lee, Indiana; Western Reserve University School of Medicine, Cleveland, Ohio, 1929; aged

45; died April 8, 1949. Dr. Lee, a Fellow of the American College of Surgeons, was medical director of the Clearfield Bituminous Coal Company since 1938. He is survived by his widow, three daughters, and a son.

○ **William J. Doyle, II**, Wilkes-Barre; Jefferson Medical College of Philadelphia, 1932; aged 41; died May 23, 1949. Dr. Doyle was a nephew of Dr. William J. Doyle, well-known Wilkes-Barre surgeon. He is survived by his widow, three sons, a brother, and a sister.

○ **Ancrum Waring, Jr.**, Sanford, Mich.; Medical College of the State of South Carolina, Charleston, 1942; aged 32; died March 7, 1949. Dr. Waring was a member of the Cambria County Medical Society.

○ **Maximilian D. Bloomfield**, Philadelphia; Jefferson Medical College of Philadelphia, 1905; aged 65; died May 5, 1949. Surviving are his widow and three sons.

○ **John M. Hutchings**, Clifton Heights; Hahnemann Medical College and Hospital of Philadelphia, 1911; aged 64; died April 26, 1949.

○ **Silas R. Posey**, Lititz; Jefferson Medical College of Philadelphia, 1911; aged 69; died May 5, 1949, following a long illness.

○ **George N. Yagle**, Red Lion; College of Physicians and Surgeons, Baltimore, Md., 1895; aged 81; died April 23, 1949.

○ **Albert F. Garton**, Philadelphia; Medico-Chirurgical College of Philadelphia, 1904; aged 69; died April 15, 1949.

○ **Joseph B. Brain**, Isabella; University of Pittsburgh School of Medicine, 1927; aged 46; died March 19, 1949.

○ **Samuel Wolf**, Philadelphia; Medico-Chirurgical College of Philadelphia, 1909; aged 77; died March 22, 1949.

○ **Carl H. Metzgar**, Altoona; Jefferson Medical College of Philadelphia, 1908; aged 70; died March 29, 1949.

Miscellaneous

GEORGE M. COATES, M.D., of Philadelphia, has been awarded the Gold Medal of the DeRoald's award of the American Laryngological Association. He has also received the Award of Merit of the American Otological Society.

THE NINETY-FIRST MEETING OF THE READING EYE, EAR, NOSE AND THROAT SOCIETY was held jointly with the Wilkes-Barre Ophthalmological Society on March 16. Clinics at Jefferson Medical College Hospital in Philadelphia were under the direction of William T. Hunt, Jr., M.D., assistant professor of ophthalmology at Jefferson Medical College.

WILLIAM HARVEY PERKINS, M.D., dean of Jefferson Medical College of Philadelphia, has been appointed by the American Medical Association as one of the five medical educators to represent the association at the Congressional committee hearings in Washington on Title I—Education of Health Personnel—of the National Health Insurance and Public Health Bill.

DR. EDMOND J. FARRIS, executive director of the Wistar Institute of the University of Pennsylvania, received the annual award of the American Urological Association at its meeting in Los Angeles, Calif., in May. Dr. Farris received the honor for "the most outstanding research in the field of human male fertility." The award consists of a scroll and \$1,000.

AT THE ANNUAL BUSINESS MEETING OF THE PHILADELPHIA LARYNGOLOGICAL SOCIETY on May 3, the following officers were elected for the coming year: president, Valentine M. Miller, M.D.; vice-president, Thomas F. Furlong, Jr., M.D.; treasurer, Harry P. Schenck, M.D.; secretary, William J. Hitschler, M.D. Chevalier L. Jackson, M.D., was elected to the executive committee.

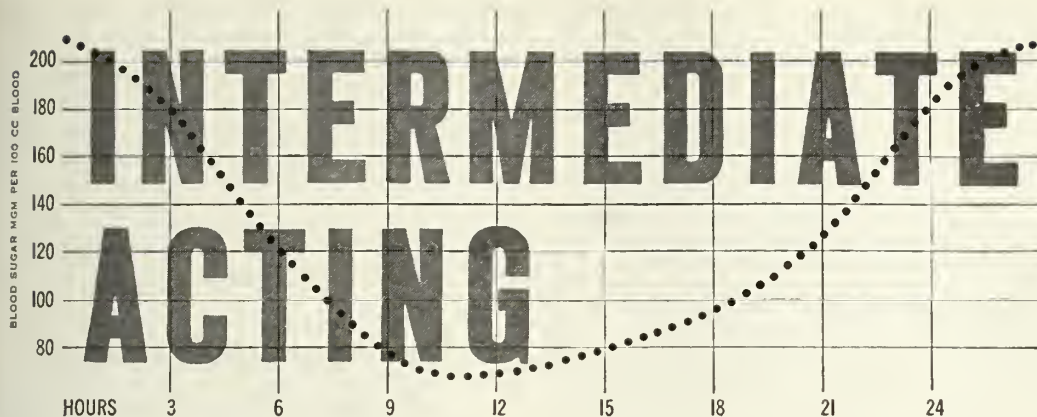
AT A REGULAR MONTHLY MEETING OF THE PENNSYLVANIA ACADEMY OF PHYSICAL MEDICINE, May 17, at the Philadelphia County Medical Society Building, William Bierman, M.D., presented a paper on "The Diagnosis and Treatment of Peripheral Nerve Paralysis." War Department films "Therapeutic Exercises in Peripheral Nerve Injuries" and "Electrodiagnosis" were also shown. The discussion was opened by Frederic H. Lewey, M.D., of Philadelphia.

WITH A GIFT OF \$250,000 FOR THE CONSTRUCTION OF A NEW HEART CLINIC AT THE UNIVERSITY OF PENNSYLVANIA and an additional \$25,000 to extend an original grant made in 1940 for cancer research, the Penn Mutual Life Insurance Company has thrown its financial strength into the fight against heart disease and cancer—America's No. 1 and No. 2 killers. The contribution was presented May 25 to Harold E. Stassen, president of the university, by John A. Stevenson, president of the company, at a luncheon held in the Barclay Hotel, Philadelphia. The sum of \$250,000 was designated for the building of a Penn Mutual heart clinic in the University's proposed new medical center. The additional sum of \$25,000 extends, for two more years, a grant made in 1940 when Penn Mutual pioneered and was the first corporation in the country to support cancer research at the university.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE will hold its twenty-seventh annual scientific and clinical session Sept. 6, 7, 8, 9 and 10, 1949, inclusive, at the Netherland Plaza Hotel, Cincinnati, Ohio. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held Sept. 6, 7, 8 and 9. These courses will be offered in two groups. One set of ten lectures will consist of basic subjects, and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to physical therapy technicians who are registered with the American Registry of Physical Therapy Technicians. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 N. Michigan Ave., Chicago 2, Ill.

THE AMERICAN COLLEGE OF PHYSICIANS announces that a limited number of fellowships in medicine will be available from July 1, 1950 to June 30, 1951. These fellowships are designed to provide an opportunity for research training either in the basic medical sciences or in the application of these sciences to clinical investigation. They are for the benefit of physicians who are in the early stages of their preparation for a teaching and investigative career in internal medicine. Assurance must be provided that the applicant will be acceptable in the laboratory or clinic of his choice and that he will be provided with the facilities necessary for the proper pursuit of his work. The stipend will be from \$2,200 to \$3,200. Application forms will be supplied on request to the American College of Physicians, 4200 Pine St., Philadelphia 4, Pa., and must be submitted in duplicate not later than Oct. 1, 1949.

THE PENNSYLVANIA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY held its annual meeting, April 22, 23 and 24, at the Penn-Harris Hotel, Harrisburg.



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1. Rohr, J.H., and Colwell, A.R.: Arch. Int.
Med. 82:54, 1948.

2. ibid Proc. Am. Diabetes Assn. 8:37, 1948.



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Among the guest speakers and the subjects which they presented were the following:

- George M. Coates, M.D., Philadelphia, guest of honor—Reminiscences in Otorhinology.
 Ralph O. Rychener, M.D., Memphis, Tenn.—External Diseases of the Eye: Treatment and Diagnosis.
 John R. Lindsay, M.D., Chicago, Ill.—Vertigo: Differential Diagnosis and Treatment, and Eustachian Tube Obstruction: Early Diagnosis and Management.
 C. Stewart Nash, M.D., Rochester, N. Y.—Functional Diseases of the Nose, and The Otolaryngologic Consultant in Compensation and Liability Actions.
 Albert D. Ruedemann, M.D., Detroit, Mich.—Beta Ray Uses in Ophthalmology, and Medical Treatment of Early Cataract.
 Ralph R. Pino, M.D., Detroit, Mich.—Economics of Ophthalmology.
 Arno E. Town, M.D., Philadelphia—Fibrin Closure of Surgical Wounds.
 Harrison F. Flippin, M.D., Philadelphia—Recent Advances in Chemotherapeutics.

In addition to the formal presentations, a round-table discussion on the subject of headache was conducted with the viewpoints of otolaryngology, ophthalmology, internal medicine, and neuropsychiatry presented by specialists in these fields. A study club on the subject of cataract problems was also conducted with discussions by Drs. Ruedemann and Town.

The meeting was well attended by specialists from all parts of Pennsylvania as well as from surrounding states.

Among the officers of the organization for the ensuing year are the following: president, Daniel S. DeStio, M.D., Pittsburgh; president-elect, Jay G. Linn, M.D., Pittsburgh; secretary, Benjamin F. Souders, M.D., Reading; treasurer, Bruce A. Grove, York.

Important messages are presented in the advertisements in your journal each month. New products are announced and information presented. Other types of ads emphasize services and commodities available that may be used in your practice. Doctors may rely on statements and facts presented, since every effort is made to include only ethical advertisements in our journal. Kindly tell our advertisers that you saw their ads in the PENNSYLVANIA MEDICAL JOURNAL.

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Take from the people of our country the source of initiative and the opportunity to aspire and to struggle in order that that aspiration may become a reality, and, though you couch your action in any sympathetic terms, it will fail of its purpose and be the undoing of the vital forces that go to make up a virile people. Look over all the world where you will and see those governments where the features of compulsory benevolence have been established, and you will find the initiative taken from the hearts of the people. . . .

Social insurance cannot even undertake to remove or prevent poverty. . . .—From address by SAMUEL GOMPERS, President, American Federation of Labor, Dec. 5, 1916.

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992 pages. 1948. Price, \$20.00

CANCER, Diagnosis, Treatment and Prognosis
By LAUREN V. ACKERMAN, M.D., and JUAN A. DEL REGATO, M.D.
1115 pages. 1947. Price, \$20.00

**CANCER OF THE ESOPHAGUS AND GASTRIC
CARDIA** By GEORGE T. PACK, B.S., M.D.
192 pages. 1949. Price, \$5.00

CAMPBELL'S OPERATIVE ORTHOPEDICS
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BOOK REVIEWS

TEXTBOOK OF THE RHEUMATIC DISEASES.

Edited by W. S. C. COPEMAN, O.B.E., M.D., F.R.C.P., Physician to the Rheumatism Department and Lecturer in the Medical School, West London Hospital; Physician to Arthur Stanley Institute of Rheumatic Diseases (Middlesex Hospital) and Hunterian Professor, R.C.S.; Senior Physician to the Hospital of St. John and St. Elizabeth; Consultant for Rheumatic Diseases, Royal Hospital for Incurables, and Consultant to L.C.C.; Hon. Medical Secretary, Empire Rheumatism Council; member of Minister of Health's Advisory Subcommittee; chairman of Chartered Society of Physiotherapy and of the British Branch of Ligue Internationale contre le Rhumatisme; Examiner in Physical Medicine for Royal College of Physicians; Heberden Medallist (1940). With 351 illustrations, some in full color. Baltimore: The Williams & Wilkins Company, 1948. Price, \$12.50.

During the past several decades much information, both clinical and experimental, has been accumulated to reduce our ignorance in the fields of medicine and surgery. However, it is through the medium of a textbook or monograph that the staggering mass of theories, facts, and conclusions is crystallized into a mass of comprehensive knowledge. Thus did the editor and assisting contributors compile the existing material and write this book, which can be recommended as an excellent text and reference for the student or practicing physician.

It is well written, consisting of 30 chapters covering every phase of the rheumatic diseases. Each problem is approached from several avenues, thereby creating a well-rounded program, including medical, orthopedic, physiotherapeutic, and psychiatric aspects. The illustrations are excellent.

The editor is to be congratulated on producing a fine book on the subject.

ATLAS OF PERIPHERAL NERVE INJURIES.

By WILLIAM R. LYONS, Ph.D., Associate Professor of Anatomy, University of California Medical School, and BARNES WOODHALL, M.D., Professor of Neurosurgery, Duke Medical School, Durham, N. C. Philadelphia: W. B. Saunders Company, 1949. Price, \$16.00.

Drs. Lyons and Woodhall have compiled and presented in a very dramatic fashion the clinical pathology of traumatic nerve injuries and the results obtained by the various methods of repair of these injuries.

The book is divided into six chapters. The first deals with the manner in which the tissues are prepared for histologic examination. The second chapter is devoted to the normal histology of all the components of peripheral nerves, as well as a glossary, as used in this text.

The third chapter deals with the completely severed nerve—gross and microscopic changes that occur in the proximal and distal stumps, the distal trunk, and end organs; the clinical appearance of the extremity with nerve injury; and photographs of the damaged nerve at the operative site showing the portion of the stumps from which sections are taken for microscopic examination. Considerable space is devoted to the change in nerves relative to time and type of injury, and injuries to the tissue surrounding the nerves. Photomicrographs of the perineural, interfascicular, and intrafascicular changes, in relation to the type of injury, are easily visualized and give the neurosurgeon the basis for evaluating the gross specimens at the time of operation.

The next chapter discusses the traumatic nerve lesion

in continuity. This includes nerve lesions as seen by the surgeon under the following category: (1) nerves found to be intact for the most part, but imbedded in dense adhesions; (2) severed nerve stumps in fibrous continuity; (3) partial neuromas in continuity; (4) complete neuromas in continuity; (5) nerves eroded by aneurysm; (6) ischemic nerve segments. Here again the changes that result are visualized by photomicrographs.

The last two chapters are devoted to the changes accompanying the various types of nerve suture in regard to the type of suture material used, the amount of mobilization necessary, the amount of traction the nerve will tolerate and regenerate, and the various types of sleeves that are used to surround the suture site.

The last chapter is devoted entirely to nerve grafts. This chapter of necessity is somewhat limited, but it does include specific examples of all types of nerve grafts which have had any degree of success. At no point do the writers become didactic as to what should or should not be done. But each one reading this text certainly will develop a most excellent type of pathologic background upon which to base sound judgment in the care of peripheral nerve injuries, and will realize from the appearance of a gross specimen (1) the amount of damage which has occurred to that particular nerve trunk, (2) the mobilization necessary for a repair which will give hope of a good result, (3) the type of suture best suited for this individual problem, (4) the use or non-use of protective covering at the suture junction, and (5) the best possible mobilization of the extremity involved.

Certainly the patients of any of us who deal with peripheral nerves will be greatly benefited by our reading of this particular monograph.

DEEP MASSAGE AND MANIPULATION ILLUSTRATED.

By JAMES CYRIAX, M.D., B.Ch. (Cantab.), Physician to the Department of Physical Medicine, St. Thomas's Hospital, London. Third edition. New York: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1948. Price, \$5.00.

In reviewing this book, one is impressed with the clear and concise way in which Dr. Cyriax has handled the subject, and one cannot help but note the different approach that has been used in the presentation of the subject. This book is extremely valuable not only as a subject text but also as a reference.

The book is divided into two parts, each of which has a separate table of contents. This is an asset to the reader desiring immediate information. Part 1, which covers the principles and technique of massage and deep manipulation, consists of the scope and purpose of deep massage; the position of the physical therapist and her hands; passive movements; and the physical therapist's working day. Part 2 consists of illustrations of various positions in manipulation and massage and a summary of procedures and results.

The illustrations, which are indexed, cover the subject completely and are extremely valuable in that they clearly convey to the reader's mind the exact procedures and manipulations.

Certainly this book is an invaluable aid to the physical therapist, the medical student, the general practitioner, and the specialist who will appreciate the style, the practical illustrations, and the easy reading. It is a valuable addition to any library and is highly recommended as a convenient and authoritative reference for those readers desiring the most effective modern methods of deep massage and manipulation.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

BRITISH SURGICAL PRACTICE. Under the general editorship of SIR ERNEST ROCK CARLING, F.R.C.S., F.R.C.P., Consulting Surgeon, Westminster Hospital, and J. PATERSON ROSS, M.S., F.R.C.S., Surgeon and Director of Surgical Clinical Unit, St. Bartholomew's Hospital; Professor of Surgery, University of London. In eight volumes (with index volume). Volume 5. St. Louis: The C. V. Mosby Company, 1948. Price, \$15.00.

OCULAR SIGNS IN SLIT-LAMP MICROSCOPY. By JAMES HAMILTON DOGGART, M.A., M.D. (Canada), F.R.C.S. (Eng.), Surgeon and Late Research Scholar, Moorfields, Westminster and Central Eye Hospital; Lecturer in Ophthalmology at St. George's Hospital Medical School; Ophthalmic Surgeon, Hospital for Sick Children, Great Ormond Street; Late Senior Open Foundation Scholar, King's College, Cambridge. With 93 illustrations, of which 85 are in color. St. Louis: The C. V. Mosby Company, 1949. Price, \$6.75.

FOOD AND FACTS FOR THE DIABETIC. By JOSEPH H. BARACH, M.D., F.A.C.P., Associate Professor of Medicine, School of Medicine, University of Pittsburgh. New York: Oxford University Press, 1949. Price, \$4.00.

HANDBOOK OF MATERIA MEDICA, TOXICOLOGY, AND PHARMACOLOGY. For Stu-

dents and Practitioners of Medicine. By FORREST RAMON DAVISON, B.A., M.Sc., Ph.D., M.B., Consultant and Toxicologist, Minneapolis, Minn.; formerly Assistant Professor of Pharmacology in the School of Medicine, University of Arkansas, Little Rock; Medical Department, The Upjohn Co., Kalamazoo, Mich.; Assistant Professor of Pharmacology, University of Tennessee Medical School, and Toxicologist to University Clinics, Memphis, Tenn. Fourth edition with 35 illustrations, including 4 in color. St. Louis: The C. V. Mosby Company, 1949. Price, \$8.50.

FUNDAMENTALS OF INTERNAL MEDICINE. By WALLACE MASON YATER, A.B., M.D., M.S. (in Med.), F.A.C.P., Director, Yater Clinic, Washington, D. C.; formerly Professor of Medicine and Director of the Department of Medicine, Georgetown University Hospital; Physician-in-Chief, Gallinger Municipal Hospital, Washington, D. C.; and Fellow in Medicine, The Mayo Foundation. Third edition. New York: Appleton-Century-Crofts, Inc., 1949. Price, \$12.00.

HISTOLOGY AND HISTOPATHOLOGY OF THE EYE AND ITS ADNEXA. By I. G. SOMMERS, M.D., Assistant Professor (Ophthalmology), College of Medical Evangelists; Medical Officer (E.E.N.T.), U. S. Public Health Service, Los Angeles, Calif. New York: Grune & Stratton, 1949. Price, \$12.00.

CARE OF THE SURGICAL PATIENT. Including Pathologic Physiology and Principles of Diagnosis and Treatment. By JACOB FINE, M.D., Surgeon-in-Chief and Professor of Surgery at Beth Israel Hospital, Harvard Medical School. Philadelphia: W. B. Saunders Company, 1949. Price, \$8.00.

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NUTRITION AND DIET IN HEALTH AND DISEASE. By JAMES S. MCLESTER, M.D., Professor of Medicine, University of Alabama, Birmingham. Fifth edition. Philadelphia: W. B. Saunders Company, 1949. Price, \$9.00.

CLINICAL AUSCULTATION OF THE HEART. By SAMUEL A. LEVINE, M.D., Clinical Professor of Medicine, Harvard Medical School; Physician, Peter Bent Brigham Hospital; and W. PROCTOR HARVEY, M.D., Research Fellow in Medicine, Harvard Medical School; Assistant in Medicine, Peter Bent Brigham Hospital. Illustrated. Philadelphia: W. B. Saunders Company, 1949. Price, \$6.50.

POLIOMYELITIS. Papers and discussions presented at the First International Poliomyelitis Conference. Compiled and edited for the International Poliomyelitis Congress. Philadelphia: J. B. Lippincott Company, 1949. Price, \$5.00.

CIVIL SERVICE VACANCIES

The United States Civil Service Commission has announced a medical officer examination for filling rotating intern psychiatric resident and surgical resident positions in St. Elizabeth's Hospital, Washington, D. C. The salaries for rotating interns are \$2,200 for the first year and \$2,400 for the second year; the salaries for psychiatric resident range from \$2,400 to \$4,100 a year; and for surgical resident, from \$3,400 to \$4,150.

To qualify, applicants for the rotating intern positions must be third- or fourth-year students in an approved medical school. Applicants for psychiatric resident and surgical resident positions must be graduates of a medical school with the degree of doctor of medicine, and must have completed a full year in an approved rotating internship. In addition to the above requirements, appli-

cants for appointment as surgical resident must have completed three full years as residents-in-training in surgery in an approved residency. No written test is required for this examination. The maximum age limit of 35 years is waived for persons entitled to veteran preference.

Further information and application forms may be obtained at most first-class and second-class post offices, from civil service regional offices, or from the U. S. Civil Service Commission, Washington 25, D. C. Applications will be accepted by the Commission's Washington office until further notice.

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Effective April 1, the Hospital Service Plan of the Lehigh Valley was named the representative of the Medical Service Association of Pennsylvania to enroll Blue Shield subscribers and to act as the central collection agency for MSAP in Northampton and Lehigh counties.

The agreement between MSAP and the Lehigh Valley organization is the same as those made in October, 1947 with Blue Cross agencies in the Philadelphia, Pittsburgh, and Wilkes-Barre areas of the State and with Inter-County Hospitalization Plan, Inc., in January, 1946. Under these arrangements the Blue Cross organizations sell MSAP's Blue Shield memberships, bill subscribers, and carry on public relations work.

As heretofore in Northampton and Lehigh counties, MSAP will continue to pay doctors for care and treatment of Blue Shield subscribers.

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The above studies should be supplemented, when possible, with courses in mathematics, qualitative analysis, physical chemistry, foreign languages (Spanish, French, or German), and sociology.

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References: 1. Dodd, K. and Minot, A. S.: *J. Pediat.*, 8:442, 1936.
2. Dodd, K. and Minot, A. S.: *J. Pediat.*, 8:452, 1936.
3. Sahyun, M.: *Am. J. Dig. Dis.*, 13:59, 1946.

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Duncan E. Reid



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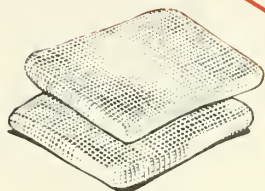
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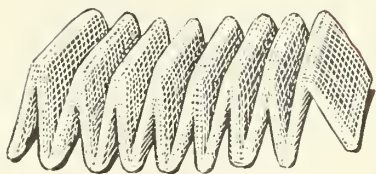
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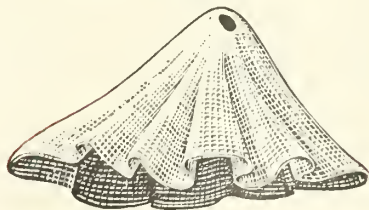
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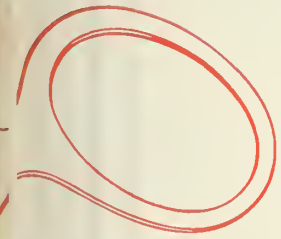


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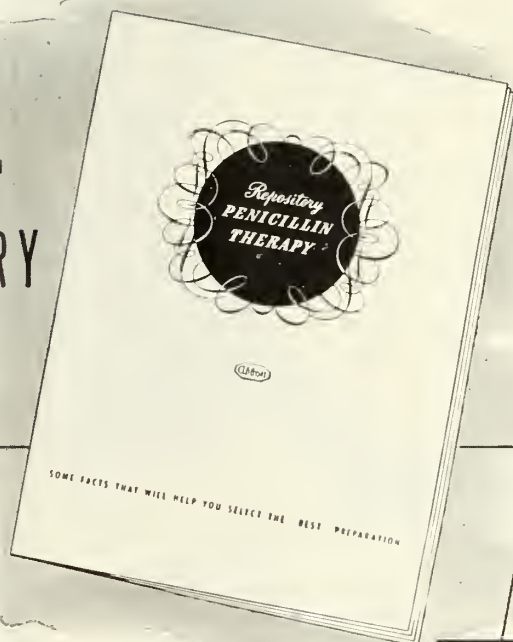
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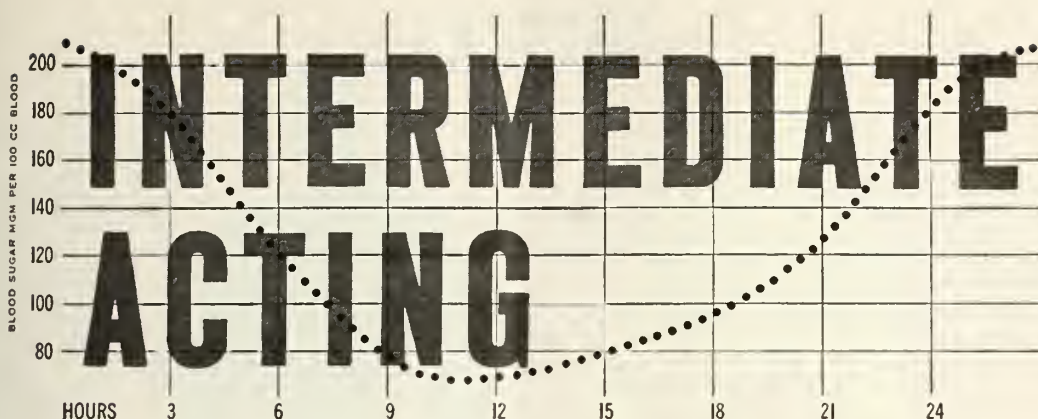
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1. Rohr, J.H., and Colwell, A.R.: Arch. Int.
Med. 82:54, 1948.

2. ibid Proc. Am. Diabetes Assn. 8:37, 1948.



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So now it is indeed a pleasure to enclose in repayment a check for \$500 with deepest appreciation.

(Signed) _____, M.D.
Erie County, Pennsylvania.

Teaching vs. Practicing Medicine

GENTLEMEN:

The appended communication addressed for obvious reasons to an unnamed acquaintance may prove of interest to your readers.—F. G. D.

DEAR PROFESSOR _____:

I shall try to answer your thesis that compulsory sickness insurance should be approved on the grounds that education has not suffered as a result of having most teachers employed by (local) government. After teaching in a large state university, I am inclined to agree with your comment about salaried teachers and the role of government in education in your recent letter. But allow me to examine candidly your analogy between teaching and the practice of medicine. As you well know, advocates of compulsory health insurance often argue that medicine, like education, is an essential good which Americans would not purchase if left to themselves. They should, therefore, be compelled to purchase medical care under a system similar to our educational system.

But is medicine like education? Is medicine the type of service that can be more effectively provided under government administration? If the advocates of compulsory health insurance limited their discussion to a comparison of education and public health, they would be on safe ground. Public health service involves problems of sanitation, the water supply, food handling in public eating places, communicable diseases, and similar matters which concern large groups of persons. These services can ordinarily be more efficiently provided by government; as a matter of fact, they usually are provided by the staff of the local public health service office.

Medical care in its entirety, however, is so fundamentally different from education that there appears little or no basis for comparison. To point out any superficial likeness is to overlook the basic function of medicine, to disregard the real role of the physician, to lose sight of the very end to be desired—better medical care for the American people.

The fundamental difference between education and

medicine arises out of the fact that the teacher is concerned with a large, fairly standardized group of persons in a class or a grade, while the doctor must of necessity be concerned with the individual. The public school teacher presents subject matter which is standardized to a large degree. He presents this subject matter to a class composed of children or young people of somewhat similar intellectual development who presumably enjoy normal health. His primary purpose is to teach these people to do things for themselves. It is true that each teacher may make exception for unusual students in the class and that each teacher may favor some particular method of presentation; nevertheless, the great bulk of the teacher's instruction is keyed to the average needs of a large, fairly homogeneous group of persons. Although it is desirable that our educational methods be more individualized, the fact remains that education lends itself to group organization.

The physician's interest, on the other hand, must lie in the individual patient. The physician cannot administer the same treatment to a large group of persons—25 boys and girls in one class or grade. He must diagnose each case separately and select the proper treatment for each case. He knows that from infancy to old age the medical needs of an individual undergo continual change, and that he must be able to administer medical treatment to people of all age groups. He is concerned with the differences, not the similarities, in persons. He not only directs the patient in improving his own condition but he provides treatment directly to him. The physician, if he is to perform his work at all, let alone maintain a high quality of medical care, cannot offer a standardized product. His services are not adaptable to government regulation and organization, to fixed rules and basic standards—the necessary concomitants of any national compulsory scheme. In fact, the physician would be rendered powerless to fulfill his primary obligation to his patients if condemned to such uniformity.

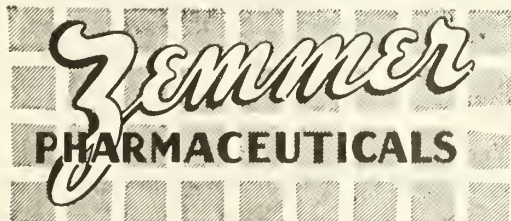
I trust that you will not read into my remarks any implied criticism of your present profession—and mine for twenty-five years. I believe in our educational system despite its shortcomings which you and I have often discussed. Likewise, I believe that "reasoning by analogy" is poor in general and especially inept when the analogy is drawn between teaching and practicing medicine.

Cordially,

FRANK G. DICKINSON, *Director*,
AMA Bureau of Medical Economic Research.

P. S. Since both of us abhor the very thought of federal control of education, I have not emphasized the obvious contrast between the local control of education and the federal control of compulsory sickness insurance.

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In evaluating the results of this treatment for patients with circulatory disorders there is no ideal test of cardiac function and in these patients the ability to walk or exercise without the production of symptoms is used in judging their clinical

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** As printed in International Clinics, Vol. 1, page 199, March 1937*



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THE EMPIRE STATE'S CONTRIBUTION TO THE MEDICAL PROFESSION

FROM SECRETARY OF DEFENSE LOUIS JOHNSON—

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Your personal help is needed to avert a serious threat to our national security!

By the end of July of this year we will have lost almost one-third of the physicians and dentists now serving with our Armed Forces. Without an increased inflow of such personnel, the shortage will assume even more dangerous proportions by December of this year.

These losses are due to normal expiration of terms of service. The professional men who are leaving the Armed Forces during this critical period are doing so because they have fulfilled their duty-obligations and have earned the right to return to civilian practice.

Without sufficient replacements for these losses, we cannot continue to provide adequate medical and dental care for the almost 1,700,000 service men and women who are the backbone of our nation's defense.

Normal procurement channels will not provide sufficient replacements!

To alleviate this critical, impending shortage of professional manpower in the three services, I am urging all physicians and dentists who were trained under wartime A. S. T. P. and V-12 programs under government auspices or who were deferred in order to complete their training at personal expense, and who saw no active service, to volunteer for a two-year tour of active duty, at once!

We have written personally to more than 10,000 of you in the past weeks urging such action. The response to this appeal has not been encouraging, and our Armed Forces move rapidly toward a professional manpower crisis!

Many responses have been negative, but worse—a great number of doctors have not replied. It is urgent that we hear from you immediately!

We feel certain that you recognize an obligation to your fellow men as well as to your profession in this matter. We are confident that you will fulfill that obligation in the spirit of public service that is a tradition with the physician and dentist.

There is much to be said for a tour of duty with any of the Armed Forces. You will work and train with leading men of your professions. You will have access to abundant clinical material; have the best medical and dental facilities in which to practice. You will expand your whole concept of life through travel and practice in foreign lands. In many ways, a tour of service will be invaluable to you in later professional life!

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The benefits derived from high-protein nutrition in pregnancy and lactation are diversified and far-reaching, embracing both mother and offspring. For this reason, a generous extra serving of meat, given daily as a routine measure, has been strongly recommended as a means of improving the health of mother and child.

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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. 139:897 (April 2) 1949.

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The Management and Treatment of Patients with Preeclampsia and Eclampsia

DUNCAN E. REID, M.D.
Boston, Mass.



THE term "toxemia of pregnancy" is used to describe those patients who exhibit any degree of hypertension and proteinuria during gestation. Actually this all-inclusive term frequently includes many patients with antecedent vascular or renal

disease and a greater number of patients who are referred to as cases of mild preeclampsia and in whom small amounts of albuminuria and hypertension appear for the first time in the latter weeks of pregnancy. Therefore, patients who develop the clinical signs and symptoms of severe preeclampsia and eclampsia (eclampsyogenic syndrome) are comparatively few in number. That is not to say that patients with mild preeclampsia or those with antecedent vascular or renal disease are not capable of developing the signs and symptoms associated with the eclampsyogenic state, namely, marked hypertension, albuminuria, edema, headaches, eye signs, convulsions, and coma. Actually, in fatal cases of eclampsia, evidence of antecedent vascular and renal disease can be demonstrated at autopsy in a fair percentage of cases. This suggests that eclampsia is many times a disease of

neglect, due to either the patient not seeking prenatal care or her medical supervision was not of sufficient quality to forestall the development of convulsions. Through constant vigilance the thorough clinician should be able to recognize in the patient with a damaged vascular and renal system the alterations which may take place in those systems during the course of pregnancy. This should enable him to avoid many of the serious complications which such patients often develop.

In contrast, it is not easy to anticipate the appearance of severe preeclampsia and eclampsia in previously normal patients. This is understandable if we are willing to entertain the concept that this disease is nothing more or less than an exaggeration of the changes which occur in the physiology of normal pregnancy. Assuming this to be true, it follows that every pregnant individual is potentially a patient who may develop severe preeclampsia and eclampsia and it may on occasion be difficult to determine with certainty when the patient is passing from the normal to the eclampsyogenic state. More accurate methods of detecting the early bodily changes which precede this disease would be most helpful in preventing its development. Certainly definitive medical treatment is unlikely to occur until this is possible.

Once the disease has developed, treatment must be both medical and obstetrical. The for-

Read before the Section on Obstetrics and Gynecology at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 6, 1948.

From the Department of Obstetrics, Harvard Medical School and the Boston Lying-in Hospital, Boston, Mass.

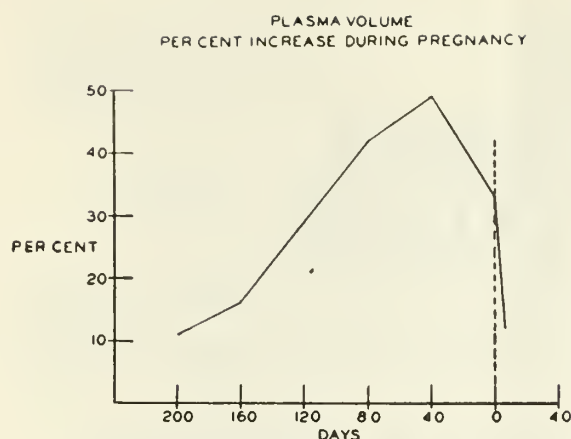


Fig. 1

mer is a prerequisite to the success of the latter. Many forms of medical treatment have been suggested, but all of them have been concerned with the following aspects of therapy, namely, *fluid balance*, as it is related to oliguria and anuria, *control of convulsions*, if present, and *acid-base balance*, as it is influenced by anoxia and oliguria. A fourth item should perhaps receive consideration in the treatment. This is concerned with the possibility that changes may occur in the circulating blood with subsequent loss of its clotting power. This is particularly important in patients who may develop toxic separation of the normally implanted placenta—a complication which frequently occurs with this disease.

However, the ultimate treatment is still obstetrical and the recovery of the patient will depend primarily upon successful termination of the pregnancy following a period of medical therapy. This discussion will be concerned principally with the medical treatment of this disease followed by a brief consideration of the obstetric care of the patient.

Fluid balance is influenced in large measure by the degree of hydration which occurs in the vascular and extravascular compartments during normal pregnancy. In the first and second trimesters the percentage increase in the vascular compartment is greater than the percentage increase in the extravascular compartment. Early in the third trimester this relationship is reversed. During this latter period the extravascular fluid compartment increases at a greater rate than the vascular compartment. These processes continue in this manner until approximately forty days prior to the onset of labor, at which time the vascular compartment or plasma volume has reached its peak, from which there is a beginning decrease. However, the extravascular compartment continues to expand up to the time

of the onset of labor. Following delivery, there is a marked decrease in both compartments. The plasma volume reaches normal non-pregnant values thirty days following delivery, while there is a further lag in the return to normal of the extravascular compartment.

At the Boston Lying-in Hospital¹ a recent study was made whereby simultaneous plasma volume and extravascular volume determinations were made on a series of individual patients throughout pregnancy and the puerperium. The following changes were observed. Fig. 1 illustrates the mean change in plasma volume which is attained during pregnancy over non-pregnant values. The maximum increase in the plasma volume was 49 per cent over the values obtained thirty days postpartum. It will be noted that of the total increase in plasma volume in pregnancy there was a decrease of 25 per cent prior to the onset of labor. In Fig 2 is shown the increase in the extravascular fluid which occurs in normal pregnancy. There is a progressive increase in the volume of this compartment which attains its peak within the ten-day period prior to labor. However, it should be emphasized that there is no decrease in the volume of this compartment until after delivery. This continuing hydration is difficult to relate with the generally accepted clinical impression of a prepartum diuresis. Furthermore, this hydration continues to occur in the presence of a pre-labor decrease in the placental steroids. When the extravascular fluid values were determined thirty to sixty days after delivery, there was a decrease of 59 per cent over the pre-labor peak.

These changes which take place in the extracellular fluid compartments during the latter part of the third trimester of normal pregnancy are exaggerated in the patient who develops eclamptogenic toxemia. This latter condition is characterized by hemoconcentration and a further in-

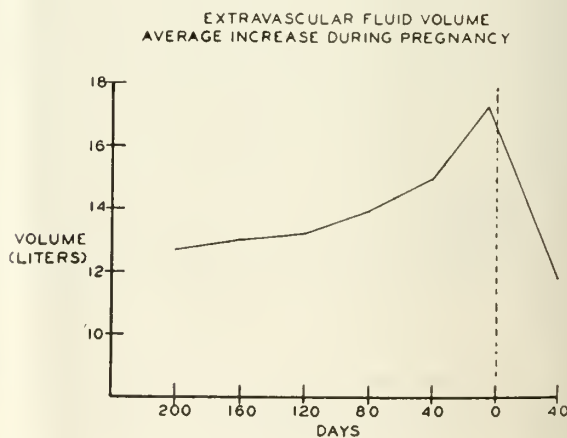


Fig. 2

crease in the volume of the extravascular fluid. In Fig. 3 is presented a comparison between the means of the plasma and the extravascular fluid volumes and the average peripheral venous hematocrit in these different physiologic states, namely, the non-pregnant individual, the normal pregnant patient, and the patient with eclamptogenic toxemia. The values for normal non-pregnant females are represented in the first group of bars. The plasma volume has a mean value of 2800 cc., while the extravascular fluid volume is approximately 12 liters. The latter value may be actually too high for the non-pregnant individual. The second bar reveals the plasma and extra vascular fluid values in normal pregnancy during the third trimester. The lowered hematocrit reflects the hemodilution occurring in the vascular compartment. The third bar represents the changes in patients with eclamptogenic toxemia recently observed by Freis and Kenny.² These observations indicate that in this disease there is a marked increase in the hydration of the extravascular compartments with a relative decrease of the plasma volume. This hemoconcentration is reflected by a rise in the peripheral venous hematocrit. In addition, these authors found that there was an actual decrease in the total amount of circulating plasma protein.

In an attempt to reverse this abnormal increase in extravascular fluid volume, various agents have been used to increase the osmotic pressure of the blood plasma.³ More recently, Golden has reported the use of twice concentrated plasma in the treatment of severe pre-eclampsia and eclampsia.⁴ Macarthur⁵ has administered the amino acid methionine to protect the liver and thus aid in protein synthesis and indirectly increase the osmotic pressure of the blood by increasing plasma protein values.

The value of improving the osmotic pressure within the vascular system must depend on the manner in which the development of edema in eclamptogenic toxemia may occur and the relationship of this edema formation to the appearance of hypertension and proteinuria. As the extravascular hydration of normal pregnancy is known to occur in exaggerated amounts in eclamptogenic pregnancy, it would be logical to assume that edema formation is the initial change which occurs in the development of this disease. One is impressed by the meager amount of data which is available to explain its appearance in eclamptogenic toxemia. If we are to adhere to the accepted theory of edema formation, the following postulate regarding its relationship to the development of this disease is presented. It must be assumed that protein material appears in the

edema fluid in abnormal amounts. This possibility has never been adequately explored. Furthermore, the electrolyte content of the extravascular fluid is not known. However, there is some evidence that the amount of base (sodium) reportedly retained even in normal pregnancy is at least twice the amount that would be accounted for by the amount of water that is actually stored. In other words, if the amount of sodium which is supposedly retained during pregnancy is present in an active osmotic state, the increase in water storage during this time would be approximately 30 liters.⁶ This obviously is not the case and suggests that, if sodium is retained in that magnitude, at least some of it must be osmotically inactive or stored outside of the extracellular compartments.

Assuming that protein and sodium in abnormal amounts are in the extravascular compartment, tissue tension will rise because of the hydration of this space from this increased osmotic activity. This is suggested by the fact that the extravascular fluid values in eclamptogenic toxemia increase at the expense of the plasma volume. This decrease of the latter, combined with an increase in tissue tension, reduces the physiologic active capillary bed. This evokes a compensatory rise in blood pressure.

It cannot be said with certainty that the renal blood flow and glomerular filtration rate are not reduced in the eclamptogenic toxemias. Certainly the renal blood flow has never been determined ante partum in patients with eclamptogenic toxemia during the phase of oliguria and anuria. With the observed decrease in plasma volume and the possible reduction of the capillary bed, it is reasonable to believe that renal

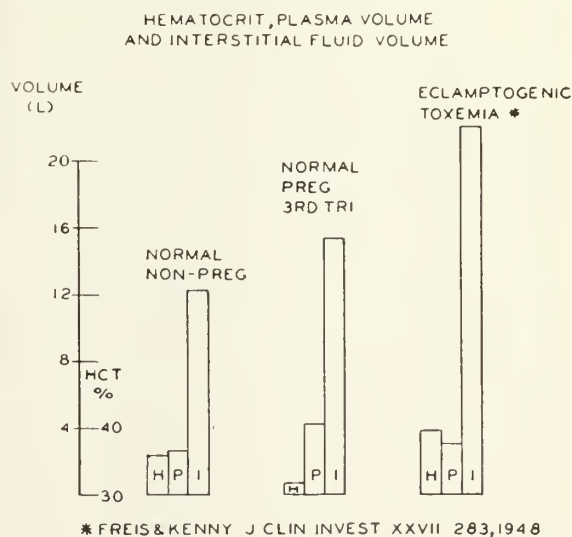


Fig. 3

physiology would be altered. It is generally accepted that there is a certain degree of avascularity of the glomerular tufts with some degree of thickening of the basement membranes of the capillaries. The anoxia which results from these changes is sufficient to explain the appearance of protein in the urine. A further decrease in plasma volume may in large measure determine the amount of the antidiuretic factor present which in turn will direct renal activity towards water conservation. The amount of water reabsorbed will influence the volume and the sodium concentration of the urine excreted.



Fig. 4

During the past year at the Boston Lying-in Hospital salt-free human serum albumin has been administered to several patients in an attempt to correct the altered fluid balance occurring in patients with severe preeclampsia and eclampsia.⁷ This material was furnished by the American Red Cross for experimental purposes. It was given intravenously in 50 Gm. amounts. The rate of infusion varied from 200 cc. (50 Gm. of albumin) in seventeen minutes to the same amount given over a period of three hours. Hematocrits were taken immediately before and following the infusion and repeated four to six hours following the completion of administration. Fig. 4 shows the changes occurring in the plasma proteins and hematocrit values following administration of salt-poor serum albumin to six patients, four of whom had severe preeclampsia and two had eclampsia. In all instances there was a prompt fall in the hematocrit values, suggesting a shift of the abnormal amounts of extravascular fluid to the vascular compartment. The hemodilution was found to be more prolonged if the material was given more slowly over a longer period of time. However, the hemodilution was not followed in every instance by a diuresis. Actually the greatest diuresis was oftentimes followed by a rapid return toward the original hematocrit level. This would be a natural sequence in the presence of the most effective diuresis. On the

occasions where diuresis did not occur following hemodilution, it is inferred that there is an antidiuretic action present even when there is no need for water conservation.

Regardless of this lack of diuresis in the presence of hemodilution, the patients were clinically improved. They were less irritable and needed less sedation. The blood pressure was not increased and there was a tendency to some decrease. The fact that the blood pressure was not increased in the presence of this supposed enlargement of the plasma volume lends support to the concept that there must be an increase in the physiologic capillary bed following the infusions.

In addition to such therapy, the daily amount of fluids which should be administered to these patients in the presence of hydration is difficult to establish. Both the limitation and the use of large amounts of fluid have been advocated. In the absence of accurate knowledge of the correct intake, it seems reasonable that 1500 to 2000 cc. should be administered in twenty-four hours to cover the daily loss of insensible fluids. If the patient is not stuporous or in coma, these can be given by mouth in the form of nourishing fluids. If parenterally administered, concentrated glucose in buffered sterile water has always been considered a valuable aid in promoting diuresis and in protecting the liver from further damage.

Should *convulsions* occur, measures should be immediately instituted for their control. Many drugs have been suggested to accomplish this. None of them are entirely satisfactory. The treatment of the hemoconcentration by the shifting of fluid from the extravascular to the intravascular spaces should reduce cerebral edema and decrease the tendency toward convulsions.⁸ It has been suggested that salt-free human serum albumin can be helpful in accomplishing this. This should encourage patients who are in coma to regain consciousness or, if they are stuporous, to become less so. Following such therapy these patients appear to be less irritable and require much less sedation. Certainly sedative drugs should be used sparingly in patients who are prone to lapse into coma. Small amounts of phenobarbital or demerol (the latter being given if the patient is in pain) are usually sufficient to control the irritability of the average patient.

Reduction of blood pressure has also been associated with lessening the irritability of the patient, hence can be considered as part of the treatment of the convulsions. There is a great variety of drugs with the ability to reduce the blood pressure. However, because of its mild sedative action and uniform behavior on the vascular system, magnesium sulfate has been given

preference over many of the newer drugs. Only in rare instances does it ever decrease the blood pressure to an alarming level. We believe this is important, for although some reduction in blood pressure is indicated in order to control irritability and prevent vascular accidents, a marked decrease can only do harm by further diminishing the physiologic available capillary bed. The drug can be administered in total amounts of 6 to 12 Gm. daily. A decrease of the deep reflexes will occur before one need be fearful of any marked respiratory or cardiac depression.

In patients with severe preeclampsia and eclampsia an upset in the *acid-base balance* has been noted. This is particularly true if convulsions have occurred. Various studies of acid-base balance have shown that in normal pregnancy the plasma bicarbonate is lowered, while the pH is at the upper limits of normal. This CO₂ deficit is probably dependent on hyperventilation, but certainly does not constitute a true acidosis. This state may be referred to as an uncompensated alkalosis or more properly as a respiratory alkalosis. The acid-base picture in eclamptogenic toxemia is merely an exaggeration of the changes in normal pregnancy with hyperventilation playing a more important role. A true acidosis does not exist until the CO₂ combining power becomes depressed because of convulsions or oliguria with retention of fixed acids. These values may be depressed 16 to 20 volumes per cent.

Since the pH is normal, the use of sodium lactate is preferable to bicarbonate in the treatment of this acid-base disturbance. The former substance will not produce as great a change in blood bicarbonate and pH as does the latter and may, therefore, be used with greater safety. Occasionally pH values of 7 to 7.2 have been recorded. Perhaps in such instances the use of a stronger alkalinizing agent may be indicated, for in this state a condition of uncompensated acidosis exists. In further combating this decrease in the CO₂ combining power, all patients with severe preeclampsia and eclampsia should be given liberal amounts of oxygen during the acute phase of the disease. The amount of capillary cyanosis oftentimes visible in the extremities of these patients is in marked contrast to the florid appearance of the skin over the remainder of the body. This latter may be misleading in evaluating the amount of anoxia which is present. Any type of therapy which can be instituted for decreasing this anoxia should prove helpful.

Hemorrhage is one of the major contributing causes of death in severe toxemia. It has been

observed that the blood on rare occasions may not clot in patients with toxic premature separation of the placenta,⁹ and in patients dying from eclampsia.³ This tendency to excessive hemorrhage in this disease has never been well understood. In certain instances it has been noted that fibrinogen may not be present in normal amounts or may be completely absent from the blood. The absence of this substance may account for the occurrence of this hemorrhagic diathesis. That the lack of fibrinogen can accompany other obstetric conditions is substantiated by the recent observations¹⁰ that it was nearly depleted from the circulating blood in a patient with incomplete miscarriage who had vaginal bleeding for a prolonged period of time, and in an Rh negative mother in whom intra-uterine death of the fetus had occurred two months prior to spontaneous labor and delivery. In neither case was there any evidence of associated liver disease and the return of normal fibrinogen values rapidly followed evacuation of the uterine contents.

The elements which are concerned with blood clotting are said to be increased during pregnancy. Furthermore, there is usually an increase in fibrinogen values in patients who develop severe preeclampsia and eclampsia. Hence it is difficult to explain the occurrence of the occasional case of eclamptogenic toxemia with blood that does not properly clot. Naturally the placental site or changes within the uterus would be incriminated as the possible source for the initiation of these changes.

Observations have been made on the character and properties of the menstrual and postpartum uterine discharge which has a significant relationship to this apparent lack of normal fibrinogen levels within the circulating blood. Whitehouse,¹¹ in 1914, added menstrual blood to recently clotted venous blood. He observed that there was a complete dissolution of the clot. In subsequent studies no coagulation defect in menstrual blood was observed and it was concluded that menstrual discharge was the product of clotted blood in which the clot had undergone dissolution and hence was devoid of fibrin.^{12, 13}

There appears to be a similarity between this process and that which occurs in postpartum blood or fluid.¹⁴ In both instances there was a proteolytic substance present which was capable of dissolving the clot. The amount of the enzyme present appeared to be related to the amount of tissue destruction rather than any inherent coagulation defect within the freshly shed blood.

In pursuing the subject in more complete manner, the Smiths (O. W. and G. Van. S.)¹⁵

have demonstrated that in menstrual discharge there is an active fibrinolytic enzyme component. This factor is also associated with a toxic substance, the latter being lethal to both rats and rabbits. Both the toxic and the enzymatic activity appear to reside within the euglobulin protein fraction prepared from the endometrial débris collected during menstruation.

These two substances have certain differences which indicate that they are separate entities. The enzymatic activity appears to be more stable than the toxic factor. The toxic factor is liberated just prior to the onset of the menstrual flow when there is beginning endometrial catabolism following the withdrawal of hormone support to the endometrium. The enzymatic factor appears to exhibit its greatest activity during the time of greatest tissue destruction, namely, when the vaginal flow is most profuse. The enzymatic factor has been observed in the circulating blood, while the toxic factor has not.

In addition to this enzymatic factor being present in the circulating blood during the menses, the Smiths¹⁶ have observed its presence in varying amounts in cases of prolonged labor and in patients with severe preeclampsia and eclampsia. The degree of activity in the latter appears to be directly proportional to the severity of the disease. This has been confirmed by other investigators.¹⁷ It has been suggested by the Smiths that there is an analogy between the appearance of this proteolytic activity in the circulating blood during menses and the eclamptogenic syndrome.

It is postulated by the Smiths that during the active menses with the casting off of the compacta and spongiosa layers of the endometrium, the fibrinolytic activity is the greatest. An inactivation of the fibrinogen and prothrombin is produced with failure of thrombosis of the spiral arterioles which allows for continued menstrual bleeding. Bleeding continues until such time as the endometrium is shed to its basal layer. With this decrease in tissue destruction, there is a disappearance of the fibrinolytic enzyme activity.

In normal pregnancy there is occurring at all times within the uterus a minimal amount of decidual regression. The degree of this regression must depend in large measure upon the rate of blood flow through a given area of the uterus. According to the Smiths, this would not affect the coagulability of the blood at the placental site, but might actually enhance the process. However, if there is a marked upset of uterine blood flow produced by an eclamptogenic toxemia (decrease in capillary bed) with subsequent placental infarction or separation following

which is marked tissue destruction, the fibrinolytic activity would be markedly increased. Hence it is felt that a small amount of tissue destruction is associated with increased coagulability of the circulating blood, but there is an opposite effect on the blood during the time of marked tissue destruction.

Although it is not certain what role these enzyme changes may play in relation to this unusual situation, certain clinical implications are suggested. Regardless of the manner in which the fibrinogen is removed from the blood in these patients, attempts should be made to correct this condition as soon as it is recognized. This is particularly true if any operative procedure is contemplated. The normal fibrinogen content of the circulating blood is 210 mg. per cent. Hemorrhage is likely to occur if the fibrinogen values fall below 50 mg. per cent. Fraction 1 of blood plasma contains fibrinogen. Ampules containing the equivalent of 100 mg. of fibrinogen are available through the American Red Cross. The fibrinogen in the ampules can be diluted with small amounts of saline and injected intravenously by syringe. It cannot be effectively given by intravenous drip. From the point of view of replacement therapy at least 2 to 4 Gm. of fibrinogen should be administered in order to restore the clotting ability of the blood. This amount is based on the fact that 8 Gm. of fibrinogen or more are present in the total blood volume of the average patient. Constant observation may reveal that these alterations in the blood of patients with severe toxemia may occur more frequently than has hitherto been suspected.

The medical treatment of the eclamptogenic syndrome as outlined usually extends over a period of forty-eight to seventy-two hours from the time that the patient is first observed. The patient should have improved at the end of that time as evidenced by the stabilization of the pulse and blood pressure and increase of urinary output subsequent to the treatment of the hemoconcentration and the control of the convulsions. However, it is felt that the improvement which has occurred is only transient in nature and complete recovery will not ensue until the uterus has been emptied of its contents.

Termination of the pregnancy should be done in the most conservative manner. The survival of the baby must on occasion be given secondary consideration for the welfare of the mother. If the patient is near term and the cervix is favorable for induction, artificial rupture of the membranes will usually suffice to initiate labor. If the fetus is premature, i.e., less than 2000 Gm. in weight or less than 35 weeks gestational age,

pelvic delivery is preferable to cesarean section, for the latter is not warranted in the presence of a high fetal mortality due to prematurity. However, at this time in pregnancy the stage is not properly set for the successful induction of labor by artificial rupture of the membranes, because the cervix is not effaced and barely dilated. One must then resort to the use of a foreign body to initiate labor and dilate the cervix. Certain objections can be raised to the use of a dilating bag. However, in this situation it is believed that the risk of using the bag is less than that of abdominal hysterotomy. It is believed best not to rupture the membranes artificially prior to the insertion of the bag for two reasons: First, the intact membranes serve as a partial barrier against the possibility of intra-uterine infection which may accompany the insertion of the bag. Second, if the membranes are intact, a Braxton-Hicks version can be readily performed at a later time. Following the removal of the bag the dilatation which has occurred by this time is usually sufficient to allow one, after artificially rupturing the membranes, to do a Braxton-Hicks version with relative ease. It must be granted that this procedure will jeopardize the baby, yet it will also insure prompt delivery within a relatively few hours after this operation has been carried out. It is believed that the combined procedure is less hazardous to the mother than cesarean section.

Cesarean section should be reserved for those patients with severe preeclampsia with more mature infants where the cervix is not favorable for induction or if there is any question as to the cephalopelvic relationship. The same type of treatment can be applied to the eclamptic patient when the pelvic conditions are the same, but only when the disease has responded well to the medical treatment and the patient is in comparatively

good condition. This means that the patient must not be in coma or stupor. Her blood pressure should be well controlled. The pulse should be below 100 beats per minute and the patient should be free of fever. Cesarean section in such circumstances is the preferable method of delivery. However, it is not the operation to be instituted in desperately ill patients or those who are not under adequate medical control. One can only continue medical therapy until such a time that the patient has shown sufficient improvement to institute the obstetric procedure necessary to successful termination of the pregnancy.

Summary

An attempt has been made to outline a conservative policy in the management and treatment of patients with severe preeclampsia and eclampsia. Special emphasis has been placed on certain metabolic changes that occur in this disease. Replacement therapy has been suggested which it is hoped may prove useful in the successful treatment of this disease.

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OFFICE GIRL PRACTICE

In the last few years, the practice has spread (and it probably reaches back many years) of office girls practicing medicine. We have had some complaints consequently. While the doctor is on vacation, his patients frequently call the office girl or office nurse and ask questions, and the answers involve the practice of medicine. Technically, these questions should not be answered but should be referred to some responsible person selected or designated by the doctor. We know that the office staff is pretty well acquainted with what the doctor is doing for a particular patient and can, undoubtedly, carry out his ideas during his temporary

absence. In cases of emergency, that is the best that can be done, unless another doctor is available to supply the answers. When this type of office prescribing is done, records should be kept and referred to the doctor immediately upon his return. Wherever possible and wherever the question is of any real medical significance, great care should be taken to secure the really proper reply, and from authoritative sources. This may well and properly mean calling another doctor and asking him the question.

Don't chance a malpractice suit. You're responsible for your agent's action!—*Journal of Michigan State Medical Society*.

Familial Periodic Paralysis as Traced in One Family for Five Generations

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THIS rare syndrome was first described by Cavare^{1, 2} in 1853. Since that time about 400 cases from all parts of the world have been reported in the literature.^{3 to 11} The clinical picture, in brief, consists of:

1. Recurrent flaccid paralysis of all or part of the somatic musculature below the neck.
2. Hereditary transmission by either parent.
3. Impairment of deep reflexes and impaired electrical excitability of involved muscles.
4. Absence of sensory or psychic disturbances.
5. Lowered blood serum potassium during attacks.
6. Attacks may be produced in most susceptible individuals by the administration of glucose, insulin, or epinephrine and terminated by means of a potassium salt.

The clinical picture as presented by this group of 25 cases from one family is reviewed because it is the largest similar group reported, and because the observations include six generations and cover a span of sixty years. Seventeen of this group were reported in detail by Holtzaple⁴ in 1905, and 8 new cases were interviewed by the writer a few years ago along with some of Holtzaple's cases, bringing the report of this family up to date.

Three additional cases in patients from the same area of rural York County, who may be related to this same family, are reported briefly.

This family is of "Pennsylvania Dutch" stock and, for the most part, still live in rural York County, Pennsylvania. Table I shows the relationship of the 24 cases to other members of the family and also summarizes the clinical picture of each case. Apparently the malady is dying out of this family, one reason being that as its members became conscious of the hereditary nature of the malady they were inclined to limit the number of their offspring, and some remained single for the same reason. Eight cases of this disease were transmitted by the father and

nine by the mother. Thirteen cases were males and twelve were females. Approximately one-third of the first, one-half of the second, one-fourth of the third, one-tenth of the fourth, and one-twelfth of the fifth generations were afflicted. It is probably a dominant trait and is not sex-linked.

In contradistinction to a group of 16 cases from one family reported by McQuarrie¹³ in which penetrance was complete, one non-afflicted parent (J. G.) transmitted it to five children. This parent, however, had severe migraine and had marked weakness of both legs late in life.

In addition to the periodic paralysis, many members of this family had typical migraine headaches. This relationship has been noted by Stewart,¹⁴ Talbott,¹⁷ and others^{24, 25} in other families. The father of the first generation had migraine and so did five of the ten members of the first generation. (One member of the first generation (J. G.) had severe migraine frequently, and five of her seven children had periodic paralysis and three died during an attack.) Ten of the 25 cases were known to have typical migraine.

This affliction in its typical form as found in this family is characterized by periodic flaccid motor paralysis, involving all of the voluntary muscles except those of the face, eyes, tongue, organs of speech and of swallowing, and sphincters of the rectum and bladder. The attacks tend to be more severe and to occur at more frequent intervals in young adults, but later in life become milder and less frequent.

Incidentally, it was found that most of the cases in this family group presented the typical clinical picture as judged by the literature. Examples of almost all of the unusual manifestations of this condition were found also. This same phenomenon was noted by McQuarrie¹³ in his report on 16 cases in a single family. He concluded that "the manifestations, as shown by the age of onset, the frequency, duration, and severity of attacks, and the duration of the disease are

as varied as those observed when nonrelated affected persons are compared," and that "the variability of manifestations may be due, in part, to intrinsic factors rather than extrinsic."

Most members of this family began to have attacks of paralysis at about puberty or later, in the second decade. The extreme in ages at onset was 8 and 31 years. During intervals between attacks they were well. The attacks usually occurred during the night (from 1 to 3 a.m.), it being not uncommon for individuals to go to bed apparently well and to awaken during the night completely paralyzed from the neck down. Individual attacks varied in length from one hour to four days with an average duration of about twelve hours. The attacks occurred at from daily to yearly intervals. Most of the cases in this family had mild and infrequent attacks with no permanent sequelae. Several were interviewed by the writer who were over 70 years of age and who were in relatively good health, although J. S. had "weakness of the legs since childhood" and knee reflexes were absent at the

time of the interview. Case 1 had weakness of the leg muscles and later developed paralysis. Two of Dr. Holtzapple's cases, Case 1 and J. G., had some permanent paralysis of the leg muscles late in life. The six persons who died during attacks ranged in age from 24 to 54 years.

The paralysis may be partial or complete, localized or general. The upper extremities alone or only the lower may be involved. It may be confined to the neck, or one-half of the body may be completely paralyzed, or partial paralysis may affect the other half. During an attack of paralysis there may be one or more periods of marked improvement, usually of a few hours' duration, followed by complete helplessness. In a typical attack of complete general paralysis the patients are utterly helpless, cannot move a finger or toe, and can neither lift nor turn the head on the pillow, but the mind is clear and the speech is unaffected. In some instances breathing becomes distinctly labored, and deep breathing, coughing, and vomiting are impossible. The order of involvement is not always the same. It most fre-

TABLE I

Case No.	Age at Onset	Sex	Usual Time of Onset	Duration of Attack	Number of Attacks	Migraine	Cause of Attacks	Age at Time of Report
1	14	M	Night	..	Many	..	Rich food	70—(1905)
2	24	M	..	..	..	..	..	..
3	15	F	Night	..	Many	..	..	33—(1905)
4	?	M	Night	15 hours	..	..	..	18—(1905)
5	20	M	..	..	Many	..	..	Died in attack, age 54
6	16	M	..	..	Weekly	..	Worse during cold weather	Died in attack, age 25
7	31	F	1 a.m.	..	Occasional	Yes	..	..
8	?	M	..	..	..	..	..	Died in attack
9	17	M	Night	2-72 hours	Frequent	Yes	Overeating	Died in attack, age 27
10	16	M	Night	3-36 hours	Frequent	..	Cold, damp weather	Died in attack
11	?	M	Night	..	..	..	..	Died in attack, age 43
12	?	F	Night	..	..	Yes	..	..
13	?	F	Night	..	Frequent	..	Damp weather	24—(1905)
14	16	M	Night	..	..	Yes	Rich food	..
15	10	F	Night	1-90 hours	Occasional	Yes	Oysters	50—(1942)
16	?	M	..	..	..	..	..	..
17	22	F	Night	12-15 hours	Frequent	Yes	Overeating; damp weather	40—(1905)
A. S.	?	F	Night	12 hours	Occasional	No	?	55—(1942)
C. S.	40	M	Night	3 hours	2 attacks	No	Winter; oysters	54—(1942)
J. S.	20	F	Night	3-24 hours	2-3 times a year	No	?	79—(1942)
M. B.	20	F	Night	1-24 hours	1	No	Overeating	45—(1942)
D. S.	15	F	Night	..	..	No	?	41—(1942)
P. Z.	12	F	Night	1-20 hours	1 a month	Yes	Oysters; menstruation	30—(1942)
E. J.	?	F	Night	2-12 hours	Occasional	No	?	50—(1942)
R. P.	18	M	Night	4-10 hours	Occasional	No	?	56—(1942)

J. G. No paralysis. Severe migraine. Marked weakness of legs late in life. Died at age 76. Three sons died in attacks.

NOTE: Case numbers are same as used by Holtzapple.⁴

quently begins in the muscles of the lower extremities, but sometimes these are the last to be involved. There are rarely any sensory symptoms, although in some instances the patients complain of numbness or pain on movement of the paralyzed parts. During an attack of complete paralysis, the reflexes and faradic excitability are abolished in the affected parts but generally return to normal with recovery. Some individuals could predict an impending attack; others could not. If any symptoms preceded an attack, they were usually a heavy, tired feeling or a feeling of muscular weakness. The most common factors that seemed to precipitate attacks, according to the patients, were cold damp weather, chilling, excessive amounts of rich food or sweets, unusual exercise, worry, fatigue, certain foods, and menstruation, in the order named.

Case Reports

The following three cases of familial periodic paralysis are from the same section of rural York County, Pennsylvania, and may be related to the family just discussed. These cases consist of a father and son and daughter. The father, W. Q., had a typical history of this condition, but the two children were atypical in that the first few attacks that were observed were not the classic type of paralysis just described. The parents described the children as being rigid during early attacks and complaining of pain on movement of arms and legs. Collier¹² mentions two cases of this type, but does not describe them in detail. McQuarrie also describes a case having muscular stiffness at the onset of an attack.

CASE 1.—W. Q., age 32, the father of Joan and Jerry, had his first attack of paralysis at the age of 14. It was a fairly typical attack. The patient stated that he awoke during the night with paralysis of both arms and legs. This paralysis lasted four hours. He had no pain except when he tried to move his legs. Seven nights later he had the same type of attack following unusual exertion. His subsequent attacks ordinarily followed unusual exertion and ingestion of excessive amounts of sweets. The attacks lasted about six hours and all were similar to the first attack. He was never unconscious and never had any difficulty in talking or swallowing during an attack.

During recovery from an attack the paralysis would leave the arms first, then in a short time the legs, and in a few hours the patient would be able to walk. The attacks gradually became less frequent and less severe. During the past few years the attacks have been very mild. He claimed that after working hard or becoming chilled he often noticed, late in the evening, definite weakness of his leg muscles, making it difficult to climb the stairs to bed. His general health had been good and the only other serious illness was diphtheria at the age of 10. He had had no allergic signs or symptoms. The family history revealed that his mother and two sisters had had urticaria and several siblings had infantile

eczema. There was no history of paralysis or migraine in relatives.

The patient was a Caucasian man of slight build, but apparently in good health. Superficial and deep reflexes were normal and the Kahn blood test was negative.

CASE 2.—Joan, age 5, the daughter of William, had her first attack of paralysis, which lasted seven days, at the age of 2½ years. She has had only a few attacks since that time. The first attack observed by the writer occurred during the winter. It came on as usual about 1 a.m. When examined at 9 a.m., she was lying in bed, apparently not seriously ill. She had no fever and the pulse and respirations were normal. She could talk and move her head, but could not move her arms or legs. She cried out with pain when an attempt was made to move her arms, legs, or body, which were rigid. Her mother explained that this was a typical attack and that she had had several before, always in cold weather and usually following some unusual exertion and excessive ingestion of sweets. The attacks generally lasted from one to two days.

Physical examination showed her eyes, ears, nose, and throat to be normal. There was no neck rigidity. Respirations and heart sounds were normal. The abdominal reflex was questionable. There was some abdominal muscle resistance to palpation. The arms and legs were stiff and seemed to cause pain when moved. Reflexes were not elicited because of pain. Family history included the father, whose case is reported above; the mother, who was living and well; and six siblings, all living and well. There had been no similar complaint in the family except the father and one brother. There was no allergic history, except the maternal grandmother, who had asthma, and the paternal grandmother and several paternal aunts, who had urticaria and eczema. The past history revealed that the general health of the patient had been good; she was normal at birth and developed normally. She had had no serious illnesses.

Physical examination one day after the attack of paralysis showed a well-developed and nourished Caucasian girl. No abnormalities were found. The deep and superficial reflexes were normal.

Urinalysis and blood count were normal. Serum potassium taken during an attack was 9.6 milligrams per cent. The spinal fluid showed 4 lymphocytes; the Kahn test was negative, the mastic test 00000, and there was no increase in globulin.

NOTE: The patient was seen in several attacks, following the attack described, in which she had the typical flaccid paralysis of the extremities and absent reflexes.

CASE 3.—Jerry had his first attack of paralysis in the spring of 1938, at the age of 5 years. There was no associated illness. It came on during the night and lasted about twelve hours, as did all subsequent attacks. He called his mother about 1 a.m. and she found his arms and legs stiff and paralyzed. He could swallow, talk, and move his head. He had no pain, but was frightened at his inability to move his arms and legs. There was no fever, vomiting, or loss of sphincter muscle control and there were no convulsions. The paralysis disappeared during the next afternoon and by evening he was well. All his attacks have occurred during cold weather, usually in the spring or fall. A sudden change of weather or a chilling seems to be the causative factor. He averages about three attacks a year—all, apparently, about the same. The first attack observed by the writer was in the fall of 1939. This was a comparatively mild attack, starting at 2 a.m., but the

patient was not seen until about 10 a.m. He was lying in bed with paralysis of both legs and partial paralysis of his arms. On examination he was found to have no fever, no pain, and did not appear seriously ill.

On physical examination the eyes, ears, nose, and throat were normal. The neck muscles were not stiff. Heart sounds were normal, with a rate of 80. The lungs were clear. Expansion was normal and equal. The abdominal reflex was present. The arms showed moderate weakness, with a tendency to be stiff. The biceps and wrist reflexes were present. His grip was equal in both hands, but weak. The legs were stiff. Knee jerks were present, but apparently movement of the legs caused pain.

The Babinski test was negative. There was normal sensation over the trunk and extremities. He was given potassium chloride, grains 10, and in one hour he seemed well and was able to walk about as usual.

Physical examination after recovery from the attack revealed no neurologic or physical abnormality.

The patient's birth was normal and his general health good. He had an attack of rheumatic fever in February, 1940, with bilateral knee joint arthritis and muscle pains. No heart murmur was heard in February, but a faint systolic apex murmur was heard in March, 1940. The parents were poor and the boy's diet had not been ideal.

Urinalysis and blood count were normal. The Kahn test was negative; the spinal fluid showed no cells and no increase in globulin; the mastic test 11,000. Spinal fluid sent to the State laboratory showed the Kolmer complement fixation to be negative, and the colloidal gold, 0,0,0,0,0,0,0,0,0. The electrocardiogram showed myocardial damage, right ventricular hypertrophy, right axis deviation, negative P₄, slurring of QRS, and negative T₄. These findings were probably due to rheumatic fever. Electrocardiographic changes have been noted during an attack, but they are not permanent.¹⁴

NOTE: Jerry was seen by the writer in several attacks following the one described. The later attacks consisted of flaccid paralysis of the extremities described previously as typical for this disease.

Etiology and Pathology

Most evidence (Pudenz¹⁵ and Ravina¹⁶) suggests that the lesion is in the central nervous system. The role of potassium in the etiology or pathology of this syndrome is intriguing, but will not be discussed here except to enumerate a few pertinent facts. Most observers^{17, 18} found serum potassium levels during an attack to be below 12.0 milligrams per cent and normal (17.0 to 19.5 milligrams) between attacks. It can be demonstrated that the attack of paralysis can be produced in the majority of susceptible individuals by giving sufficient glucose, insulin, or epinephrine, which reduce serum potassium.^{15, 16} Low serum potassium in diabetic acidosis may cause respiratory failure according to Nicholson¹⁹ and Holler.²⁰ A diet low in potassium has produced paralysis in dogs and an increased serum potassium occurs after adrenalectomy. It is also increased in Addison's disease, in status epilepticus, and in 50 per cent of infantile tetany

cases according to Gradwohl.²⁹ The thyroid seems to be involved in some cases, as cures following thyroidectomy have been reported.^{21, 22, 23}

Electro-encephalograms are normal during and after attacks according to Watson,⁸ and abnormal during attacks according to Stewart.¹⁴

Differential Diagnosis

Familial periodic paralysis must be differentiated from atonic cerebral diplegia, early myotonia congenita, acute anterior poliomyelitis, polyneuritis due to infection, poison, toxins, vitamin B deficiency, and so forth; transient paralysis following convulsions, recurrent polyneuritis, myasthenia gravis, disseminated sclerosis, neuromyelitis optica, tic paralysis, and hysteria. Usually most of these possibilities can be eliminated immediately. Isolated atypical cases, however, may be confusing.

A therapeutic test with potassium chloride or induction of an attack with epinephrine, insulin, or glucose as noted above should make the diagnosis.

An accurate serum potassium determination is a delicate procedure, so should not ordinarily be relied upon.

According to Ford,²⁸ "the recurrent attacks of weakness or paralysis occurring over a period of many years are almost pathognomonic. The diagnosis is greatly strengthened if a positive family history is obtained, and if the electrical reactions are lost during an attack, the classification of the disease cannot be questioned."

Treatment

Dr. Holtzapple believed that "triple bromide mixture" (contains potassium bromide) gave the best results as treatment during an attack and as a prophylactic. Most of the cases in this family interviewed by the writer are still using his treatment of triple bromide, but two are getting satisfactory results with potassium chloride, grains 10, whenever necessary. The three cases treated by the writer were relieved promptly with potassium chloride, grains 10. Avoiding excessive ingestion of carbohydrates, especially in cold weather, seems to prevent attacks in some individuals. Most cases, but not all, according to the literature, are relieved by taking potassium salts. Cholinergic drugs relieve attacks in some patients but not in others.^{26, 27} Thyroid extract is also effective at times as well as subtotal thyroidectomy.^{23 to 27}

Summary

1. Eight additional cases are added to a family group of 17 cases of familial periodic paralysis reported by Holtzapple in 1905.

2. The clinical picture of the disease, as revealed by this family, is presented.

3. Three additional cases, probably from the same family, showing unusual manifestations, are reported.

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THE HEALTH POSTER CONTEST

This contest, discreetly wished on the Woman's Auxiliary, has finished up a great success in Northampton County. The Auxiliary agents visited the school districts—urban, suburban, and rural, after which came an era of quiet and your secretary-editor began to think the contest would be "just another of those things." Then about a week or ten days before the judges were to act, posters began to pour in upon him and the committee, until the number totaled several hundred.

The corridors of the Nazareth High School "Arts and Crafts Department," with the cooperation of Miss Clute, the art teacher, were begged from superintendent Mareks, and when the Auxiliary committee finished the work of hanging posters the walls were covered from one end to the other, and also most of the available space of the walls of the music room, and even after that a number of posters had to stand on tables and hang from table tops; it was no easy job to hang all those posters. Then on Thursday, May 5, the committee of judges, appointed by President Brenholtz of the Auxiliary, went to work. The chairman was George Grim, former County Superintendent of Schools; other members were Miss Mary Hess, formerly a teacher in the Hellertown and Bethlehem schools, and Mrs. William R. Stecher of Easton. The posters stood or hung facing the judges with every possible identifying mark concealed. For a whole morning the three judges

walked up and down, the discussion waxed earnest—no one has suggested that it was "heated"—and finally after a long session the winners were announced.

These posters will all be entered in the state-wide contest in September. Our society owes a debt of gratitude—and some cash expended in travel and telephone bills—to the members of the Auxiliary, to the various teachers of art, to the school nurses in several of the rural districts (particularly Miss Balliet of the East Allen and Moore Townships), as well as to the three judges. In Bangor the service clubs cooperated by conducting an elimination contest in which they also offered prizes.

Prizes offered by the medical society are five dollars, three dollars, and two dollars in each class. It is planned to award them at the commencement exercises of the various schools.—*The Bulletin* of the Northampton County Medical Society, June, 1949.

"... A national compulsory health law by contrast in its final evolution defeats and denies private initiative and throws instead the entire burden upon government. At the same time it will lower the standard of health care by its quantitative methods as European experience has convincingly demonstrated."—THE MOST REVEREND KARL J. ALTER, D.D., Bishop of Toledo, Ohio.

"Simplifying" Dermatology for the Practitioner

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SOME thirty years ago, a Yugoslav, speaking a dialect utterly incomprehensible to the available interpreter, entered my clinic with an extensive dermatitis. He received two prescriptions, and was told in sign language what we thought appropriate to instruct him in their use. One was for 3 per cent ichthyol in unguentum zinci oxidi (Stokes' mud as my preceptor, Dr. Pusey, used to call it). The other was for Pusey's alkaline laxative—a mixture of cascara, syrup of rhubarb and potash compound, and milk of magnesia. A week later the patient returned much improved. As he stood stripped, I thought I detected an odd odor, sniffed him up and down, and caught the smell of aromatic rhubarb. Then we *did* hunt down an interpreter in real earnest and found that he had eaten the ointment and applied the laxative with excellent results for his skin.

A year or two later, on the eve of reading a paper before the American Medical Association in Boston, I arrived at my hotel in the throes of a violent attack of pruritus ani et scroti, at an hour when no help was obtainable. I could hardly picture myself taking the stage at nine the next morning. In desperation I inuncted the only thing I had available, a well-known tooth paste which at that time contained oil of peppermint and potassium chlorate. In the ensuing bonfire I achieved a one-night cure. Ever since I have been watching with interest the possibilities for simplifying dermatology for the practitioner. I have even shown that a scalp lotion can work at both ends.

The Practitioner's Difficulties

The difficulties that practitioners experience with dermatology arise first from deficiencies in teaching, which fail to delineate the average doctor's field in fundamental terms of physiology, pharmacology, physical diagnosis, and therapeutic principle; and second, from the fact that the doctor himself seems to take leave of his basic medical common sense and knowledge when he

encounters a dermatosis, and wanders like a little boy lost in the thicket of redness, scale and scratch, the impossibly complicated terminology, and the etiologic hiatuses of the early days of the specialty.

There are, all told, not more than a dozen conditions with which the average doctor needs to be conversant, and a few cat's-eye markers that warn him to seek advice. There is a not too complicated physical diagnosis, seldom taught as such. There is an anamnestic background which the Hebra type of dermatologist explicitly ignored and did not teach. There is a basic tissue reactive mechanism very similar to that in other medical conditions. There is a therapy so simple that I have often said that I had seen a whole repertory of symphonic cures played by an expert on a five-key therapeutic piano. And there is even a psychosomatic treatment of the skin that, when properly used, can teach psychiatrists a thing or two and put the Pharmacopoeia with the x-ray machine onto the side table.

To attempt to deal adequately with any one of these fields in twenty minutes savors of high farce, and to cover them all would show that I had reached the age of indiscretion if I even thought of attempting it. But I can attempt a sampling, if I may have your indulgence for my presumption, and for a dogmatic tone due to overcondensation.

The dermatology of everyday practice is mainly inflammatory, i.e., dermatitis; and its failure to stay well, even more than to get well, brings the consultant into the picture. Next in order of importance are the erythemas and urticarias, then the neurodermatoses, the premalignancies and malignancies, the granulomas, the metabolic disorders and cellular dyscrasias, and finally the rarities. Translating these diagnostic groupings into etiologic terms, we find that infections and allergic disorders dominate the field. Intoxications, including drugs, come next, then disturbances associated with endocrine, renal, hepatic, and glucometabolic disorders, sweat disorders, the seborrheic or excessive fat gland activities and their reverse inadequacies (in the form of xeroderma). Perverted vascular physiology,

Read before the Section on Dermatology at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 5, 1948.

particularly flush and stasis, is climbing higher in importance; neurogenic factors, both general and local, which basically involve the itch-mechanism and the vascular and sweat mechanisms through the nervous system, are growing in importance too. The histamine triple response reaction and sweat physiology and chemistry in their own right are the most recently appreciated etiologic forces in the production of many dermatologic pictures.

Going back to dermatitis at the head of the column, infection with pathogenic strains of staphylococci and streptococci dominates the dermatitic dermatology of ordinary practice. It is hard to conceive a dermatitic picture in which primary or secondary activity of these organisms, and particularly hemolytic staphylococci, does not presently come to play some part. They complicate and at times obliterate the symptomatology of the next great group of infections, the fungi, which seldom hold the dermatitic field alone for long, being quickly overrun by pyogens. Next should be named the complications rather than the actual forms of virus disease, for viruses are only on the threshold of recognition yet, and manifest much of their causal participation by the sensitization to pyococci which they apparently induce. As causes of infections not dermatitis, we have the spirochetoses, tuberculoses, and other granuloma-producing organisms.

In the allergic field the practitioner must be constantly on the lookout for epidermal allergy or contact sensitivity; for vascular allergy ranging from urticaria to periarteritis nodosa and lupus erythematosus disseminatus; for the wide range of infection-allergies, focal and local, which produce the perplexing "ids" in both the dermatitic and the granuloma fields; and especially for the generalized flares that are based on a local bacterial or fungus process gone berserk as the individual becomes allergic to his infecting agent. And finally, for the moment at least, the practitioner is of necessity concerned with atopy and the skin as a shock structure in the eczema-asthma-hay fever complex.

The Causal Interplay

In any etiologic analysis, adequate to the securing of lasting results, the physician must search for the interplay between the etiologic agencies. The seborrheic-infective complex, for example, in one of its phases is a staphyloiderma; in another it can be a mycotid or fungous-allergic manifestation. The flush and stasis vascular mechanisms determine the localization and persistence of infections. The neural controls, many of them in the sympathetic system, deter-

mine the flush, the stasis, or the sweat. The sugar metabolism affects the severity of infections, the intertriginous localization to apocrine sweat areas (apocrine sweat is high in sugar), and the refractoriness of other infections through its influence on hydration and glucose accumulation in the skin. The hydration of the skin and the acid-base equilibrium influence infections. Drug intoxications are inextricably entangled with infections, of which, according to Milian's biotropic conception, they, the drugs, are merely activators, the drug intoxication being in reality partly an infection revival or an infection-allergic manifestation.

It must be clear then that, if the practitioner is to move rationally in his proper field of dermatology, the commoner dermatoses, he must have at least some familiarity with the basic etiologic elements not only of skin disease but of disease, and infection, and allergy at large.

Physical Diagnostic Essentials

Suppose we turn now for a moment to physical diagnosis and offer one or two samples of "simplification." The practitioner can learn to identify by sight the vesicle, pustule (even a tiny one or two), the crust, (and distinguish it from) the scale. He can identify cracks or fissuring, and leather or lichenification. On the vesicle, its ooze when ruptured and the crust, depends his recognition of acuteness in an inflammation and its corresponding soothing therapy; on the milium pustule (which it takes a lens often to see), the staphyloiderma; on the scale, the crack and the leather, the chronicity of the process, and its corresponding need for stimulative therapy. Furthermore, he must know the finger feel of *induration* which identifies the granulomas and lymphoblastomas; he must have an eye for arcs, which are apt to mean something dangerous rather than merely "ringworm"; and he must spot atrophy and scars which again mean something serious and destructive. Induration, arc, and scar are a critical triumvirate in skin physical diagnosis and, when identified, call for critical general study, usually a biopsy, and always a serologic test for syphilis.

One of the most revealing elements in skin physical diagnosis to me is distribution. Although there are too many special cases from mule-spinners' cancer of the scrotum to nail-polish dermatitis of the eyelids for a complete enumeration, several great groups of what might be called "habitus" distributions provide important and easily remembered keys to the identity and causal background of a wide range of erup-

tions. These are illustrated in the following figures.*

To appreciate distribution along with the identification of the elementary lesions, it is essential to stand off far enough to recognize the geography or topography of the eruption. It is this as much as anything that makes necessary the inspection of the entire body in a really adequate dermatologic examination. As one inspects the whole body one appraises the person also for height-weight ratio, vasomotor lability, sweat activity, and above all for the signs of nervous tension and make-up which form so important a part of our currently developing psychosomatic approach. The French clinicians, particularly Ferrand, in my acquaintance were adept at this eye-summarizing, and I have known Ferrand to send a patient back to the dressing room for a urine examination before he was half across the theater of his clinic, and to receive a report of glycosuria as the patient later stood stripped before him, after predicting that the test would be positive.

Differential Diagnosis and Etiologic Analysis

Once the practitioner has identified the process as a dermatitis (or a possible granuloma, or other destructive lesion, or a pre- or actual malignancy, or finds himself frankly at sea and in need of advice), he must proceed to etiologic analysis instead of reaching for the prescription pad, as he too often does from sheer lack of confidence in himself. To be sure he may at this point feel that he has to retreat behind the alcove curtain to consult the book and find a picture, though I have learned to bring the books right out onto the desk and pore over them with the patient rather than to be shamefaced about it.

The physician will next have to draw on a mental or a visible list of diagnostic possibilities determined by what he has seen in the way of lesions, localization, habitus, etc. These lists are the stock in trade of the expert and the amateur alike. He ought not to rely on a snap "impression" (an abominable word and concept for which I have always blasted the student) and say it "looks like" this or that. He must accept the labor of analysis based on objective signs and rigorous differentiation, or be a dub. We will suppose that he has accepted this responsibility even to the point of refusing to call a rash a drug eruption just because the patient has been taking a drug. Having decided or nearly decided what

the patient has, he must now proceed to figure out why the patient has what he has.

Causal analysis in dermatology contributes to immediate relief and it nearly always determines ultimate cure, that is a lasting result, by treatment. Causes have had the minor share of attention through the period when dermatoses were being differentiated from each other on the basis of morphologic characteristics. Neglect of them established the saying that a dermatologist's patients never die and they never get well. Now causes are coming into their own again, and patients are being cured under the modern revival of basic physiology, under the reapplication of general medical principles, and under the concepts of multiple cause and generalized or type-form reactions, of which Hans Selye's work¹ is so significant an example. This is just another way of saying that the well-trained, fundamentally thinking medical man can take dermatologic etiology in the same stride that he does etiology throughout the whole field of disease. He must begin by recognizing that causes are rarely single; that there is a foreground and a background group of causes of which it is easier to study and emphasize the former than the latter; and that there is always the tendency to *post hoc* thinking and, if I may say so, to overuse of let-

THE ICTHYOTIC COMPONENT IN DERMATITIS AND ECZEMA

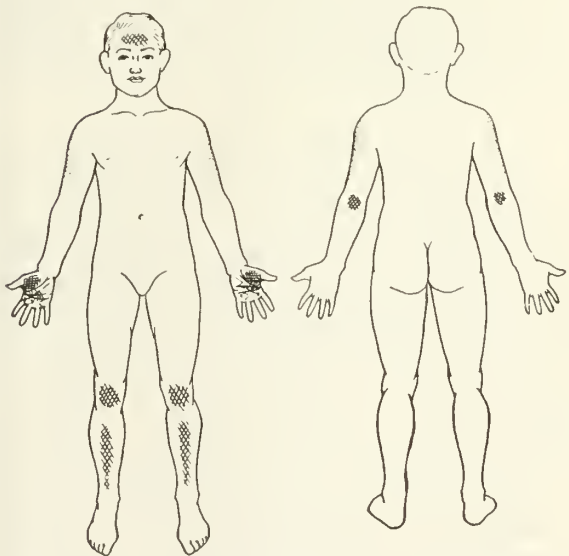


Fig. 1. The distribution landmarks of the ichthyotic component in "eczema" etiology. This "dry skin" element is recognized by the "parchment" or heavily striated palm, the tendency to horny plugging of the hair follicles along the outer sides of the arms, the ready callusing of elbows and knees, and the presence of dry, plate-like scaling on the uninfamed forehead and pretibial skin. From *Fundamentals of Medical Dermatology* by John H. Stokes and associates (7th revision), Philadelphia, 1942.

* These are selected from *Fundamentals of Medical Dermatology* by John H. Stokes and associates, 7th revision, 1942.

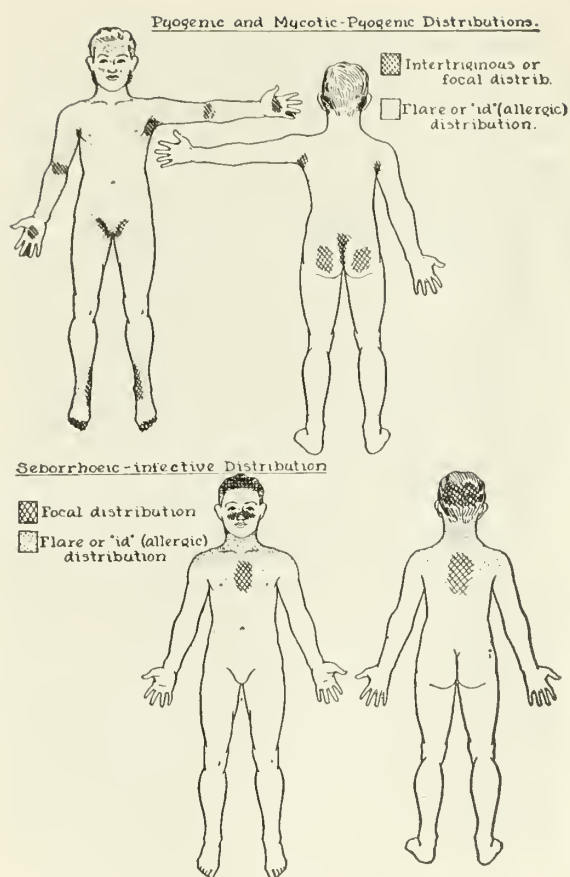


Fig. 2. From *Fundamentals of Medical Dermatology* by John H. Stokes and associates (7th revision), Philadelphia, 1942.

out or escape diagnoses, including overemphasis of the neurogenic factor. "It's your nerves" when, as a matter of fact, it's your kidney, and your ancestors.

Taking the Dermatologic History

Causal analysis begins with the taking of a history, which can be done before or after the examination and which requires from twenty to forty minutes for the inflammatory dermatoses in general. The carefully taken history explores the family and constitutional or habitus trends; seborrheics run in families; so do dry-skinned or xerodermic persons, and each has his own way of reacting to irritants, infections, etc. Pyogen or staphylococcus and streptococcus susceptibles run in families and with them goes infection-allergy. Allergies run in families, and the more complicated psychoneurogenous and vascular background of the EAHF or eczema-asthma-hay fever type does likewise. Unstable nervous systems and vascular systems and the neurogenic background in general are largely identified or at least forewarned of by family history. Diabetes forewarns of skin hydration and glucose storage

and perverted metabolism with increased infection susceptibility. Diet, contacts, bathing and cleansing practices, habits and practices of work and rest, and the tensions and troubles of the patient himself must be asked about, for the key to a successful analysis may be in any one of these compartments or any two or more of them taken together. It is impossible to list in a short space the full compass of a quiz of this sort, but I have brought a few history sheets from my office to illustrate what I mean. Is it worth the trouble? After thirty years and more, I can say that it certainly is.

Perhaps an example or two will bring out the multiple cause element in the commoner inflammatory dermatoses. Take the staphylodermas—seborrheic, mycotic-pyogenic, virus-pyogen, apocrine hyperhidrotic, intertriginous, etc. A patient with extensive and persistent staphyloderma is apt to come from a family with more than the usual proportion of rufous individuals, and whose members have had staphylococcal lesions of various kinds such as acute ears, eczemas of the auricle and canal, furuncles, acne, impetigo, styes, and erysipelas, in much more than an average frequency. A diabetic or two may turn up, but even without a family history of diabetes, an overweight person on a high alkaline-ash, high-sugar diet (fruit, fruit juice, and sweets) can be expected to be promoting his skin infection by hydration and the beginnings at least of a threshold or non-glycosuric prediabetic state. His history may suggest further that he is an allergic individual, hence probably infection-allergic; his vasomotor reactions suggest that he is overworked, worried, and of a neuro-susceptible type. The flare that brought him to you followed two weeks or less after an attack of diarrhea with fever thought to be due to food poisoning but coincident with a wave of "virus X" infection in the community—in other words, a virus-pyogen sequence, likely to be repeated in the future. And examination of his mouth shows him to be edentulous except for four rotting snags at the front of his lower jaw. On examination of his urine he turns out to have clumped pus cells and albumin. His prostate is enlarged and boggy.

Of what use is it to write this patient a prescription for an antibiotic ointment or give him a few lamp or x-ray treatments, and send him away? Unless all the elements of his factor analysis get adequate attention, or at least a majority of them, his staphyloderma will persist.

Take the boy or girl with acne. A factor analysis of acne by Sternberg and myself a decade or more ago revealed, I think, 13 causal elements

and I believe three more have been added since that time. No one of them offers the single key. Dysfunction of the pilosebaceous system has an endocrine and a vitamin factor in it. It has also a profound neurogenic element which may perhaps be a thalamic dysfunction or may be dependent on the flush reactions of the face, scalp, and even neck and shoulders expressive of deeply concealed resentments and stigmatization. I now have a class of young men, steadily growing, in whom recovery has followed the stopping of treatment and the removal of the psychogenetic drives that were disturbing each individual. This is not to say for a moment that acne is a psychoneurosis. In its foreground it is a seborrheic-infective process with metabolic, hereditary, psychogenetic, endocrine, and vitamin elements all crowded into the background. As I have become cognizant of this interplay and of modes of dealing with it, two of my four x-ray tubes have just been removed from my office and the use of x-ray in acne has shrunk to almost nothing in my practice. What is there about such an analysis of the acne complex that the practitioner versed in medicine cannot undertake to deal with?

Time is too short to permit my planned examples of the EAHF complex and the dermatophytic-pyogenic-allergic eruptions of the hands and feet to be summarized here, but some of you at least are familiar with our Army lecture on hands and the paper by Walter Lee, Howard Johnson, and myself² that summarized it, so that you realize the approach is medical, and easily accessible to any well-trained doctor who will take the time to use it.

"Simplified" Treatment

Now we must proceed to simplify treatment. Let us begin instead by complicating it with the statement that good treatment, as I know it, does not consist in treating one factor or cause, general or local, at a time. It consists in treating as many as possible all at the same time—in using the therapeutic battery in salvo, not gun by gun. Go after everything you honestly believe you can correct or help, even if, as it sometimes means, the patient pays more for his first prescriptions than he does for his first office consultation, and has to go to school, in the form of painstaking verbal and written instruction in your office, to learn what he is to do and *why he has to do it just so*. In other words, practice good medicine on him as well as good "skin." I cannot over-emphasize how many failures are due to not doing enough, and to not educating the patient as to what, how, and why. It takes time and it cuts

down income (a single visit may cure an affair of months and even years standing), but it fills the appointment list for weeks ahead.

The first generality I would offer in the cause of simplification is that excellent dermatology can be practiced without a single piece of treatment machinery in the shop and especially without x-ray or radium. The chief exception to this sweeping statement is in the treatment of the premalignancies and malignancies of the skin and mucosa, in which one should strike with every resource at once, and in which the worst mistake of even the equipped man is to try one thing, then another, fractionally, and each in just insufficient amount. The tools of good general and much special dermatologic practice remain relatively few and simple.

Pusey, who was a master of this simplified therapy, used to say that you could always recognize a dub at golf because he appeared on the links with a trunk full of clubs. The amateur at dermatotherapy is the prescription collector, the man whose desk is covered with a changing array of samples and at whose office door one usually meets a detail man coming out. This is

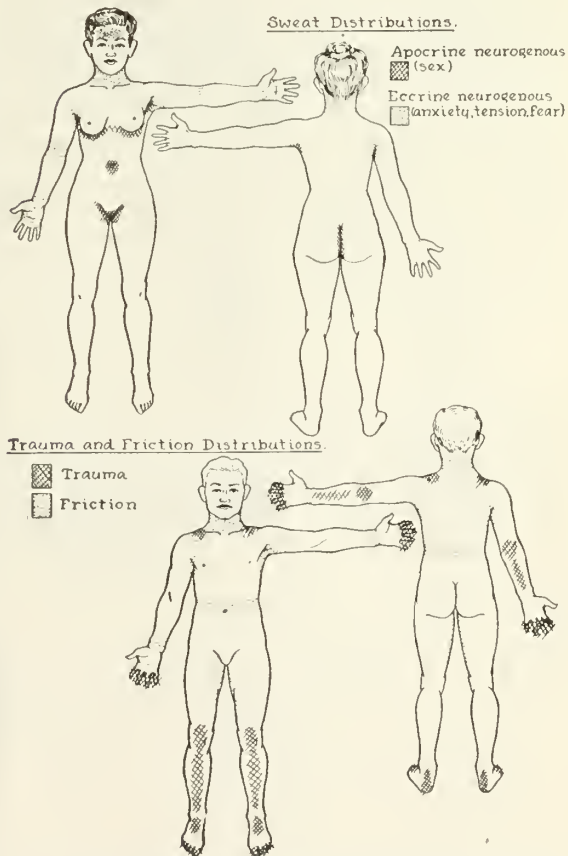


Fig. 3. From *Fundamentals of Medical Dermatology* by John H. Stokes and associates (7th revision), Philadelphia, 1942.

not to minimize the worth of many pharmaceuticals, especially since the antibiotics began to appear, but too often their contribution is in the field of elegance rather than necessity.

The complex antiseptics, other than the dyes; the so-called fungicides and the fungus inhibitors and most of the newer penetrant and detergent vehicles are a help, but by no means a necessity. Even the antibiotics and especially the sulfonamides have the double-edged quality of inducing allergic sensitivity in exchange for a short-lived improvement. They do not change the background or they alter it unfavorably. The new antipruritics that act by inducing anesthesia rather than treating the cause; the new sedatives that blunt the central end of the itch mechanism and numb the patient's sensibility to his neurogenic itch stimuli have similar weaknesses. It is wise, therefore, to stay a long enough time with a single rationally indicated and somewhat old-fashioned therapeutic agent to find out how to use it, and if you can, how much of its usefulness is due to the base and not the medicament, and to the look of confidence in your eye and the ring in your voice as you prescribe it. As one

observes the powerful influence of psychotherapy on the behavior of dermatoses one is more and more impressed with the maxim I give my EAHF patients, "Any old salve will do if you get the philosophy."

Of course, this can't be literally true; it is possible for a salve to cause serious results, and it was done to the extent of making dermatoses major casualty producers in the last war. Can we frame a few rules that will keep us on the hither side of doing damage in our skin therapy? Only a dermatologist will appreciate the folly of my attempt, but I shall make it nonetheless.

Some Rules of Thumb for Dermatitis Dermatotherapy, as of 1948

1. *Do what is medically indicated*, and do it promptly, for the patient as a whole.

2. *If in doubt about the skin, soothe it*; if it is acute, as shown by vesicles, oozing, crusting, or scaling plus crusting, *soothe it*. If it is chronic, soothe it first, then cautiously try stimulation.

3. *Soothing means wet dressings*, compresses, baths for extensive processes and for sedational balneotherapy; grease or a detergent substitute to restore the fat-protection against infection and allergens, and the preservation of the "acid mantle" by avoiding the raising of skin pH by any agent, especially soaps. The modern detergents are effective non-alkalinizing cleansers.

4. *Weak potassium permanganate solution* (1:4000 to 1:8000), saturated boric acid solution, thin boiled starch solution and Burow's solution (1 to 16 aqueous dilution), in the order named, are adequate for (a) relief of burning and itching and (b) nearly all local antibacterial effect (especially the KMnO_4). Wet dressings of antibiotics are experimental.

5. *Every wet dressing must be followed by a grease*. The official boric acid ointment is a good all around grease. Cholesterinized paraffin bases, lanolin carriers, and ointments rendered hydrophilic are useful but have disadvantages and are not essential. A non-allergic grease is a highly refined paraffin.

6. *Make it a rule never to add more than 2 per cent of anything to an application*, and especially an ointment, until you are an expert. One-half to one per cent of most things like antiseptics and tars, sulfur (good old sulfur!), and scale dissolvers such as salicylic acid and resorcin is enough to start with.

7. *Promote drainage of infected surfaces and promote vasoconstriction by wet dressing*. Do not allow to dry.

8. *Start antibacterial measures early* since most of the commoner inflammations soon develop secondary if they are not primary infections.

9. *These include*, in addition to (4) and (7), the use of dyes (the Castellani carbolfuchsin paint is the best) and one-half per cent ammoniated mercury. No iodine, no bichloride.

10. *Short wave-length light* is a useful bactericide (cold quartz lamp, S-1 lamp, R-S lamp) in just below to just above a mild erythema dose.

11. *For fungi* try the ointment-based undecylenates.

12. *If you must use antibiotics*, prefer tyrothricin to penicillin if usable, because it is less sensitizing. Streptomycin is markedly sensitizing.

13. *Use sulfur* (start with 1 or 2 per cent) on the *scborrhic patient*, and just plain grease (cholesterin-

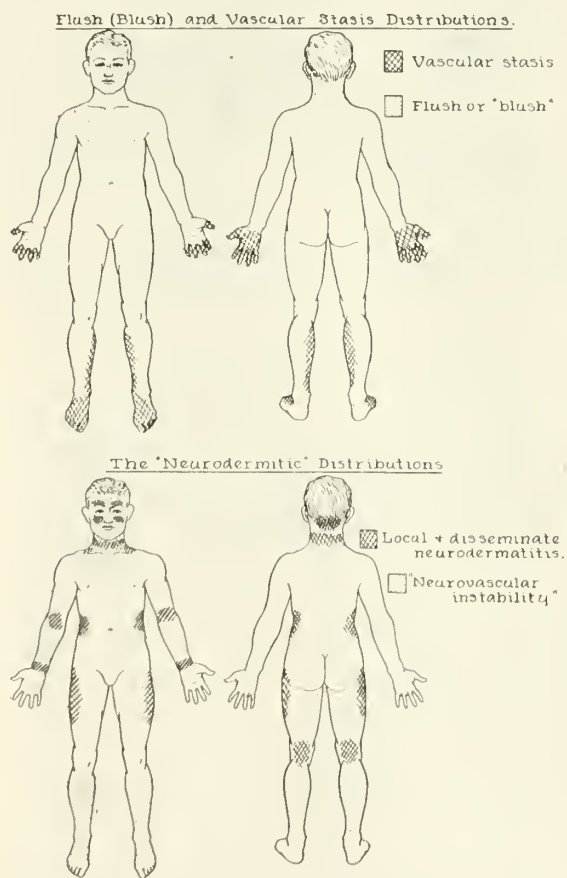


Fig. 4. From *Fundamentals of Medical Dermatology* by John H. Stokes and associates (7th revision), Philadelphia, 1942.

ized petrolatum or boric acid ointment) on the xero-dermic patient. Never mind the fancy names and bases.

14. *Use the antihistaminics* where there is an allergic background or urticarial or marked pruritic symptoms. Pyribenzamine is our preference thus far, 2 per cent ointment, 50 milligrams three times daily and 100 milligrams at bedtime.

15. *Dehydrate the patient* and swing him toward the acid side of his acid-base equilibrium by prescribing a high protein, low fruit, and low sugar diet, and glutamic acid hydrochloride by mouth.

16. *As a semi-empirical or stock anti-allergic procedure*, (a) avoid known allergens of any kind, not foods alone; (b) in staphylodermas and "ids," avoid the White-Cormia-Flood allergens (milk, chocolate, orange, nuts, tomato, pork); give 10 cc. autogenous whole blood once or twice weekly with calcium gluconate 10 per cent solution, 10 cc. intramuscularly.

17. *As desensitization or hyposensitization therapy* against bacterial agents and more specifically staphylococci, we have found most useful (a) the Squibb multiple strain phage-lysed staphylococcus vaccine with toxoid (marketed as ambotoxoid), and (b) autogenous house-dust extract, which is a goulash of the patient's local bacterial and fungus and foreign protein (dust) allergens.

18. *I do not recommend* trichophytin hyposensitization or Rhus antigen.

19. *Control of the flush and vascular stasis mechanism* may make the difference between success and failure in the whole range from rosacea to blue hands and feet, to outright low-grade or marked venous stasis of the leg and foot (varicosities). The latter, which can be remedied by elastic compression bandaging, may maintain an "athlete's foot" indefinitely.

20. *Psychotherapy*, the setting of the patient at rest in fundamental ways and not by a merely ephemeral flourish of barbiturates, plays a fundamental part in dealing with all the inflammatory dermatoses, and not with the neurodermitides alone. The operator's receptiveness and his conviction that the patient can be helped are integral parts of the mechanism. Relatively simple tension-reducing measures are often effective. Calcium and atropine are often all that is called for as sedative medication.

Wasn't it Hahnemann who said, "Die milde macht ist gross"?

This brings me to the close of what, as a twenty or even a thirty-minute literary adventure, any dermatologist would have recognized as folly. Inevitably it is at best only a confession of

faith in my own methods. Much that bolsters up and activates this skeleton before you has been dealt with more extensively elsewhere. I have brought with me a few samples of instructional material for patients, intended to develop the doctor-patient relationship most conducive to effective treatment, in use in my practice, for such of you as may be interested in seeing them.

Summary

1. The physician competent to practice good modern medicine can practice good modern dermatology over a wide range, especially of the overwhelmingly common inflammatory dermatoses, by applying some relatively simple diagnostic rules; by being analytically and not impressionistically minded; by using his medical knowledge in interpreting and treating the whole patient, and not merely his skin.

2. In doing so he must accept multiple causes and causal interplay; he must treat as many of the causes as possible wherever they may appear in body or mind; and he must treat them all at once and not piecemeal.

3. Modern polypharmacy, chemotherapy, and even the antibiotics have helped but hardly revolutionized and in some instances have seriously prejudiced dermatologic therapy. The chief valuable contributions have been the detergents and wetting agents, the antihistaminics, the unsaturated fatty acids and, within limitations, the antibiotics. Without any of them, good and rational dermatology can still be practiced.

4. A similar statement applies to some of the physical agents used in skin therapy.

5. A series of 20 personal suggestions for a simplified dermatologic therapy covering the range of skin inflammations other than the granulomas is offered.

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Results of Conservative Treatment of Peptic Ulcer

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IT IS now a fairly well accepted fact that the treatment of uncomplicated peptic ulcer is essentially a medical problem. This study is presented to add further evidence in favor of this concept.

All peptic ulcer patients who were admitted to the Geisinger Memorial Hospital during the ten-year period beginning Jan. 1, 1937, and ending Jan. 1, 1947, have been reviewed. Age occurrence and sex incidence for both gastric and duodenal ulcer have been tabulated. A more complete study and follow-up evaluation has been made of those patients who were treated with medical measures alone. This was the only means of selectivity used in this study. All of the patients have had ulcers proved either by characteristic x-ray findings or by surgical exploration. Patients with excellent histories for peptic ulcer permitting one to make a clinical diagnosis, but with normal gastro-intestinal x-rays, have not been included. No individual examined and treated completely in the out-patient department has been included. All of the patients studied have had symptoms severe enough to warrant hospitalization and, accordingly, were admitted.

A total of 438 patients have been reviewed as indicated in Table I. Of this number, 96, or 21.9 per cent, have had no recent follow-up visit, nor have they responded to a questionnaire regarding this problem; 128 patients have required surgical treatment and will not be discussed except to be included in the general statistics of age and sex; 205 of the 438 have been treated medically and have been either followed regularly or have responded to the forwarded questionnaire. The questionnaire was sent to all patients who had not been seen either in the out-patient or hospital services within three months. This questionnaire concerned itself with the symptoms of the individual, method of treatment being followed, length of time such treatment has been followed, incidence of disability, and condition of health in general as well as the status of

the ulcer at the present time. This study is essentially concerned with the above-mentioned 205 cases.

There were 152 cases of duodenal ulcer and 53 with gastric ulcer. Each type of ulcer is discussed separately.

TABLE I

Total number of patients studied	438
Total number of patients with duodenal ulcer ..	344
Total number of patients with gastric ulcer ..	94
Total number of patients with gastric and duodenal ulcer	17
Number of patients having no office visit recently and not responding to questionnaire ..	96
Percentage of patients studied with no recent checkup or questionnaire response	21.9%
Total number of patients followed under medical treatment	205

Plan of Treatment

The principles of medical management of peptic ulcer which have been practiced in this hospital are largely those of the Sippy program. This includes rest, physical as well as mental, diet, antispasmodics, and alkalis. The dietary program used is the usual progressive Sippy diet. The individual is placed on the progressive scale according to his general status at the time of hospitalization. By that I mean that all patients are not necessarily started on the first-week Sippy diet if it is thought that they can tolerate a more generous one. The usual alkalis administered are the Sippy tablets—magnesium oxide with sodium bicarbonate, and calcium carbonate with sodium bicarbonate. These are commonly given on a two-hour schedule. Aluminum hydroxide gel is used also, but not as frequently as the alka-

TABLE II

	Duodenal Ulcer	Gastric Ulcer
Total number of patients	344	94
Males	287	79
Percentage of males	83.4%	84%
Females	57	15
Percentage of females	16.6%	16%
Number with acute perforated duodenal ulcer	45	
Percentage with acute perforated duodenal ulcer	13%	

Read before the Section on Medicine at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 6, 1948.

From the Medical Department of the George F. Geisinger Memorial Hospital, Danville, Pa.

TABLE III

Age	Duodenal Ulcer	Gastric Ulcer
10-20	4	..
20-30	40	3
30-40	65	16
40-50	96	26
50-60	92	33
60-70	30	7
70-80	17	6
80-90	..	3

line tablets. This is most often used with patients who are either unable to tolerate the tablets or on whom they seem to be ineffective. Tincture of belladonna as the antispasmodic of choice is used in practically all cases. Usually upon discharge from the hospital the ambulatory Sippy diet is provided. As the patients progress and improve at home, medication is discontinued and they gradually modify their diet to a less restricted program. However, most patients eliminate from their diet selected foods difficult to digest. Surgical treatment is reserved for the complications of peptic ulcer and for those refractory to medical treatment.

Age and Sex Incidence

The usual predominance of peptic ulceration in the male is present in the ratio of about six to one as shown in Table II. Age occurrence, as presented in Table III, indicates the majority of patients to be older than most studies reveal.

The fifth and sixth decades have the largest number in contradistinction to the third and fourth decades. Three patients over age 80 were discovered with gastric ulcers. The oldest was aged 84. The youngest patient was a 15-year-old girl with a duodenal ulcer. Both gastric and duodenal ulcer occurred most frequently in the fifth and sixth decades.

The cases followed have been classified according to their symptomatology and treatment after the plan of Nichol. As we see in Tables IV and V, there are five groups.

- Group I. The patients are completely asymptomatic under no treatment or diet.
- Group II. The patients are completely rehabilitated, but follow modified diet restrictions.
- Group III. The patients have some mild dyspeptic symptoms periodically, but no disability.
- Group IV. The patients have had some disability as hemorrhage, perforation, or some such event to cause bed rest.
- Group V. The patients are those with constant symptoms who require constant treatment.

We are considering patients of Groups I, II, and III as those getting along very well under medical treatment. Those in Groups IV and V may perhaps be listed as failures of medical man-

TABLE IV
FOLLOW-UP STUDY OF DUODENAL ULCER CASES TREATED MEDICALLY
Total patients followed—152

Years followed	1	2 to 4	4 to 6	6 to 8	8 to 10	10+
Number of patients	21	44	25	20	22	20
Group I						
Number	14	24	10	4	13	3
Percentage	66.7	54.6	40	20	59.1	15
Group II						
Number	5	8	3	3	2	5
Percentage	23.8	18.2	12	15	9.1	25
Group III						
Number	..	3	5	4	3	2
Percentage	..	6.8	20	20	13.6	10
Group IV						
Number	2	7	5	7	2	7
Percentage	9.5	15.9 (3x)	20 (1x)	35 (2x)	9.1 (1x)	35 (2x)
Group V						
Number	..	2	2	2	2	3
Percentage	..	4.5	8	10 (1x)	9.1	15

(x—uncooperative in treatment and/or alcoholic.)

agement. This statement should be qualified, however, since several patients in these latter groups are the uncooperative ones. They either do not follow any ulcer régime and refuse all medical advice or often are frequent users of alcohol.

Results

The follow-up results in the patients with duodenal ulcer revealed the information as recorded in Table IV. Cases are listed according to the length of time followed and results obtained. It is evident in these statistics, as in those reported by other investigators, that the longer a patient is observed, the more likely he is to have recurrence of symptoms. A total of 66.7 per cent of the patients followed for one year were free of all symptoms. Generally speaking, the percentage decreases as the follow-up period increases. However, a startling figure is noted in the eight to ten year group, which has almost a 60 per cent recovery rate. This includes essentially the same number of patients as in the one year group. Only 15 per cent of the cases followed for more than ten years remain well.

Less than 10 per cent of the cases followed for one year required constant treatment or had serious disability. This percentage increased again as the period of time lengthened, save for the eight to ten year class. The most uncooperative patients are marked with an (x). These

are either alcoholics or those who absolutely refuse to follow any ulcer régime. Such patients all fall into the non-satisfactory Groups of IV and V. The summation of this table shows that the majority of patients, an average of over 70 per cent followed over a period of ten years for duodenal ulcer, have good results on medical treatment. Only a very small percentage, 10 per cent or less in any one follow-up period except those over ten years, require constant medication and diet for constant disabling symptoms.

In the gastric ulcer series presented in Table V, almost the same results are found. These patients, however, usually get along better. A greater percentage remain free from symptoms in any one follow-up period compared to duodenal ulcer. The total number of cases is smaller; therefore, the statistics are not as reliable. This shows that from 55 to 78 per cent of the patients remain essentially free of symptoms throughout the ten-year period. An additional 10 to 44 per cent require a diet or have mild dyspepsia. The percentage of cases requiring constant treatment or experiencing some serious disability is smaller than in those with duodenal ulcer. This is probably because these patients are more readily subjected to surgical procedures. Both of the patients followed for more than ten years refused to adhere to any regulated treatment program and have refused consideration of a surgical procedure. Concerning the three cases

TABLE V
FOLLOW-UP STUDY OF GASTRIC ULCER CASES TREATED MEDICALLY

		Total number of patients—53					
<i>Years followed</i>		1	2 to 4	4 to 6	6 to 8	8 to 10	10+
<i>Number of patients</i>		9	16	9	8	9	2
<i>Group I</i>	<i>Number</i>	7	9	5	5	5	..
	<i>Percentage</i>	78	56.2	55.6	62.5	55.6	..
<i>Group II</i>	<i>Number</i>	..	1	2	..	1	..
	<i>Percentage</i>	..	6.3	22.2	..	11.1	..
<i>Group III</i>	<i>Number</i>	1	3	2	2	..	..
	<i>Percentage</i>	11	18.7 (1x)	22.2	25	..	..
<i>Group IV</i>	<i>Number</i>	1	2	..	1	2	2
	<i>Percentage</i>	11	12.5	..	12.5	22.2	100 (2x)
<i>Group V</i>	<i>Number</i>	..	1	..	..	1	..
	<i>Percentage</i>	..	6.3	..	..	11.1 (1x)	..

(x uncooperative in treatment and/or alcoholic.)

followed eight to ten years with treatment failure, one is a chronic alcoholic, one is now 83 years old, and the third having severe cardiac disease is obviously a poor surgical risk.

Summary

1. A total of 438 cases of peptic ulcer were reviewed and, of this number, 205 patients treated medically and followed from one to ten years are discussed.

2. The age occurrence in the total of 438 is higher than that reported by most investigators. The majority of patients are in the fifth and sixth decades.

3. An average of 70 per cent of patients with duodenal ulcer are either completely rehabilitated or have only mild dyspeptic symptoms when followed from one to ten years.

4. An average of about 10 per cent of the patients can be classed as medical failures.

5. Conservative medical treatment is still the method of choice for uncomplicated duodenal ulcer, with surgical procedures reserved for the complications and treatment failures.

6. More than 80 per cent of gastric ulcer patients are practically well when followed one to ten years.

ABSTRACT OF DISCUSSION

PAUL L. SHALLENBERGER (Sayre): I would like to compliment Dr. Collins on his handling of a difficult subject. I believe that there is a great need to re-emphasize the fact that all uncomplicated ulcer cases are medical and not surgical problems. He covered 152 cases of duodenal ulcer and 53 cases of gastric ulcer and showed clearly the end result of medical management of those cases over a ten-year, plus, period. I would like to point out that the primary diagnosis, that is, the evaluation of the patient when first seen, is the most important part of the entire medical management. The examination must be adequate and complete, because it determines the future course of the patient.

The psychogenic factors that are going to be evident in the course of the patient's progress should be determined in large part at the first or second examination of the patient. They should be evaluated as properly and as accurately as possible, and, of course, the treatment planned with them in mind.

I believe that an indication for surgery is the inability of the patient to manage his living with an ulcer. That is not usually taken into consideration adequately or with enough significance. There are many people who cannot live with an ulcer. Education of the patient in the earliest stages of the ulcer is as important as the diet or the alkalis that are given.

The question of medical or surgical management of gastric ulcer is extremely important, because upon that decision rests the future of many patients. The doctor selecting the course, whether it be medical or surgical, has a great responsibility if the patient does not cooperate. If the patient cannot cooperate, medical management is extremely dangerous.

At the present moment our plan of management (and I say "the present moment" advisedly because next week it may be different) of gastric ulcers at the Guthrie Clinic at Sayre is as follows: An accurate diagnosis of the case is made, or attempted, on the first examination. Physical examination, including a search for Virchow's glands, is followed by a minimum laboratory examination of the blood count, urinalysis, Kahn test, gastric fractional analysis, and any cytology that can be used, complete fluoroscopic and x-ray examination, and a gastroscopic examination.

We feel that most of the cases (perhaps 96 or 97 per cent) can be accurately evaluated if proper emphasis is placed upon each of these methods of evaluation. Then a decision is reached as to whether the case is medical or surgical. If it is surgical, it is the internist's job to prepare the patient for surgery. If it is medical, the patient is maintained on an extremely rigid management for about three weeks. At the end of the three-week period, he is completely re-evaluated, that is, another history is taken and fluoroscopic, x-ray, and gastroscopic examinations are made. If at this time the ulcer has not healed, the case is usually surgical. However, if it has healed, or shows evidences of healing, it does not completely exclude the possibility of a malignant ulcer.

Another three-week period is given the patient. If at the end of this six-week period the ulcer is not completely healed, after the same evaluation again, the patient is considered a surgical case. Medical management thereafter is risky, dangerous, and should be adopted only after a great deal of thought. None of these methods of evaluation are infallible. The x-ray as well as the gastroscopic examination has its difficulties. If we wait until there is no acid present, we have waited too long. However, if we use all of the methods available at this time, and give each its proper balance and weight in the picture, I believe that an accurate diagnosis can be made and the patient's course determined.



Lupus Erythematosus and the Collagen Diseases

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DISSEMINATED lupus erythematosus has been recognized as a disease entity for the past fifty years. Since 1911 the many facets of its expression have been clearly described by Libman and Sachs,¹ Gross,² Baehr,³ Stickney,⁴ and Reifstein⁵ and the basic structural tissue changes were described in detail by Klemperer.⁶ Though the early symptoms are often vague and the expression protean, in its fully manifest state it should rarely be misdiagnosed.

In essence it is an illness found predominantly in white females of the second and third decades. Since it is a disease of the mesenchymal derivatives, the morphologic lesion is seated in fibrous connective tissue and its product collagen and the functional alteration is related to the activity of the reticulo-endothelial system and its derived cells. The minute ramifications of the arterial system and their supportive structures in the covering or surface tissues undergo a curious hyaline degenerative change resulting in a characteristic "inflammatory" reaction in the pleura, pericardium, endocardium, peritoneum, joint lining, and skin. Thus arise symptoms of pleurisy and pleural effusion, pericarditis, cardiac murmurs, ascites, arthritis, and a characteristic skin rash. Analogous vascular structures in kidney glomeruli and interstitial tissues of the heart and lungs are involved resulting in kidney dysfunction, myocardial failure, and pulmonary disease. The aberrations in reticulum function are expressed in increased serum globulin levels, leukopenia, thrombocytopenia and anemia, enlargement of the spleen, liver, and lymph nodes, and eventually in abnormal sensitivity reactions and loss of resistance to infection.

To review the results of a study of a relatively small series of nine cases of lupus erythematosus would add little to what is already known of this most interesting condition. Today the features of interest about lupus are its relation to the other diseases of the so-called "collagen group" and the mechanism by which the degenerative

process and altered function, apparently common to all, are produced.

We have chosen to consider as members of this group: serum sickness, periarteritis nodosa, rheumatic fever and, of course, disseminated lupus erythematosus. We should also like to include rheumatoid arthritis for reasons which will be stated later.

Though the symptoms of these diseases are sufficiently kaleidoscopic to serve as the material for a general text on symptomatology, actually the fundamental lesions are found in but a single system, the mesenchymal derivatives. The primitive mesenchyme gives rise to connective tissue, fat, cartilage, bone, and reticulum and the functions of these derivatives in their adult state can be summarized as those of support and locomotion, repair and defense. Let us first review the structural alterations as seen through the microscope in this group of diseases and then examine the evidence of abnormal function.

In those patients dying of lobar pneumonia who at death showed clinical evidence of serum sickness due to serum therapy there were proliferation of the endothelial lining cells of heart and blood vessels, a fibrinoid degeneration of the fibrous vessel wall, a perivascular monocytic, lymphocytic, and plasma cell infiltration, and changes in the capillary permeability which resulted in urticaria.^{7, 8} Note that all of these changes are found in the adult tissue derivatives of mesenchyme. The reaction is essentially a degeneration of connective tissue and intercellular collagen and a proliferation of the cells which spring from reticulum.

Periarteritis nodosa is characterized by degenerative and inflammatory changes in intermediate and small arteries. The degeneration of the fibrous tissue is first manifested by swelling, then by splitting into fibrinoid strands, and finally by hyalinization and then fracture. The cellular exudate in young lesions is of the same mononuclear type as that in serum sickness though it is eventually replaced by neutrophilic and eosinophilic leukocytes which one might expect in consequence to the ensuing necrosis. Should one compare the classical lesions of serum disease

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and periarteritis nodosa, the similarity is not striking; but if one thinks of the one as a progression of the other, an idea which is supported by experimental data,⁹ these lesions appear to be of the same genus.

The hallmark of rheumatic fever is the Aschoff body, but in fulminant cases in young children the classic pattern becomes distorted to more closely approximate a widespread fibrinoid necrosis of the fixed fibrous tissue and collagen and a proliferation of the motile elements from reticulum. The lesions are situated in relation to the smallest representatives of the arterial system and in the supportive tissue most closely associated with the blood stream. Again the lesion is different in pattern and extent from the two previously discussed, but the same types of tissue are involved and the kind of degenerative reaction appears to be the same.

The structural alterations in rheumatoid arthritis are also located in the fixed mesenchymal derivatives—fibrous tissue, cartilage, bone, and skeletal muscle, but the reticulum is also involved. The changes in the fibrocytes and their formed collagen are not greatly dissimilar to those in cases of attenuated rheumatic fever in adults. Indeed, if one reads the textbook descriptions of the rheumatic and the rheumatoid nodule, one finds it difficult to find real differences. In the fibrous structures of the joints there is fibrinoid degeneration and the endothelial and motile reticulum derivatives are as much in evidence here as in rheumatic fever though their arrangement is not that of the Aschoff body. In the diseases mentioned thus far cartilage, bone, and muscle lesions are not characteristically manifest, so we cannot compare these aspects of rheumatoid arthritis with other collagen diseases, but it is significant that osteoid, the matrix of hyaline cartilage, and muscle are all mesenchymal derivatives. Though in the late stage of the lesion's life cycle the picture is largely that of regeneration, in the earlier degenerative and inflammatory stages the osteocytes and chondrocytes apparently suffer the same type of injury as that seen in the fibrocytes.

The tissue alteration which characterizes lupus erythematosus has been stated to be a fibrinoid degeneration of mesenchymal tissue. By this is meant a peculiar hyalinization of the cytoplasm of fibrocytes and its associated collagen, a splitting of the tissues to form a fibrillary pattern, and eventually a dissolution into a substance resembling degenerating fibrin. Actually this does not completely describe the changes seen in the fully developed lesions. Everywhere are found alterations in arterioles and capillaries in the na-

ture of a proliferative endothelial reaction and associated aggregations of histiocytes, lymphocytes, and plasma cells.

Thus we find that the morphologic changes involve not only collagen but all the derivatives of the mesenchymal system. It should also be stressed that not only are there alterations in the morphology of this tissue system but, quite as important, there are changes in its function. The common functional change seen in all of these five diseases is the increase in serum globulin. At some stage in each of these conditions it is usual to find an elevation in the globulin fraction. At present it is hazardous to draw conclusions which are founded upon our knowledge of globulin formation since evidence is as yet incomplete, but there is much to support the hypothesis that it is the product of reticulum activity.¹ Just how globulin formation is concerned in lymphocyte and plasma cell production is not yet clear, but there is very probably some close relationship. The rather constant elevation of the serum globulin level in the collagen diseases becomes significant when we remember that reticulum is also a mesenchymal derivative. This enhances the concept that these diseases are the result of a process which affects a single embryonic tissue type creating both morphologic and functional alteration.

Just what is this process? In serum sickness and in periarteritis nodosa it appears to be an abnormal response by the mesenchymal derivatives to an antigen, a hypersensitivity reaction. In rheumatic fever it is probably an altered reaction to the hemolytic streptococcus or its product. In rheumatoid arthritis and lupus one is tempted to suppose by analogy that these diseases are also the result of an abnormal reaction to an antigen, but to date there has been no clinical nor experimental evidence for the existence of such an antigen.

However, even though lupus and rheumatoid arthritis are the expressions of an abnormal response to an antigen, the clinical and even the morphologic changes are different enough from those of serum disease, periarteritis, and rheumatic fever to cause one to turn his attention to another factor or group of factors within the organism which may affect these tissues. These we have chosen to call the modifying factors.

One set of these factors appears to be the endocrine hormones. Although we are far from an understanding of the relationship of the adrenal cortical, pituitary, and perhaps gonadal hormones to the reactions of the mesenchymal system, the data presented in recent years make us quite positive that such a relationship exists.

Still another factor, constitution, the "stuff" out of which the mesenchyme is made, must not be omitted for it quite surely plays a role in determining the reactions of these tissues.

In conclusion, we have expressed the idea that the collagen diseases are the various manifestations of a process which affects the structure and function of not only connective tissue but all the derivatives of the primitive mesenchyme. A comparison of their lesions and evidence of their abnormal activity lead us to believe that this process is concerned with the reaction of immunity. Since a variety of antigens cannot be demonstrated, we propose that the variations in these diseases may be explained on the basis of modifying factors within the tissue system itself. For an understanding of the mechanism of these

reactions we must wait for a clearer delineation of the physiology of immunity.

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EXCERPTS FROM AMA SECRETARY'S LETTER

AMA People Attend Washington Hearings. Several AMA people went to Washington recently in connection with House and Senate committee hearings on pending national health bills. Among those who attended were: President R. L. Sensenich; Speaker Francis F. Borzell; Dr. Lowell Goin, a member of the House of Delegates; Dr. Louis H. Bauer, chairman of the executive committee of the AMA Board of Trustees; Dr. Ernest B. Howard, assistant secretary; Dr. Harvey B. Stone, member of the AMA Council on Medical Education and Hospitals; J. W. Holloway, Jr., director of the AMA Bureau of Legal Medicine and Legislation, and myself.

Results of Diabetes Detection Drive. Dr. Howard F. Root, of Boston, of the American Diabetes Association, reports that the diabetes detection drive, which was inaugurated by the association during Diabetes Week, December 6-12, covered 145,960 patients, including 37,243 children. The program is continuing and the results are not yet complete.

No money was sought from the public during the drive. Local committees of doctors from county medical societies provided for free testing of urine of patients either in the doctors' offices or in detection centers.

This attempt by American physicians to attack a public health problem without asking for money is certainly a good-will gesture.

Diabetes week this year will be observed from October 10 to 16.

Major General Grow to Head Air Force Medical Service. General Hoyt S. Vandenberg, Air Force Chief of Staff, recently announced the organization of the U. S. Air Force Medical Service within the department of the Air Force. It will be headed by Maj. Gen. Malcolm C. Grow, the Air Surgeon.

Highlight of the plan for the service is the provision assuring career opportunities for personnel. Housing for medical officers and their families, stability of assignment, and opportunities for medical and scientific advancement are features of the plan.

"Medical specialists are assured of opportunities for advanced training in both clinical medicine and research in aviation medicine. Professional facilities of general hospitals and laboratories, approved civilian institutions and air force facilities will be used to provide regularly spaced training tours for members of the air force medical service," the announcement stated.

The plan is designed to correct major objections of professional people to a career in the armed forces. Medical officers will be given every opportunity to pursue their specialties and doctors and dentists who volunteer to serve for more than one year will continue to receive the extra \$100 a month. Officers, nurses, and enlisted technicians who qualify and are assigned flying duties will receive additional hazard pay.—GEORGE F. LULL, M.D., AMA Secretary and General Manager.

LUMBAR SYMPATHECTOMY

Increasing interest has been shown in recent years in measures producing increased arterial circulation in the extremities by interruption of the sympathetic nerve pathways. In the lower extremities the most effective and permanent method of producing vasodilatation and increasing blood flow is lumbar sympathectomy. At one time arterial sympathectomy was thought to be an adequate procedure, but for the most part it has been abandoned because of the fact that the sympathetic denervation following its use is incomplete and of relatively short duration.—*West Virginia Medical Journal*, March, 1949.

The Role of the General Practitioner in the Prevention of Psychiatric Disorders

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AN OLD and logical story points out that the best way to ensure a long, healthful life and a prosperous old age is to *select one's parents with the greatest of care*. To be certain that our *adult* patients have good mental health, we must train them properly when they are children. Who shall do it? Certainly not the psychiatrist. His contacts with patients are "too few and too late." The only men who can turn the trick for the vast majority are the general practitioners.

At one end of the life span you must team with the pediatrician to orient parents so they will not be too severe a problem for their children to manage during the nursery years. At the other end, you must join the specialist in geriatrics to promote constructive interests and hobbies that will make the transition to old age a busy, healthy, dignified, and happy era and postpone premature senility due to loss of interests and withdrawal from reality. Between these extremes, it is your role to stabilize your patients through stresses associated with disease, adolescence, marriage, child-bearing, marital friction, involutional changes, desertions, deaths, and the innumerable blows that the Fates decree.

Good preventive medicine must begin early. To strengthen the soma, there is need for proper diet, rest, exercise, and inoculations to help the body to tolerate the impact of pathogenic bacteria. To strengthen the psyche, there is need for development of a sense of security, accomplishment, and tolerance toward the impact of people, cultures, and emotional tension.

The child is born with a great need for "security." He is precipitated abruptly into a hostile world where he must strive and work (breathe, eat, et cetera) or die—a world of pain, noise, hunger, and cold. He is the most helpless of all animals, unable even to search for food; able to use only the proximate senses of taste, touch, and smell, and two semi-voluntary coordinated mus-

cular acts, the "sucking reflex" and crying. To make matters more difficult, the human infant is born into a world of conceptual ideation at a time when words are only noises and when he is not even able to focus clearly on material objects. He can protest to and against his environment only vocally or by food rejection.

All parents now seek advice on what is needed for the baby's stomach, and they are becoming increasingly interested in knowledge concerning needs for the baby's mind.

It is your duty to impress upon them the child's intense fear of rejection and his need for a stable, harmonious home. He needs obvious gestures of affection. Only in this way can he be certain that he is wanted and loved and develop a feeling that his home and his parents belong to him.

There can be security only if parents are taught the importance of keeping their promises. They must be helped to understand that rules for children must be reasonable, clear, and administered firmly, consistently, and without creating undue fear of punishment in the mind of the child. As a matter of fact, children despise parents who are afraid to discipline them. They prefer mild and appropriate punishment. It bolsters their conscience and gives them a feeling of security. It is evidence of law and order. Parents must be taught not to display undue concern when a child refuses to eat or has a fall or minor injury. They can better understand the importance of a proper attitude if you explain the obvious relationship to neurotic responses in adulthood.

When examination of a woman patient discloses that a new baby is to be added to a family, advice is immediately given to the expectant mother to prepare her for the event. But have you thought to explain to her how she must prepare the first child for the arrival of a competitor? How the child must be taught to feel a partnership interest in the new sibling? How the parents must strive to make him feel that the

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new baby has not caused him to be displaced in their love and affection? Help them to understand that excessive jealousy will spoil proper sibling relationship and may set up a pattern which interferes with adult friendship.

A sense of security is only the first step, a secure base from which he can launch a healthy, successful campaign against his environment. He must develop pride and confidence in personal accomplishment. His curiosity must be encouraged and he must explore on the material level through his senses and theoretically through his questions.

Parents must be taught to restrain their natural tendency to do *too much* for the child. Because it is quicker to tie his shoes for him or to feed him is not an adequate reason for preventing the development of manual skills and for blighting his initiative. Let him make mistakes, pass through trial and error and find that success follows persistence. Parents must remember that a feeling of accomplishment comes from within the child. They cannot give it to him, but they can make a great contribution toward helping him to achieve it. He must not be made to feel inferior by forcing him beyond his capacity. Assign him tasks which he can accomplish successfully and do not demand perfection. Instead, set a goal of progressive development and improvement.

We see altogether too many cases of neurotic and psychotic illnesses precipitated by well-meaning parents who demand impossible successes of their children. As an extreme example, a little high school girl with exaggerated neurotic symptoms came to the attention of one of our clinics. Her parents demanded that she complete high school and business school and become a secretary. It is obvious what such a demand was sure to do to the personality of a child with an I.Q. of 51. The physician might have assisted the family to achieve a more realistic viewpoint of the child before neurotic distortion developed which necessitated attention at the clinic. An ounce of prevention is less expensive than a pound of cure.

With our hypothetical child well started in life with a feeling of security and of personal accomplishment and confidence, he is now ready for the third major hurdle—social adjustment, which comes from receiving a calm understanding tolerance from others and being able to pass this on to his fellows.

How can a child be naturally tolerant of others when he has met only unyielding rigidity in nursing habits and weaning techniques and when demands for toilet habits have been premature

and threatening? Adults have laughed at his efforts and ridiculed him. Rules have been arbitrary and often inconsistent. He has found that "don't" means only that the larger person does what he wishes and the smaller individual's desires are ignored. Other children are certain to teach him the meaning of destructive competition. The parent must see that he learns the advantages of tolerance and friendly cooperation.

A child should be warned before his play is interrupted. If one must interfere with his play, a pleasant substitute should be provided whenever possible. Parents must be interested in the child's activities. As he develops, they must increasingly participate with him on a footing of equality, say for instance—"Shall *we* go for a walk?" *not* "Shall *I* take you for a walk?" Questions must be answered frankly and honestly. Certain parents must be specially prepared for the time when their child will first say: "I hate you; I wish you were dead!" It is an important moment. If the parent shows distress, the child tends to adopt outbursts to control his environment. If the adult is obviously unimpressed but tolerant and friendly rather than mocking, the child learns that emotions do not require excessive repression, that they may be regarded tolerantly by others and by the child, and that there are more successful ways of achieving a desired goal.

A final warning to be given to parents. If actions must be forbidden, teach the child that they are bad *manners*, not that they are *bad*. It should not have taken the era of Prohibition to teach us that old and young alike may find an irresistible lure in something prohibited as *bad*.

Why do I lay such stress on children's needs? Simply for the reason that neglect at this age is certain to mean that a much greater expenditure of energy must be made to prevent or to cure pathologic mental mechanisms at a later age.

Ask yourselves a few questions. Are you able to tell when your adolescent patients are troubled by more than a passing physical illness? If you can discreetly quiet their fears concerning masturbation, you may spare them much misery and increase the number of patients who believe that you are the world's most astute doctor. Have you made the effort necessary to be a good marriage counselor? Do your former patients who have grown up and married desert you after you have failed them because you were too busy or too embarrassed? Are you aware how many patients who come to you with a multitude of complaints but little physical pathology are unconsciously trying to tell you that marital friction is about to wreck their lives? Are you

astute and patient enough to discover that arranging for an in-law to live elsewhere will multiply the efficacy of your tonic? Have you discovered that many cases of sexual incompatibility when seen early and before deeply set antagonisms have developed can be completely resolved by a frank discussion with one or both marital partners? Do you give such people the help they need, or do you dismiss them with the statement, "There's nothing organically wrong with you"?

How do you prepare patients for surgery? With drugs alone, or do you supplement such a régime with explanations and reassurances? Do you realize the young child's need of his mother's presence when he must endure the frightening experience of "going under" or "coming out" of an anesthetic? Many adults react with feelings of panic to the suggestion of surgery. This is especially true if it involves the genito-urinary tract. They need unusually careful emotional preparation and complete understanding of what we hope to do for them since they will be prone to think in terms of mutilation and impotence. Frequently explanations must be repeated at a later date when time has softened the impact of the doctor's news and the patient is able to discuss the situation realistically instead of being blinded by fears and sometimes feelings of guilt.

Do you skillfully orient your patients to face the problems of serious illness, or are you merely a pill and hypodermic doctor, one who wishes to see a maximum number of patients per hour, a relative of the surgeon whose greatest interest is the record he can set for a rapid appendectomy?

A young girl's reaction to the abrupt announcement that she has been infected with gonorrhea may be conversion hysteria. A patient may respond to a chronic disease by developing suicidal ideation. Sometimes the individual may not even be conscious of this, though it is obvious to an observer.

A 20-year-old male who developed a minimal tubercular infection cooperated fairly well with treatment for several months, then hired a car and went for a joy ride over roads covered with a smooth coat of ice. The ride was climaxed by driving at full speed down a long hill and across a one-way bridge at the bottom. It was obvious that his emotional state was such that it would imperil what should have been an excellent prospect of recovery and this was borne out by the progress of his illness.

The fact that states of emotional tension can exaggerate organic disease processes is now so

generally known and accepted that nothing could be gained by offering further proof of the role that anxiety and frustration can play in such conditions as peptic ulcer, hyperthyroidism, and hypertension. However, it is interesting to note that much has been contributed to psychosomatic understanding by men whose primary interest has been in organic disease—gastro-enterologists, cardiologists, dermatologists, and others.

Emotional factors may still require considerable attention following a physical recovery. Otherwise the patient may fail to remember that hygienic rules must still be observed in order to perpetuate his recovery. However, an opposite course must be followed for certain individuals. This occurs with those persons who are prone to maintain a state of chronic semi-invalidism, do little work, and fail to reassume their normal responsibilities. Such a reaction occurs in people who cherish a more or less unconscious wish to return to a childish level of dependence. A prolonged illness helps to facilitate a gradual loss of interest in the outside world and of concentration of the patient's attention upon himself. This is accentuated by the fact that interest and sympathy are lavished on the individual by doctors, nurses, friends, and relatives. The emotionally immature individual may be loath to abandon this situation and deliberately seek the stress of the usual life struggle. Such people require careful handling and encouragement if they are again to become useful members of society.

Even after resuming his old life, marked difficulties may eventuate if the patient has not been wisely prepared for changes or new handicaps.

Sam was an intelligent, well-mannered lad. While in grade school he showed promise of becoming a star athlete. An attack of rheumatic endocarditis changed that picture and left him with only sufficient cardiac reserve for ordinary physical activities. Unable to attract attention by athletic ability, he regained the limelight by such conduct as placing limburger cheese on the school radiators. His success was such that he was the only boy who was ever expelled from every school in town—a response to illness in a boy who had not been well prepared emotionally to adjust to his altered status.

As a physician, it is your responsibility to do more than to make a diagnosis in terms of organic pathology and to write a prescription. It is your function and privilege to rehabilitate human beings. You must be on the alert to identify psychologic factors which have helped to precipitate a major illness.

It is routine for a doctor to have a definite program for the organic treatment of a sick pa-

tient. He is less likely to realize that many of the individuals who seek his aid require as definite a program in the psychiatric sphere. You must ascertain if they have exaggerated fears of the physical results of their disease and quiet their apprehension. Tuberculous patients may anticipate rejection and ostracism by fearful relatives and friends. Some will be overwhelmed by a sense of guilt; some will blame others. Many will be too engrossed with the thought of the hardships which will accrue to their families to be properly concerned about themselves. A special word of caution is perhaps justified regarding patients who are too casual. Some may be masking a much deeper emotional reaction and should be carefully watched for a time. All patients who are suffering from a major illness need to develop an emotional adjustment toward the disease. They must be imbued with a determination to recover, the resolution to cooperate fully with treatment, and above all, hope. And nearly all need simple psychotherapy in the form of an opportunity to put their fears into words and thereby learn to look at them from a more realistic and less emotional viewpoint.

Individuals displaying psychotic symptoms usually require hospital care. Those who are not hospitalized should be seen in consultation with a psychiatrist so that a plan of treatment may be developed and possible difficulties anticipated and evaluated.

A final group includes patients with neurotic symptoms who constitute a large percentage of the cases seen by every busy physician. The general practitioner should be able to treat successfully most of such cases, have psychiatric consultation for a few, and refer only the difficult cases to the psychiatrist for treatment.

We must admit that the medical profession should plead guilty to being responsible for much of the thriving practice of the cultists. All too frequently the physician brushes aside one of these distressed patients with the old cliché, "There's nothing the matter with you; go home and forget it!" The natural reaction to such stupidity is to become antagonistic toward the doctor and, by natural extension and generalization of emotional reactions, toward all physicians. The patient knows that something is wrong with him and can react only by seeking elsewhere for someone who is understanding and more interested in his troubles.

What must a physician do to be able to prevent emotional problems from blossoming into functional disease and to treat successfully incipient and mild forms of such illness?

1. Recognize that a large percentage of illness is functional.
2. Devote a moderate percentage of his medical reading to recent scientific articles and books dealing with child guidance, psychosomatic disease, and neuroses.
3. Recognize that emotional factors may precipitate or reactivate physical illness (peptic ulcer).
4. Recognize that emotional upsets may mimic physical disease (substernal pain may mean heartache, not coronary occlusion).
5. Recognize that while neurotic symptoms serve a purpose, the patient may be unaware of this.

What are the steps by which this knowledge is applied?

1. A preliminary history is obtained.
2. The physician must show a sympathetic interest in the patient's problem.
3. Physical examination and laboratory studies must be careful and impressive. This helps the patient to have confidence when you inform him that his symptoms are not due to organic pathology. Such studies must not be unduly prolonged or the patient will feel that you are uncertain of your diagnosis. Special care must be taken to avoid unwise comments concerning minor pathology which may be observed.

One of our neurotic patients was sent to a roentgenologist for a fluoroscopic examination and gastric series. He commented to her that she had some ptosis of the stomach and the colon. She tried to lean over the top of the fluoroscopic screen and observe where his moving finger indicated the final resting place to be. On the following day her symptoms were in full bloom. She was "dying of a dropped stomach." Remember, examinations are necessary and may be of material help in psychotherapy, but slight carelessness will permit them to boomerang.

4. The patient is told that no organic disease is present but at the same time he is assured that his physician appreciates the reality of his symptoms.
5. Explanations are given to interpret how emotions may bring about physical symptoms.
6. A detailed history is obtained of the emotional background, childhood experiences, previous attacks, precipitating factors, and present symptom picture.
7. Sedation is used only as a temporary crutch, and this attitude is explained to the patient who must be made to understand the difference between palliative and curative measures.
8. Environmental manipulation may suffice to

readjust some situations, as in the case where uncongenial relatives living in the home become the source of too great friction. Or, it may be possible to change the attitude of others sufficiently to help a patient to readjust. Parents may be induced to moderate their demands or a husband helped to see how his lack of understanding may have been responsible for the wife's frigidity.

9. A few patients must be carried at the superficial therapeutic level of suggestion and reassurance, reinforced by physiotherapy and perhaps some form of environmental alteration. Some of these patients, especially those with hypochondriacal symptom patterns, also require a daily program of planned activities.

10. Dynamic psychotherapy is based on ventilation of emotionally charged thoughts and attitudes. Everyone gains a feeling of relief if he can share his troubles with a sympathetic listener. In addition, putting a problem into words helps to convert an emotional problem into an intellectual one which can then be dealt with more easily and realistically.

Do not be surprised or distressed if a patient omits many important details and occasionally falsifies others. Remember that it is natural to shrink consciously and unconsciously from baring many of our hidden actions and desires. If one can be patient, understanding, and non-critical, the true picture and background will gradually emerge.

Although many such patients besiege you with questions, you must beware of "talking too much." Especially avoid giving detailed "Freudian" explanations. Remember that your role is often that of a mirror. You help the patient to view his problem from various angles.

It is wise for patients to undergo a gradual learning process. When you wish to implant suggestions, it is best to do so obliquely or through questions so that they tend to feel that they made the discovery. This does not mean, of course, that you should not discuss frankly certain subjects, such as masturbation or sexual adjustments, when the patients are emotionally prepared, but you must expect to progress slowly. As patients' confidence and reliance in you increase, you must help some to be more independent of their mammas and papas, while others must learn to accept a reasonable dependence (as in the common cases of women who are excessively perturbed over their financial relationship to their husbands). Gentle persuasion and re-education will accomplish marvels in bringing about more mature marital relation-

ships, and the lessening of guilt through ventilation and understanding may moderate excessive emotional explosions.

The practice of medicine is an especially interesting vocation. To see a cardiac patient regain compensation or to see a dramatic fall in temperature as the result of your medication gives you the feeling of accomplishment. It is an equal source of satisfaction to see the patient who has been disabled by emotional turmoil regain the ability to make a productive work adjustment and to live at peace with his fellowmen and with himself.

The old-time family physician had few reliable and efficacious drugs for the battle against infection and only his instincts to guide him in dealing with functional ills. Present-day physicians are armed with better drugs and a systematized knowledge of psychopathology and psychodynamics. They can plan effective therapy of both soma and psyche.

I confidently predict that the modern specialist in general practice will apply psychiatric knowledge and techniques to the problem of rehabilitating his patients to an increasing degree.

ABSTRACT OF DISCUSSION

LAUREN H. SMITH (Philadelphia): I had a very interesting experience this morning. Embarking on the Philadelphia express at the 33rd Street station in New York at eight o'clock, I made my way into the diner and sat down to get a cup of coffee.

There were three gentlemen already seated at the table to which I was assigned busily engaged in conversation. It was obvious that they were coal barons from the Pennsylvania area, all fine-looking gentlemen, one a little fellow, one a great big six-footer, and the third looked quite a bit like a bookkeeper, all of rather different types of personality.

They had evidently heard an address last night by Dr. Vincent Peale, who recently published a book dealing with the relationship of religion, psychiatry, and psychosomatic medicine. It seemed to be their opinion that Dr. Peale was a little bit out of his field. In fact, one said, "You know, this man is over in the field of what they call 'psychosomatic medicine.'"

This especially awakened my interest, so I started listening carefully. The second man at the table said, "That is the new thing now. You know," he continued, "the way they are handling patients now and treating them, the mind and the body are not separate; the stomach and the feelings are hooked up. They are really doing things along those lines now."

The fellow across the table commented dryly, "There are darned few of the doctors doing it that I know."

Finally, the third man stated, "You wait and see. I think the medical men who are now graduating, these young fellows, are going into this specialty, and they are going to pack it from now on."

Evidently he took "this specialty" to mean a new specialty in medicine, whereas, actually, I think we all are aware and are trying to teach all doctors that it is the basis of all medicine, that it is the practice of real medicine.

I want to thank Dr. Israel for sending me a copy of his paper. One important point which he emphasized throughout his paper is that there is a penetration of psychiatry into all aspects of medicine in the community. I believe that is what we want to see; that is, as psychiatrists, we want to see the general practice of medicine handled not so much as a direct psychiatric attack for specific neurotic patterns or specific psychiatric illness, but as psychotherapy and mental hygiene applied to all aspects of family medical problems so that as the family grows and becomes involved in serious illness or social or economic problems, the medical aspects will be cared for by the doctor, who is the key man to them, with a new viewpoint, with a new attitude, and with a psychiatric coloring.

A good deal of psychotherapy is rather technical and can be handled only by specialists, but what we are speaking of is psychotherapy for the kind of problems seen in family life in the average community, which are now talked about and handled perhaps by psychiatrists. Such problems really are not the field of psychiatry alone but are, in my opinion, the field of any kind of medicine.

The practical problem, of course, is how to meet the needs of community life and the borderline maladjustments, as well as the actual psychiatric problems. A doctor with a good psychiatric viewpoint, interest, and sympathy can maintain a number of borderline or actual psychotics in part-time jobs or home situations.

There are about three or four thousand qualified psy-

chiatrists in the country now, yet we know that the psychoneuroses in every type of practice run into the hundreds of thousands. Therefore, education in psychotherapy in the medical schools, throughout all departments of training and teaching, will probably be the only means by which we can produce a complete coverage in medicine so that we may meet the needs of patients who have functional conditions.

I do not believe that specific psychotherapy can be taught alone by psychiatrists; I doubt if it can be taught in the medical school only by the psychiatric department, except perhaps for specific psychiatric conditions. What we speak of as psychotherapy, which Dr. Israel has emphasized, is the way of treating patients which must be taught and developed through the professor of medicine, the professor of surgery, the professor of pediatrics, and the professor of orthopedics, so that general practitioners will begin to observe and handle patients with psychosomatic principles and psychologic mechanisms in mind. This is the point from whence we may expect progress in meeting the practical problems in the community not yet met today.

It is not the responsibility of the psychiatrists, nor do they alone have the ability and the knowledge, any more than other doctors, to translate all this into the general need of community medicine. It appears that medical education, as being aggressively studied and worked out at the moment, has begun to pass this milestone already in the better medical schools.

RING DEATHS "SHOCKING"

The shocking incidence of ring deaths and serious injuries among professional boxers make the "sport" the greatest killer in American athletics, says Thomas Gorman, Chicago, assistant managing editor of *Hygeia*, health magazine of the American Medical Association.

Boxing has produced more deaths per number of participants than any other sport, and 50 per cent of active fighters are punch-drunk to some degree, he points out in the June issue of the magazine.

"The 13 ring deaths of 1948 form a continuation of a series over the years since professional boxing has become widely legalized in the United States," Mr. Gorman says. "According to recent figures, five boxers were killed as a result of bouts up to April 20 this year, thirteen in 1948, nine during 1947, and eleven in 1946.

"A boxer doesn't have to be knocked out or have his skull broken to be seriously injured. He may suffer pinpoint hemorrhages or other harm to his brain not outwardly apparent even to the trained physician.

"These injuries can result from any hard blow to the head. Pinpoint hemorrhages caused by the concussion from a hard blow may destroy nerve tissues. Brain tissues do not heal as do other tissues of the body.

"Some parts of the brain can suffer destruction of a small amount of tissue without immediate paralysis or changes in behavior. These injuries are permanent. As more are received they will contribute to loss of mental powers or bodily control.

"Doctors who have pointed out the dangers of organized mayhem based on scientific observations over the years are only permitted on the sidelines as members of advisory boards and as medical examiners dependent for their fees on the whims of politicians. Use of doctors has the effect of furnishing a phony respectability to an otherwise dubious activity.

"The participants for our 'sport' of professional boxing come from the thousands of high school boys and young men in college who engage in amateur boxing. This has become so highly organized through vast inter-city tournaments that the only division between professional and amateur boxing is the funnel by which the first is supplied with manpower from the great reservoir of the second. They are both part of the same picture."

OINTMENT GIVES RELIEF FROM PAIN OF BEE STINGS

Thephorin, a drug which counteracts the effects of chemicals released from body tissues during allergic reactions, gives almost immediate relief from the pain of bee stings and ant bites, according to a report in the June 18 *Journal of the American Medical Association*.

In eight cases in which an ointment of the drug has been used for these stings and bites, the patients obtained relief in one or two minutes, says William Theodore Strauss, M.D., Upper Montclair, N. J.

Further Experiences with the Rooming-in Project of Baby with Mother

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Philadelphia, Pa.

HOSPITALIZATION of the maternity patient for delivery and puerperal care has become the rule of the day. If the trend continues as rapidly in the next five years as it has in the past five, delivery in the home will become a medical curiosity. Like all changes in the conduct of human affairs, this has brought some good and some evil.

On the part of patients it has been found much easier to go to the hospital for delivery and puerperal care than to set up a unit in the home and secure the help which is necessary. On the doctor's part the hospital has provided better facilities for the handling of obstetric deliveries and particularly improved conditions for the treatment of obstetric complications. In general the treatment of the mother has improved under hospital care, particularly if the lowering of obstetric morbidity and mortality can be considered as the criterion in such matters.

While the hospital has seemed to provide a quite satisfactory solution for the care of the parturient, the question has arisen as to whether it is the best environment for the protection and treatment of the newborn. While present hospital architecture and aseptic surgical practice have made it possible to protect the mother from infection, it has been found more difficult to maintain the health of the newborn and protect the susceptible skin and the gastro-intestinal and respiratory tracts.

It has generally been assumed that the newborn babies must be housed together in a common nursery where they can be attended by trained personnel, that the mother is incapable of or should not be asked to participate in the care of her baby, and that the baby should only briefly and occasionally be exposed to the "contaminated" air and furnishings of the mother's room.

This conception of baby care has grown in the medical profession of this country in the past

twenty-five years, in spite of the fact that these same babies must in the due course of a few days be transported to the parental home in which all of the same factors of "contamination" exist, in spite of the fact that babies have been delivered for centuries in the home and known to be free of skin and gastro-intestinal infection unless such were introduced directly by infected persons, and in spite of the record of maternity hospitals on the continent of Europe and in the British Isles where babies have for a long time been taken care of by their mothers and housed in cribs at the foot of the bed.

With the increase in the birth rate which took place just before and during the last war, with the increase of hospitalization, and with the falling off of new hospital construction, the conditions of crowding in maternity hospitals and in the maternity division of general hospitals reached an acute stage. Also with the decrease of nursing personnel the amount of time that could be devoted to the care of the individual baby diminished; practically no institution in the state of Pennsylvania has been able to meet the standards of the State Department of Health as regards the nursing care of the full-term and premature infant.

As a result of these several conditions there has been a marked increase in the occurrence of contagious disease of the newborn to such a degree that many institutions have had to close their doors to obstetric practice for varying periods. Serious epidemics of diarrhea and impetigo have been reported, and many times the number of epidemics have never reached the literature. The boards of health of many of our large cities in Pennsylvania consider this one of the major public health problems of the day. If all of their statistics could be combined and placed before you, I daresay the report would be grimmer than any one of us would want to believe.

It was because of these considerations that we undertook the rooming-in program of baby with

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mother, hoping that we could prevent epidemic disease of the newborn in our own institution and shed some light upon the practicability and feasibility of this plan as an improvement in present-day hospital obstetrics. In this undertaking we were certainly not the first. Barnett³ submitted an article on his experiences with the rooming-in arrangement for newborn infants in a small hospital. Bartemeier,¹⁰ Montgomery, and others¹ participated in a similar undertaking in Detroit hospitals, being primarily interested in the psychologic relationship between the mother and baby. Jackson, Olmsted, Ford, Thoms, et al.,¹¹ in New Haven, have established a four-bed unit for the study of common care of mother and baby.

I suspect, however, that we have inaugurated the method on a larger scale and have had a more extended practical experience with it than any other institution in the United States. In the spring of 1948, at a meeting of the American Gynecological Society,¹² we reported on our observations of 1018 newborn babies cared for in this fashion. Today we wish to submit our further observations on the rooming-in project based on the care of 1400 ward and low-cost semiprivate patients and 75 private patients.

Experience in these additional four or five months since our first report has only served to emphasize and extend the favorable impressions that we have of "rooming-in" as (1) a preventive of epidemic infection, (2) an improvement in mother and baby relationship, (3) a stimulus to breast feeding, (4) an implement to improved baby care, and (5) a method of education of the mother in the responsibilities and techniques of raising a baby.

Epidemiologic Significance

Among the 1400 babies of the ward service who have been cared for at the bedside of the mother there has not been one case of skin infection or one case of significant gastro-intestinal disturbance. One baby was isolated because of a suspected respiratory infection, but was found upon re-examination by the attending pediatrician to be actually free of pulmonary disease. On the private service there was one baby and its mother who developed severe illness with fever twenty-four hours after delivery. The baby, in fact, was apathetic from the moment of delivery. This mother and her baby were quite ill for four or five days with an obscure type of virus infection. The second day of illness the mother volunteered the information that every member of her family, including three children, had been or were ill at home with a peculiar virus infection of

influenza-like character. The mother's own symptoms and those of the baby were precisely the same. Fortunately, this mother and her baby had been taken care of together in one room in the rooming-in project, and no other baby or mother on the floor became infected.

There were five babies who recently became infected with thrush in the centralized nursery for premature babies. Two babies housed in the central nursery of the private floor developed diarrhea. Immediately all the well babies were isolated with their mothers, and all newly delivered mothers and babies were placed on an enforced rooming-in régime. No further cases of diarrhea developed.

On the basis of this epidemiologic experience we feel that any single infection of a newborn baby, even though it is of contagious nature, can be controlled by confining the disease to the room in which it occurs. In the instance of the six-bedded wards there will, of course, be four or five other babies exposed. However, it would seem that the infection can be kept confined to the single ward room, the babies discharged from this ward in sequence, and that single ward cleansed and thoroughly aired. The chances of other babies being affected in the ward with the mother taking care of her own individual baby should be relatively low, and the other ward rooms of the floor need not be involved.

The Cornelian Corner

In the various reports that have emanated from the Detroit and the New Haven clinics considerable emphasis has been placed upon the psychologic significance of housing the baby with the mother, and the term "Cornelian Corner"⁹ has been presented to the literature as an insignia of the personal devotion which a good mother ordinarily expends upon her offspring. While our own project at the Jefferson Hospital was not undertaken with this motive primarily in mind, I believe we can lend evidence to the proof that the rooming-in arrangement does restore and enhance the mother-baby relationship.

We notice that the atmosphere of our obstetric wards has changed since the babies have been placed with the mothers for their personal care. Formerly the patients would lie about the ward with more time on their hands than they knew what to do with, telling ribald stories and in general manifesting poor cooperativeness if not complete failure of responsibility. Since the babies have been moved into the wards beside the mother's bed the atmosphere is hushed and quiet. The mothers keep close guard over their infants and take great pride in their care. Conversation

between mothers has to do with baby progress. Advice is given from the older mothers to the new mothers. One has the feeling that the sanctity of the home has entered the four walls of the hospital. Also, the babies seem happy with this arrangement, assuming that happiness can be assayed at such an early age. Certainly there is very little appearance of distress or unhappiness among these babies. Rarely does one cry, and if it does the mother reaches out, pats it on the back, makes sure that the diaper is dry, and feeds the baby if it is hungry. As we make our rounds through the wards from day to day, rarely do we hear any of the babies crying. There is nothing remotely approaching the pandemonium that used to reign in the nursery as the formal four-hour nursing hour was approached.

Effect on Breast Nursing

The presence of the baby at the mother's bedside has undoubtedly been a stimulus to lactation—first, a stimulus to more mothers undertaking lactation, and second, an improvement in the efficiency and response of the mother's breasts to the babies' requirements.^{5, 6, 7, 8} Eighty-five per cent of our ward patients are now nursing their babies and more than 50 per cent of the private patients undertake to nurse theirs. On a so-called demand schedule the baby is placed at the breast whenever it is hungry. Generally, the demands upon nursing are rather heavy in the first twenty-four to forty-eight hours, but the breasts seem to stand up under this strain better than on the old schedule. The milk comes in more promptly and more freely; 25 per cent of the babies have regained their birth weight by the fifth or usual day of ward discharge. Many private patients who came to the hospital vowing that they would not nurse their babies have found the demands of the infants so appealing that they have undertaken breast feeding.

Baby Care

As to the fourth consideration, the kind of care which these babies are receiving, we can say positively that these babies at the bedside of the mother are receiving the best that we have ever observed. In the first twenty-four hours 90 per cent of that care is given by undergraduate and graduate nurses with the mother observing. After the first day, 80 to 90 per cent of the care is given by the mother herself. The mother is quick to note any disturbance in the baby's progress or condition; if she can attend to it herself, well and good, if not, she immediately calls a nurse and continues to call until she gets adequate help. I would not say that the rooming-in

project has reduced the amount of nursing help that is essential on the maternity floor, but it has made it possible to reassign the help to where it is most needed, namely, the first-day care of newborn babies, the care of premature babies, the care of weak or ill babies, and the care of complications in the mother.

While the regulations of the Department of Health of the State of Pennsylvania require that two and one-half to three hours of nursing care be provided for each baby per twenty-four hours, or about one nurse to every 7 or 8 babies, and the same regulations require that each mother be provided with four hours of nursing care daily, or one nurse to every 6 patients, we found upon a frank review of our situation during war-time and in the subsequent period of nursing shortage that we were providing an average of about one hour for each baby per day and about two hours for each mother per day. With the inauguration of eight-hour general duty nursing these figures did not improve. However, with the mothers participating, the hours of observation and individual care of the normal full-term infant have been increased to practically twenty-four hours, and the attention given to the baby by its own mother during these twenty-four hours is as meticulous as that which would be rendered by a graduate nurse assigned to each individual baby. Our reaction to this whole situation has been a turning from a most pessimistic view concerning the hospital care of the newborn to a state of genuine optimism.

Of course, early ambulation of the mother plays an important role in the success of this procedure unless the patient has a private nurse. We find that the combination of baby care and early ambulation offers the psychic and physical stimuli which lead to early, rapid, and complete recovery of the patient from her obstetric experience.



Fig. 1. Crib completely equipped at bedside.

rience. The patients leave the hospital at an earlier date feeling better than they have before.

Education in Baby Care

As to the matter of educating the mother in the techniques of baby care, and of sending her from the hospital with a feeling of confidence in her ability, there is no procedure which compares with the rooming-in project. With the baby at her bedside the mother first observes the care as given by a trained person, then she undertakes this care under trained supervision, and finally she assumes responsibility for this care with trained personnel nearby. Her pediatrician examines the baby in her presence and she talks over with him the problems of its health and feeding. She is acquainted with the baby's habits and is not frightened at its cry. She has an entirely new sense of confidence in her ability to manage the situation in her own home. One and all mothers have testified to the significance of this feature, whether or not they have agreed upon all other points in rooming-in care.

Before leaving this discussion of results, some mention should be made of the pleasurable reaction of the husband upon having an opportunity to see and enjoy his baby with his wife. This of itself seems an added reward for the additional trouble and expenditure of effort on the part of the mother. It is really a happy, homelike scene

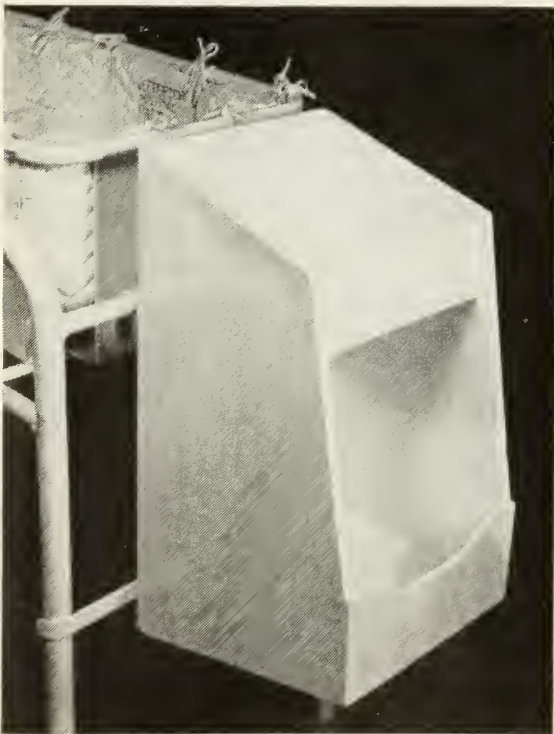


Fig. 2. Detail of crib wardrobe.

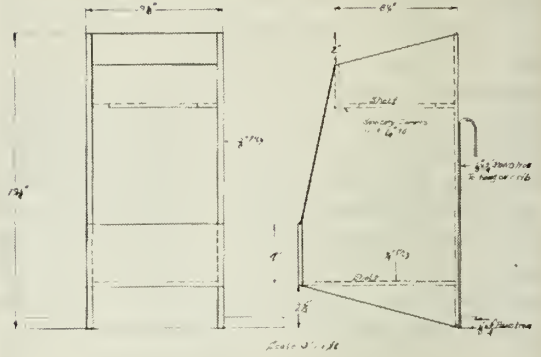


Fig. 3. Construction plan of crib wardrobe.

with the father, the mother, and the baby together in the room at visiting hours, the mother relating the various experiences that she has had and the mannerisms and idiosyncrasies of the child. I suspect that our psychiatrist would tell us that this has some significance. To us it seems a normal, pleasant family relationship.

Rooming-in on the Private Service

The question most frequently put to us by obstetricians who have visited the hospital is "How do your private patients react to this project?" Our answer is that once they have tested its responsibilities and its pleasures they react in just the same fashion as the ward patients, namely, with a natural display of mother instinct, and a day-by-day increase in their appreciation of the plan. Our experiences on the private side are considerably more limited than on the ward because of the fact that equipment has been available only the past two months, that the arrangement is optional rather than mandatory, that few of the mothers have been prepared for the idea during the prenatal period, and that some of the physicians are hesitant to suggest it to their patients. Among certain private patients there is quite a strong desire to have the baby housed in the room throughout the hospital stay, while others consider it an imposition.

Some older multiparae, who have had adequate training in the care of the newborn and come to the hospital with the expectation of having a six- or eight-day rest, look upon the idea with disfavor. Until both the physician and the lay person can be convinced, as most of our modern surgeons are now convinced, that early activation, muscle exercise, physical and mental activity, are important considerations in recovery from surgical procedure, it will be some time before all private patients will want to participate in this project.

Fully realizing these facts, we have made the rooming-in project optional on the private service. We plan to distribute information concerning the rooming-in project with our hospital letters, setting forth its advantages and its responsibilities. We anticipate that in the due course of time the safeguards of this procedure will be so amply demonstrated, and the advantages to the patient and baby so clear, that all of our obstetricians will desire the arrangement for their patients and personally recommend it to them. In the meantime, whenever a condition threatening an epidemic appears on the private floor, the rooming-in arrangement will become mandatory.

Technique and Procedure

For those who desire to undertake a rooming-in project we would submit the following suggestions:

In the first place, it is unnecessary to have architectural reconstruction to inaugurate this plan. While it would be very nice to have individual nurseries in connection with each private and semiprivate room, it will undoubtedly be a long time before new hospital construction will permit of these luxuries.² In our own situation we considered it unnecessary to request them. However, it is important that running water be readily available.

It is very important that the proper equipment be provided for the individual care of each baby. For instance, one cannot preserve individual technique and protection against infection by putting the baby's crib at the mother's bedside and then placing all the materials for baby care on a common central table. Our solution for this problem has been to design a special crib wardrobe which is attached to or hung on the end of the crib (Figs. 1, 2 and 3) and provided with shelves on which are placed the materials for the baby's care, the care of the mother's breasts, and sterile cotton or paper diapers. Generally each crib is also provided with a small laundry bag for the disposal of the infant's clothing and a wastebasket is placed nearby. All of this must obviously be within ready access and reach of the mother when she is in bed and readily available when she is out of bed. We would emphasize that it is impossible to make a success of this plan unless equipment of this kind is provided.

Second, where conditions permit, we would suggest that the project be started on the ward service—first, with one small ward, and then expanded to include the entire ward service as the nursing personnel become accustomed to procedure and technique. On the ward service it is

possible to make the arrangements mandatory and it is easier to carry out the policy uniformly for all patients.

Next, it is essential to indoctrinate the nursing personnel in the theory and practice of a procedure which seems to them quite revolutionary. The program must be carefully worked out, modified, and perfected to meet the needs of the individual unit. For our own department we have found it wise to preserve the old division of nursing duties, namely, the labor and delivery room, the nurseries for full-term and premature infants, the day and night general duty. The nurses assigned to nursery duty spend a great deal of time in the first twenty-four hours attending to the new babies in the ward and instructing the mothers in their care. Each morning the nurses of the nursery make formal rounds through the wards and private rooms with a specially prepared ward carriage equipped with scales, thermometers, antiseptics, and dressings. They go from bed to bed weighing each baby, taking its temperature, dressing the cord, and collecting the data of feeding, bowel movements, etc., which the mother has kept in the previous twenty-four hours. At periodic intervals a graduate nurse makes rounds through the wards and private rooms to check up on the care and progress of each baby. During the remainder of the time it is expected that the general duty nurses will also respond to calls from the mother and help her with any problem that arises in the care of her baby as well as herself.

After the morning rounds are completed, the nurses from the nursery for full-term babies participate in the preparation of formulas and assist in the care of premature babies. In this fashion their time has been readjusted and redistributed.

It is our impression that the rooming-in project should not be undertaken on the private floors until its techniques have been perfected in the wards of hospitals, where the training of student nurses takes place. Whether or not the plan is then made optional or mandatory on the private service depends upon the exigencies of the individual institution. In the presence of an actual or a threatened epidemic, I believe that it should be made mandatory, and I am not at all sure but what the time may come when our boards of health will insist that such a practice be carried out routinely in maternity hospitals. However, at the moment it would seem best to make the practice on the private service optional and to devote efforts to the education of the patient and the obstetrician in the advantages of rooming-in, to the end that this method will acquire popularity because of its own virtue. At

the moment we feel firmly convinced that the plan offers a logical solution of the difficulties and problems of institutional care of the newborn, and we believe that it is here to stay.

Summary

We have reported our experiences and further observations in the treatment of 1400 babies in ward and low-cost semiprivate service and 75 babies in private and two-bed semiprivate rooms.

It has been noted that no contagious disease has developed among the 1400 ward babies housed at the mother's bedside.

The epidemiologic significance of the method has been pointed out in the care of one mother and baby who developed a serious virus infection apparently acquired at home, and in the management of a situation in which two babies developed diarrhea in the central private nursery.

In addition, our observations would support the contention that mothers are more likely to nurse their babies, that the babies receive better care, and that the mother is better trained in the techniques of raising her child when the baby is housed at her bedside.

It would appear that the rooming-in enhances the pleasure and satisfaction of the mother, and promotes contentment in the baby. A family, homelike atmosphere is established within the hospital.

For those who would undertake the rooming-in project, certain suggestions are made concerning architecture, equipment, the training of nursing personnel, and the approach to the ward and private services of the hospital.

Finally, it is felt by the authors that the rooming-in project offers a solution to some of the more difficult problems of institutional care of the newborn and might well become an expanded policy in American obstetrics.

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ABSTRACT OF DISCUSSION

HOWARD A. POWER (Pittsburgh): Such an excellent paper as this leaves very little to discuss; however, in going over the history of the development of the rooming-in plan of infant and mother, an interesting factor occurred to me. In its inception in 1942 it was started by the rebellion of two psychiatric social workers in a Washington hospital, and at that time the extreme emphasis was placed upon the psychologic angles of the plan rather than its practical medical angles.

Among the contributions that Dr. Montgomery has made to this procedure, then, is its rationalization as a medical procedure rather than primarily as a psychologic experiment. In proof of my statement I offer the fact that it was initiated by Frances P. Simsarian and P. A. McLendon, in 1942, with observations on their own newborn infants. As a result of these observations, they determined that both babies demanded more than the six traditional feedings, but by the end of the tenth week they had stabilized themselves rather accurately to a five- or six-feeding program.

The stated advantages at that time were that the mother and baby become more nearly an entity, that the mother got acquainted with her baby and recognized pain, discomfort, contentment, satiety, and, further, that the mother was impelled to care for her baby. They further stated that the routine obviated or minimized prolonged crying with its subsequent fatigue, anorexia, distress, anger, and frustration, and reduced the coercion to eat when not hungry, which might produce aversion, disgust, and anger. All the emphasis was placed upon the psychologic angle.

As a result of further experience, Henry L. Barnett, of Cornell—and this is the second phase of the investigation—felt that rooming-in was an important experience in the emotional development of the mother and secondarily of the child; that the babies received more attention and cried less; and that there was no increase in the incidence of infections. After five or six days the mothers were able to assume the major portion of infant care. The mothers disturbed the infants more frequently than seemed necessary, but as association developed, the enthusiasm of the mothers waned.

From a professional angle, the physicians received fewer calls. The time assignment of nurses was not definitely changed. This is a development of the initial trial on a more practical basis, with "de-emphasization" of the emotional or psychic side and emphasis upon the medical side of the program.

An analysis of a series reported by Shirley E. Lundgren indicates that the plan was much more interesting to primiparae than to multiparae. This is a perfectly logical assumption in that the primiparous patient has frequently had little or no antenatal instruction in infant care, and this procedure offers a splendid opportunity to send the mother from the hospital with at least a rudimentary education in the elements of such care. At the present time it is much more feasible with ward patients than it is with private patients.

The essentials, as Dr. Montgomery emphasized, include proper equipment, adequate personnel, and an especially designed medical setup. He has made another contribution in that he has simplified the technique so it can be adapted readily to any hospital in case an emergency should arise.

Practical considerations apparently prompted the third phase of this procedure. As Dr. Montgomery has stated, it was initiated primarily to control an incipient epidemic of enteritis and this is perhaps, medically speaking, the most important contribution of the procedure at the present time. His observations added a great deal of interesting data, but on the basis of rationalization one may wonder whether the psychic traumata incurred during the present short period of hospitalization are any more permanent than the brush burns occasionally produced on the face of the newborn. Further trial may give us the answer.

The chief benefit derived from the plan would seem to be the educational value to the primiparous patient. The saving in nursing hours is an additional advantage at the present time. Lastly, there is the fact that it does offer us what seems to be a fairly simple and efficient method of controlling epidemics which occur from time to time in even well-regulated nurseries.

ROLAND D. PORTER (Abington): After the newspaper publicity given this rooming-in plan, we considered adopting it at Abington, but before doing so, I went to see its use in a couple of hospitals and we looked over the literature on this subject. We were particularly interested in epidemic diarrhea and we found 3700 cases in the literature, though all had not been carefully studied, either bacteriologically or as to their manner of spread. However, summed up, we found that 50 per cent of them were due to contaminated milk; 25 per cent were caused by personnel, largely by hand or rectal thermometer; and 25 per cent were caused by droplet infection from the nose and throat of attendants.

I cannot quite understand how we are going to cut down on the spread of infection in the ward, where a great number of contacts are usually present, unless every individual is prepared aseptically, or in other words, wears a mask and has absolutely sterile hands.

I should like to ask Dr. Montgomery how his rooming-in plan can possibly take care of this very important phase of newborn care.

JAMES D. STARK (Erie): After our epidemic of diarrhea, we felt that we had to control any further spread of infection, and while we did not put this system (rooming-in) in the wards, we did put it into private rooms.

Our biggest problem, we thought, was the visitor, and we placed the responsibility upon each mother for the care of the child within her room. Each mother, when she comes into the hospital, is given a slip stating that the responsibility of and for the possible chance of infection from visitors is placed upon her. This plan has been in force ever since our epidemic in 1946. We

find that primiparae are very enthusiastic, but some of the multiparae are not. Our greatest opposition is from the doctors—the outside men, not the staff men.

We occasionally move a baby into the nursery if it disturbs the mother too much. We have had little or no trouble, and we have had no infection. We have had happy mothers and happy babies, and I think it is an excellent plan. I wish we could put it into our wards.

QUESTION: Dr. Montgomery, what has been your practice with regard to visitors?

DR. MONTGOMERY (in closing): It is quite true that we undertook the rooming-in of baby with mother in the hope primarily of preventing epidemic infection of the newborn, particularly the serious epidemics of infectious diarrhea.

It seemed to us that having the baby separately placed with the mother and cared for by the mother should cut down on the frequency of occurrence of infection and also reduce the possibility of such infection being transmitted to other babies. After all, separation and isolation of babies is the procedure when an epidemic breaks out, so why should babies not be separated before the epidemic occurs?

Of course, such a procedure is not intended to replace nor *should* it replace careful technique all along the line. The same care must be adhered to rigidly in the central nursery and in the preparation of formulas. Terminal sterilization of formulas is an advancement in this direction. One cannot practice rooming-in carelessly and hope to avoid illness of the baby.

The statement has been made that the baby in the room is exposed to contact with visitors. This is perhaps true if the patient is allowed to have unlimited visitors. In our own institution we have restricted visitation to the mother and the husband of the patient. Generally the patient herself is pretty well satisfied with such an arrangement inasmuch as she has the companionship of her baby during the day. Also, we have had less difficulty in controlling visitors inasmuch as even the most uneducated person realizes that a group of people cannot crowd into a patient's room without courting danger. There is always the possibility, of course, of some visitors coming in with a cold or infection, although we have specifically requested in our regulations that they avoid doing so.

Rooming-in is not a panacea for all the difficulties of hospital obstetric practice, but it permits of arrangements for separation and isolation and individual treatment of the baby, which make for an easier and simpler technical procedure that is probably more honestly carried out than some of the very rigid arrangements that are impossible for a nursing force to meet in their practical work.



NEOPLASMS OF THE KIDNEY

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THE Medical Society of the State of Pennsylvania had reached its twenty-first birthday when on August 2, 1869, Gustave Simon of Heidelberg did the first deliberate nephrectomy. At the time of its founding in 1848, renal surgery comprised the incision and drainage of perirenal abscesses and, on rare occasions, the extraction of stones from resultant fistulas, which procedures had been practiced since the days of Hippocrates. These historical facts illustrate the great advances made in renal surgery during the past eighty years, notwithstanding which the ultimate results of nephrectomy for malignant neoplasms are disappointing. Indeed, with the exception of a marked reduction in the primary mortality rate, the patient who now submits to nephrectomy for this condition has little better chance of cure than one similarly situated at the turn of the century.

The introduction of transperitoneal nephrectomy by Kocher in 1876 raised the unfulfilled hope that this procedure would increase the curability of renal cancer by operation, and it seems reasonable to anticipate little more from the thoracico-abdominal approach.

In 1937 Beer described the technique of separate ligation of the renal artery followed by careful dissection of the renal vein and removal of neoplastic thrombi which he found in 35 per cent of cases. Beer reported several instances of long survival following this procedure which, incidentally, increased the primary mortality rate 3 per cent. This technique has not been adopted widely, probably because of the technical difficulties involved.

Finally, the high hopes engendered by success with irradiation in certain types of cancer are largely if not completely lost in the case of renal neoplasms.

Statistical studies disclose some of the reasons for surgical failures, with which we are chiefly concerned in an analysis of 74 case histories. The latter are from the records of the Pennsylvania and Bryn Mawr Hospitals and comprise

approximately two-thirds of the cases studied by the senior author and his associates during the past twenty years.

Classification

Neoplasms originate from the cortex of the kidney (88.7 per cent) or from the mucosa of the renal pelvis (11.3 per cent). The latter include the comparatively common papillary types, which are more malignant but behave otherwise much like similar tumors of the bladder, and the rare, highly fatal, infiltrating, flat, epidermoid carcinomata.

Classifications of cortical epithelial neoplasms on the basis of either origin or structure remain unsatisfactory. In the present series 37 (59.6 per cent) were classified as hypernephroid, with only 12 (19.3 per cent) adenocarcinomata. The clear cell neoplasm is thought to be less malignant than the granular cell type, and this finds support in Mesina's demonstration by ocular transplantations in animals that the granular cell tumor is far more invasive and more prone to metastasize than the clear cell type. There is little supportive evidence of this in our clinical experience however, and the curability of renal cancer by operation cannot be predicated accurately on cellular structure. This is attributed by Greene, Deming, and others to an inherent benignancy in certain neoplasms that can be determined only by the conduct of heterologous transplants which, if malignant, grow with varying degrees of rapidity, and if benign, fail to develop.

Brief mention may be made here of the case of intrarenal cortical cell neoplasm of the adrenal gland which occurred in a male aged 65. The neoplasm was asymptomatic and was first demonstrated as a soft tissue mass in the right renal area during a gastro-intestinal x-ray study. The neoplasm, which was imbedded in the upper pole of the kidney, was 8 cm. in diameter, completely encapsulated, and was composed of large, pale, finely granular polygonal cells similar to those of certain cortical adrenal carcinomata. Evidence of adrenal insufficiency, including excessive nocturnal polyuria, followed operation and was con-

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trolled by Cortin therapy. The Kepler, Robinson, and Power test showed hypo-adrenalism. The patient has survived operation three years and nine months.

TABLE I
CLASSIFICATION
Cortical Neoplasms

	Cases	Per Cent
Hypernephroma	37	59.6
Adenocarcinoma	12	19.3
Sarcoma	3	4.6
Intrarenal adrenal carcinoma	1	1.6
Undifferentiated carcinoma	1	1.6
Lipoma	1	1.6
	55	88.7

Pelvic Neoplasms

	Cases
Papillary carcinoma	6
Epidermoid carcinoma	1
	7 (11.3%)

Predisposing Causes

The neoplasms in this series occurred most often in white males between the ages of 40 and 70. The left kidney was involved in 64.9 per cent, the right kidney in 35.1 per cent of cases. In one instance the tumor originated in the cortex between the two pelves of a fused crossed ectopic kidney.

TABLE II
PREDISPOSING CAUSES

Age Incidence	Cases	
1-10	2	
10-20	2	
20-30	2	
30-40	8	
40-50	11	71.6%
50-60	24	
60-70	18	
70-80	6	
80-90	1	
	74	
<i>Race</i>	<i>Cases</i>	<i>Per Cent</i>
White	65	87.9
Colored	9	12.1
<i>Sex</i>	<i>Cases</i>	<i>Per Cent</i>
Males	55	74.3
Females	19	25.7
<i>Side</i>	<i>Cases</i>	<i>Per Cent</i>
Right	26	35.1
Left	48	64.9

Epidermoid cancer of the renal pelvis usually occurs in association with epithelial metaplasia incident to chronic pyelonephritis and calculi. With this exception, no reasonable explanation

can be found for the development of renal neoplasms. Several of our patients suffered renal injuries prior to the appearance of symptoms leading to the discovery of new growths in the kidney; one, a girl aged 17, was found to have a large round cell renal sarcoma soon after the receipt of a renal injury due to a fall from a horse, while a man aged 62 developed hematuria, due apparently to rupture of the kidney, one month after being run over by a wagon wheel.

Metastases

Most patients dying as the result of renal neoplasms, unlike the usual hospital case, are found at autopsy to have widespread metastases. In the absence of suspected lesions elsewhere, we limit preoperative x-ray studies to the lungs, spine, and pelvic bones, and in 46 (62 per cent) of this series these studies, as well as routine physical examinations, were negative. However, as the operative results indicate, undemonstrable lesions in the lungs and other parts were present in many of these cases. This is further shown by the fact that enlargement of the liver was found on physical examination in only 2 cases of the present series, whereas in apparently favorable cases subjected to transperitoneal nephrectomy unsuspected liver involvement was found by Graham in 61 per cent of cases.

Metastases to the lungs were found in 14 per cent of our cases and in 6.7 per cent there were questionable lung changes. Bone lesions limited to the spine or pelvis were demonstrated in 6 cases. Multiple lesions were the exception. The femur was involved in 2 cases and the clavicle, eye, scalp, ribs and brain, in one each. Available means of determining the presence of early metastatic lesions are obviously inadequate.

Symptomatology

Renal neoplasms are comparatively rare and vary widely in behavior. With few exceptions they are malignant. In 11 (14.8 per cent) of this series there were no renal symptoms, these patients usually seeking treatment because of symptoms arising from metastatic lesions, or from toxemia apparently due to necrosis of the primary tumor. Deming's series contains 22 per cent of symptomless cases, the kidney lesions having been found in routine examinations, while in 26 of Graham's 195 cases unsuspected cancer of the kidney was found at autopsy.

Metastases to the lungs cause cough, dyspnea, and in some cases hemoptysis; to the bones, pain and pathologic fractures; to the brain, headache, convulsions, and coma. Toxic symptoms include progressive anemia, weakness, loss

of weight, fever, nausea and vomiting. These symptoms have serious import, but it is possible that they may occur while the tumor is confined to the kidney. One of our patients had progressive weakness, anemia, and fever for four years, while another had nausea and vomiting for three years before operation. Both of these patients died as the result of metastasis, but it is conceivable that earlier operation might have saved them.

Unwarranted emphasis is placed on the diagnostic importance of the classical triad of symptoms of renal neoplasm, namely, hematuria, pain, and mass, all of which may be absent and rarely occur together.

Table III shows that while hematuria was the initial symptom in 36 or 48.65 per cent of the series, it occurred later in only 11 or 15.9 per cent additional cases. Renal pain and mass are less commonly the initial symptoms, but develop later in about 30 per cent of cases.

It will be observed further that while the initial symptom was extra-urinary in 21 or 28.4 per cent of cases, only one-half of these subsequently developed renal symptoms.

The correct diagnosis was made at the outset in 59 or 77 per cent of the series; of the remaining 16 cases (23 per cent), delay in two instances in making the correct diagnosis possibly contributed to the fatal issue. The incorrect diagnosis of bleeding hydronephrosis was made twice, but immediate nephrectomy was done in one case. The other patient, a woman with gross hematuria, was found to have an apparently simple small hydronephrosis. Disregarding our advice to return should the bleeding recur, she continued to have intermittent hematuria for one year, when examination disclosed erosion of all the calices due to a large centrally placed hydronephroma. The patient was alive and well more than five years following nephrectomy. In another case both the function and pyelogram of

TABLE III
SYMPTOMATOLOGY

Initial Symptoms	Cases	Per Cent
Gross hematuria	36	48.6
Renal pain	10	13.5
Renal mass	6	8.1
Extra-urinary symptoms	21	28.4
Asymptomatic	1	1.3
Added Symptoms	Cases	Per Cent
Hematuria	11	17
Renal pain	21	30
Renal mass	26	37.1
Fever	15	21.4
Loss of weight	18	25.5
Cough and dyspnea	3	4.2

TABLE IV
EXTRA-URINARY INITIAL SYMPTOMS

	Cases
Loss of weight and strength	4
Pathologic fracture (femur)	2
Weakness and fever	2
Cough and dyspnea	2
Vague abdominal pain	2
Pain in spine	2
Varicocele	1
Nausea and vomiting	1
Pain in hip	1
Pain in chest	1
Pain in shoulder	1
Pain in knee	1
Pain in testicle	1
	21 (28.4%)

the bleeding left kidney were normal, but one month later there was incomplete filling with elongation and compression of the lower calices. The patient survived one year after removal of the rapidly growing neoplasm.

A well-encapsulated cyst was easily enucleated from the middle third of the kidney of a man aged 32 who refused nephrectomy when the cyst wall was found to contain an area of adenocarcinoma; death due to metastasis occurred one year later.

One of our patients had a pneumonectomy performed, on account of a neoplasm (said to be an adenoma), of the bronchus, one year before an initial attack of hematuria. The right kidney containing a large hypernephroma was removed and comparison of the two neoplasms showed them to be identical in structure. Biopsy studies of specimens taken from the site of a pathologic fracture of the neck of the femur of a 62-year-old man showed hypernephroid tissue. There were no urinary symptoms, but routine studies disclosed a defect in the right pyelogram and the extirpated kidney was found to contain a small hypernephroma.

In several cases pyelographic defects due to neoplasms were misinterpreted as caused by cysts, but these cases were subjected to immediate nephrectomy. An abdominal mass due to an enormous cystic hypernephroma was operated upon on the general surgical service in the belief that it was a mesenteric cyst. The series contains only one case of asymptomatic and unsuspected renal carcinoma found at autopsy. There is one instance of closed kidney which was caused by an epidermoid carcinoma at the ureteropelvic junction, but in another case a large closed kidney mass was thought to be neoplastic and a course of x-ray therapy given before operation which disclosed a large hydronephrosis. A

negro, aged 62, was admitted to the hospital with gross hematuria, having been run over by a wagon wheel one month before. Pyelography of the bleeding left kidney showed extravasation of the medium through a rent in the superior minor calyx. Operation was refused and two years later the patient returned after having had intermittent hematuria for one year. The large renal mass now present proved to be a cystic papillary adenocarcinoma containing 500 cc. of blood.

In the cases subjected to nephrectomy, the average duration of symptoms was 12.9 months; this series does not include a case of hypernephroma that was studied fifteen years before operation elsewhere on account of gross renal hemorrhage, the cause of which was not demonstrated at that time.

Delay in treatment is usually attributable to negligence on the part of the patient or of his physician, in illustration of which we cite the case of a man, aged 47, who gave a history of intermittent abdominal pain of five years' duration. Three years before admission he suddenly developed a large left varicocele, and two years later a large mass was discovered in the left renal area. Metastasis could not be demonstrated, but the renal pedicle was widely infiltrated with tumor. The patient survived nephrectomy two years and three months, death occurring as the result of extensive lung involvement.

Urography

Small cortical neoplasms may fail to distort the pelvis or calices although giving rise to gross hemorrhage, in which event correct diagnosis is rarely possible; or they may cause minute indentations due to pressure which may be obliterated as the result of overdistention incident to retrograde pyelography, although evident in secretory urograms. The latter seldom permit perfect visualization of every segment of the interior of both kidneys, without which they are useless in diagnosis. However, the secretory urogram is valuable as a pilot study since it may permit complete visualization of the hypertrophic normal kidney and show changes at least suggestive of disease on the suspected side, thus removing the necessity for bilateral retrograde pyelography. Cytologic studies of the urine from the bleeding kidney after the technique of Papanicolaou may prove to be a useful diagnostic measure in obscure cases; as yet we have not advised operation on the evidence above.

We will not discuss pyelographic interpretation. Suffice it to say that the experienced urologist will rarely fail to identify defects due to surgical lesions, although as mentioned above

various lesions may cause identical distortions. In the event of uncertainty, the study should be repeated within six weeks or earlier and as often thereafter as is necessary to establish the diagnosis. Pelvic filling defects due to blood clots and invisible stones sometimes mimic neoplastic deformities, but the former disappear or change in size and shape while the latter usually change their position, so that repeated pyelography serves to differentiate them from neoplasms in most instances.

Patients, especially males, with a history of antecedent gross hematuria should be subjected to intravenous urography preceding cystoscopic examination lest the hemorrhage be ascribed to an associated lesion such as benign prostatic hypertrophy. The latter condition complicated four cases of our series.

In one of these, a man aged 75 with prostatism, the x-ray study disclosed three rounded shadows in the region of the right kidney. Urography was not done, and the hematuria having ceased it was decided to withhold operation. Several months later gross bleeding recurred and persisted. Re-examination failed to disclose the previously observed stone shadows, and pyelography revealed duplication of the right renal pelvis with a large filling defect of the inferior pelvis characteristic of papillary neoplasm. It was found that the supposed stone shadows were cast by pills which the patient had been taking without our knowledge. Fortunately, the patient has survived nephrectomy two and one-half years and is apparently well.

Renal Function

Total renal function is little impaired as the result of neoplasm of one kidney, so that marked dysfunction in the presence of a renal mass raises the suspicion of polycystic or other bilateral renal disease. Chronic nephritis with neoplasm in one case of this series precluded operation; this diagnosis was confirmed at autopsy. In only five of the series was the blood urea nitrogen over 18 mg. per cent, and in only ten was the total phenolsulfonphthalein output less than 50 per cent.

The kidney urine is usually sterile. Only one instance of complicating renal infection was found in the series; this occurred in association with an epidermoid carcinoma of the renal pelvis.

Differential renal functional studies are important, although the tumor-bearing kidney may function normally in cases of pelvic tumor, and rarely in the case of cortical tumors. Illustrative of the latter is the case of a negress who presented herself for examination several days after

an initial bleeding. There was a mass in the left flank. The total phthalein output was 75 per cent and each kidney excreted 17.5 per cent of the dye during a fifteen-minute period. The pyelogram disclosed marked inward displacement of the ureter, but insignificant distortion of the lower calices. The kidney with large attached hypernephroma was removed on July 16, 1940, and the patient was known to be alive and well seven years later. The tumor in this case originated from the periphery of the renal cortex and grew outward, causing little renal destruction. Compare the foregoing with the case of an adult male who was admitted after two days of moderate bleeding from the left kidney. The pyelograms were normal and the bleeding kidney excreted 22.5 per cent of phthalein during a fifteen-minute period. The bleeding continued and one month later the left kidney excreted 20 per cent of dye, notwithstanding the presence of pyelographic distortion characteristic of neoplasm. The kidney containing a large hypernephroma involving the lower and middle third was removed, but the patient survived the elimination of this rapidly growing cancer only fourteen months.

Forty-four of the 48 cases in which careful differential kidney studies were done showed complete or partial loss of function on the diseased side and normal or hypernormal function of the uninvolved kidney. Neoplastic invasion of, or pressure on, the renal vein is, as Beer showed, a cause of renal dysfunction as indicated by complete failure of roentgenographic visualization with secretory urograms.

Hematology

Anemia, usually mild, was found in 19 per cent of the patients and 57 per cent had leukocytosis ranging up to 20,000 per cc. One patient without demonstrable metastasis, but advanced anemia, failed to improve despite repeated blood transfusions. The combination of fever, leukocytosis, and anemia almost invariably presages death. With few exceptions, blood loss due to hematuria is intermittent and not excessive.

Nephrectomy was performed 45 or 60.8 per cent times—in 43 cases by the lumbar route and in 2 advanced cases, transperitoneally. One of the latter was the case of an aged male with extensive perirenal involvement causing intense pain. The pain was relieved, but the patient survived the operation only four months. The second patient, a girl aged 13, had an enormous hypernephroma weighing 1400 grams, with nodules in the liver and retroperitoneal lymph nodes; she survived operation eleven months.

TABLE V

<i>Operative Treatment</i>	<i>Cases</i>	<i>Per Cent</i>
Nephrectomy	45	60.8
Exploration	3	
Renal biopsy	2	
Biopsy of femur	1	
Drainage of cyst	1	
	52	70
<i>Unoperated Cases</i>		
Metastases	13	18.5
Refused operation	4	
General debility	1	
Renal dysfunction	1	
Coma	1	
	20	28.5

This series contains additional cases in which nephrectomy was done solely for the relief of pain or prolonged hemorrhage. We have not observed the disappearance reported by others of a single metastatic lesion after the removal of the primary growth, but believe that nephrectomy is justifiable under such circumstances.

In 3 cases, clamps were left on extensively infiltrated pedicles, also in one case in which a short pedicle in a very stout woman precluded safe ligation. The latter survived operation six years and two months when she returned with a pathologic fracture of the right humerus. The other patients died within one year, one as the result of hemorrhage incident to removal of clamps.

We did not find it necessary or desirable to remove the twelfth rib in any of the present series.

Inasmuch as papillary tumors of the renal pelvis are associated with ureteral implants in 75 per cent of cases, the ureter and a segment of the bladder wall should be removed together with the kidney in suitable cases. Carcinoma of the ureteral stump appeared in one of our cases eight years after nephrectomy for a small papillary tumor of the renal pelvis. In a remarkable case in the care of Dr. Lloyd B. Greene the patient was operated upon for papillary carcinoma of the bladder eight years before symptoms of renal neoplasm appeared. The kidney, containing a similar tumor, and subsequently the ureteral stump, which was found to be tumor-free, were removed and since then several small recurrent tumors of the bladder have been destroyed by desiccation. The patient is alive and apparently well sixteen years after the original operation.

Among the palliative procedures employed was that of dissection of an obstructed ureter from an encircling neoplasm in a case of crossed renal ectopia. The anomaly had been discovered

TABLE VI
LIVING PATIENTS AND THOSE WHO DIED OF CAUSES OTHER THAN CANCER

Years	Cases
1-2	4
2-3	4
3-4	2
4-5	2
5-6	2
6-7	2
7-8	2
9 plus	3
	21 (46.6%)

3 years

5 years

6 years

7 years

9 years

13 cases

9 cases

7 cases

5 cases

3 cases

28.8%

20%

14.1%

11.1%

6.6%

by us eleven years before symptoms of neoplasm appeared. Re-examination disclosed complete loss of function of the lower half and dilatation of the upper half of the renal mass. The large hypernephroma developed from the cortical tissue between the two pelves.

Operative Mortality

Nephrectomy for neoplasms is attended by a higher mortality rate than for any other lesion with the possible exception of secondary operation for ancient pyonephrosis with fistulas. Recent reports, however, show a decided improvement.

There were two operative deaths (4.6 per cent) in our series—an old man dying of a coronary thrombosis eight hours after operation, and a negro, aged 41, who died of hemorrhage following the removal of pedicle clamps three days postoperatively. Autopsy in the latter case showed lacerations of the aorta and extensive metastasis.

Graham reports a primary mortality rate of 11 per cent, Deming 5.4 per cent.

Of the 45 cases subjected to nephrectomy, more or less of the postoperative course of 44 is known. In computing the end results of nephrectomy, we include the two primary deaths and count as dead the one untraced case. It is probable that figures based on complete knowledge of the ultimate fate of all the patients in the series would show improvement, but the conservatism shown is justified by the experience of others. Thus, Deming in a series of 69 nephrectomies for neoplasms reports a survival rate of 19.5 per cent, 14.6 per cent, and 9.8 per cent for the five-year, ten-year, and ten-year plus periods respectively. In Graham's series of 60 cases, seven (11.6 per cent) survived the five-year period, two of the latter having survived more than ten years.

Twenty-six (57.3 per cent) of our patients are known to be dead, nineteen (42 per cent) as the result of metastatic carcinoma; two died as the

result of operation. With three exceptions the patients with recurrence of the neoplasm died within two years after operation including one case with late recurrence (six years and two months). Two patients died from heart disease within two years after nephrectomy, while three other patients dying of causes other than cancer survived five years, six years, and nine years respectively. In this connection it may be recalled that 25 or 55.5 per cent of the patients in this series were more than 60 years of age.

As Table VI shows, 21 or 46.6 per cent of patients have survived operation or died of causes other than cancer. The latter group comprises five patients, of whom three survived operation five or more years, including a case of nine-year survival in which death occurred as the result of cerebral hemorrhage and autopsy failed to disclose any malignancy. Thirteen (28.8 per cent) patients have survived nephrectomy three years or more, nine (20 per cent) five years or more, seven (14.1 per cent) six years or more, five (11.1 per cent) seven years or more, and three (6.6 per cent) nine years or more.

These studies show that the behavior of cortical cell tumors is highly paradoxical. In some instances widespread metastasis occurs from a small, well-encapsulated primary growth, while another, apparently identical neoplasm may grow to enormous size yet remain confined to the kidney. For this reason it is impossible to prove on statistical grounds that the poor results of nephrectomy are due to procrastination, although it is difficult to believe that correct and prompt interpretation of the initial symptom, thus eliminating an average delay in treatment of 12.9 months, would not lead to improved final results.

Late recurrences take place, especially in the lungs and bones, as long as ten years after nephrectomy, but the same is true of mammary and other forms of cancer.

The following are among the factors that make renal carcinoma a serious disease: (a) the insidious nature of the lesion due in part to its

intraparenchymal origin, (b) its propensity to early invasion of the renal vein, (c) a lesser tendency to invasion of the perirenal tissues, and (d) procrastination on the part of the physician or patient in seeking the explanation of indicative symptoms.

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ABSTRACT OF DISCUSSION

WILLIAM J. DAW (Forty Fort): I would like to congratulate Dr. Herman on his perfectly lucid discussion of renal neoplasms and his honest interpretation of the results. He reported 20 per cent of five-year cures, but only 3 patients were living at the end of twelve years plus, which is not very many from such a large series of cases.

We know, of course, that renal tumors are deadly things, as are also tumors of the breast and of the intestinal tract. We know also that the treatment of deadly tumors is early, quick, and thorough eradication.

Some tumors, no matter how early one diagnoses them, are still fatal. However, as stated by Dr. Herman, there are many cases which present absolutely no renal or urinary symptoms. Recently I saw a patient who was brought into the hospital with weakness, pallor, and loss of weight, and x-ray of the chest showed widespread metastases. The patient had a couple of nodes scattered around on his body. One was removed and examined microscopically and it had hypernephroid tissue. An intravenous urogram showed a very faint indentation of one calyx. At autopsy we found widespread tumor metastasis throughout almost the entire body and a primary tumor in the upper pole of one kidney no larger than a quarter. Now, there was a case in which it was absolutely impossible to make a diagnosis preoperatively, because that man was doomed from the time his tumor first developed.

Most of the cases that we see are sent to us by other physicians, mostly general practitioners. We have tried to implant in their minds the absolute necessity for doing complete urologic examinations in all cases of urinary bleeding. In that way we have been able to pick up many cases of early tumor. We are not particularly interested in tumors that show a huge deformity of the kidney because we know most of those patients are doomed before we operate on them. The small, early tumors are the only ones in which we have a chance of effecting a cure.

Early diagnosis is also aided by the urogram. A good survey film of the urinary tract by urography helps us to find one good kidney. If the other one is at all unusual, that can be confirmed or ruled out by retrograde pyelography. That and cystoscopy are still the two most important methods of diagnosing renal conditions.

There is another point that I would like to discuss and that is the routine use of urographic studies whenever patients come into the hospital for general x-ray of their intestinal tracts. How many cases of intestinal symptoms do we see that are absolutely referable to

the kidney and not to the intestinal tract itself? The intestinal tracts are merely secondary and the renal symptoms are primary.

The prognosis of these cases depends on the early or late metastasizing of the tumor. No matter how good we are as surgeons, if we have a metastasis, we are licked. I have had the privilege of operating upon four Wilms' tumors. I lost one case in three months; the other three patients have survived seven, six, and four years. That does not mean that I am any better a surgeon than anyone else in this room. It merely means that I was lucky enough to get tumors that had not yet metastasized and was able to remove them before any implant had been made in other parts of the body.

Operation, I think, is absolutely necessary as soon as the diagnosis is made, and, of course, the operation of choice is nephrectomy. I have removed tumors the size of a man's head and the patients have remained well. One of these is now going on four years, and another is going on three years. The size of the tumor, however, is absolutely no indication of the degree of its malignancy.

We should consider the use of x-ray therapy in tumor metastasis or as a postoperative adjunct to tumor therapy. I will not go on record as saying whether it is curative or not, but I think it is valuable in postoperative metastatic lesions.

EDWARD J. McCAGUE (Pittsburgh): May I ask if there was any preoperative irradiation of these tumors?

DR. HERMAN (in closing): In answer to Dr. McCague's question, I would state that one of our twelve-year, apparent cures occurred in a patient who had prolonged preoperative irradiation. However, the probabilities are that irradiation had nothing to do with the result. It seems to be the consensus of opinion that the only benefit to be derived from this is to render operation less difficult through reduction in the size of the tumor.

I think it quite possible that procrastination is an important factor in jeopardizing the patient's ultimate chances of recovery from operative treatment, although I do not doubt that there are marked differences in the biologic behavior of these tumors.

I appreciate very much Dr. Daw's able discussion.

You are perhaps familiar with an article by Priestley, in which he discusses death during nephrectomy as a result of emboli. We recently had this unfortunate experience in the case of a patient who was discovered to have a left renal tumor two years after one breast had been removed because of malignancy. This patient, in addition to lung metastases with hemothorax, suffered uncontrollable nausea. We considered the case inoperable, but at the insistence of the patient I removed the kidney. The operation was extremely easy, but while tying the pedicle, complete respiratory failure suddenly developed, and the patient died.

Autopsy disclosed widespread metastases with extensive involvement of the liver and an enormous neoplastic embolus plugging the pulmonary circulation. This embolus undoubtedly had been displaced from the renal vein and vena cava during our manipulations incident to mobilizing the kidney, which is an ever present danger in these cases.

In these obviously inoperable cases, episodes like the one just described certainly have an evil effect on the minds of other patients who contemplate operation, but I suppose that it is our duty to disregard this when the effort to relieve distress seems otherwise justifiable.

PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division, American Cancer Society, in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

Exchange Fellowships

The American Cancer Society and the British Empire Cancer Campaign have worked out a plan under which exchange fellowships in cancer research will be made available to an equal number of persons from the two countries as a step toward advancing the study of the disease.

The Committee on Growth has consented to screen applicants desiring to study in Great Britain under this program, and it will recommend to the American Cancer Society that it provide specialized training for American investigators in Great Britain where opportunities exist for study in facets of research in malignant disease not widely available in this country. Training for an equal number of young British scientists selected by the Campaign will be provided in this country.

The Cancer Society, the Committee on Growth, and the British Empire Cancer Campaign believe that the training of young men and women in the many complex disciplines of modern scientific thought and techniques is fundamental to a sound approach to the problem of human cancer.

Candidates will be favored who express the intention of following a career in a discipline applicable to the study of growth. In evaluating fellowship applications the committee will keep in mind potential applicability of the proposed training program to problems of neoplastic growth in specialized scientific areas in which superior facilities exist in Great Britain.

Fellowships, which will be made effective at the convenience of the institution and the fellow, are open to citizens of the United States who possess the degree of Doctor of Medicine, Doctor of Philosophy, or Doctor of Science. They are intended for young men and women embarking upon a career in clinical medicine or basic research, and also for more mature candidates desiring to extend their fields of competence in these categories.

The fellowships will be for one year, and the stipend will be \$4,020, with a \$600 travel allowance. Application forms may be obtained from and submitted to the Executive Secretary of the

Committee on Growth, Division of Medical Sciences, National Research Council, 2101 Constitution Ave., Washington 25, D. C.

Professional Education

Funds have been made available by the national office of the American Cancer Society for a broad program of professional education as a service to physicians. The program will be conducted by the Pennsylvania Division with the cooperation of The Medical Society of the State of Pennsylvania. These three types of professional educational programs are suggested:

1. Refresher courses—held preferably in conjunction with medical schools, teaching hospitals, and tumor clinics to take advantage of their facilities and faculty.

2. Cancer teaching teams or traveling clinics—groups of prominent physicians interested in cancer may cover the State during a period of several months or a year, giving talks and clinics on the early recognition of cancer to county medical societies or hospital professional staffs.

3. Postgraduate instruction in cancer at the county level by a traveling instructor—an effective plan is to have a traveling instructor, a physician, and a field representative, a layman, cover every county in the State over a two-year period presenting a series of formal lectures on the early diagnosis of cancer, giving demonstrations at hospitals, and conducting clinics.

Cancer Bulletin

The Division of Cancer Control of the Pennsylvania Department of Health has made arrangements to send *The Cancer Bulletin* to the members of The Medical Society of the State of Pennsylvania.

This bimonthly publication contains numerous precise facts and many practical points which should be beneficial to the practicing physician. Prepared in two colors, this magazine has an appealing layout and good typography that will attract much reader interest. If enough interest is shown by the profession, distribution of this publication will be continued indefinitely by the Division of Cancer Control.

We Are Never too Old to Learn

American medicine can point with pride to the fact that doctors have never been satisfied to rest on past laurels. They have continually sought new methods, new fields of endeavor. Their constant search for knowledge has created the best system of medical care in the world.

In this tradition, eleven centers will function as postgraduate schools for five weeks during the fall of 1949 and for five weeks during the spring of 1950. Beginning the week of October 3, 1949, each center will conduct weekly sessions designed to aid the membership of The Medical Society of the State of Pennsylvania in keeping up to date on the latest developments in diagnosis and treatment. Use the form below to enroll now in the center of your choice.



Subjects included this year are:

Medical Jurisprudence	Early Detection of Cancer
Respiratory Diseases	Eye, Ear, Nose and Throat Diseases
Neuropsychiatry	Physical Medicine
Fractures and Traumatic Surgery	Preventive Medicine and Public Health
Allergy	Surgical Diagnosis
Dermatology-Syphilology	Medical Diseases of the Urinary Tract
Care and Treatment of Patients in the Event of Atomic Disaster	Care of the Postoperative Patient and Chronic Invalid in the Home
Recent Advances in Drug Therapy	

Please enroll me in the Graduate Education Institute Program for 1949-50 in the center indicated. I enclose a check for \$25 as my registration fee. (Make checks payable to The Medical Society of the State of Pennsylvania.)

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EDITORIALS

THE FISHBEIN INCIDENT

For nearly fifteen years, before nation-wide audiences composed of professionals (medicine, dentistry) or audiences captured by professional groups, the speaker of choice on controversial phases of professional service to the public, in sickness or health, has been Morris Fishbein, M.D., editor of the weekly *Journal* and of other periodic publications of the American Medical Association.

Dr. Fishbein's native intellectual power, fortified by his editorial experience (thirty-seven years), wide contacts in science related to medicine, a photographic memory, a broad vocabulary, and a facile tongue, has made him a popular lecturer as well as a keen opponent in debate. It is a not uncommon editorial experience to have expressions of editorial opinion on newsworthy topics, when printed in the official publications of medical societies, local, state, or national, appear later in newspapers and be interpreted as authoritative from the organization represented rather than merely an expression of the editor.

Such a misapprehension has been repeated so frequently and so widely in the name of the American Medical Association that many of its members, glad to hear him speak or see him quoted by national or world-wide press news as-

sociations, had come to think of Dr. Fishbein as the spokesman of the AMA. Naturally millions of laymen who read newspapers and listen to the radio broadcasts may have been similarly impressed.

The benefits derived in earlier years from this situation are recognized in the reports referred to below. However, since in December, 1948, when the House of Delegates of the American Medical Association unanimously approved the AMA two-year National Educational Program for the public, now in effect six months, the writer believes that all citizens who appreciate the radical transposition in the AMA public relations policy that is involved will agree that henceforth there should be no doubt as to who shall speak authoritatively for the American Medical Association on its policies.

The clarifying report of the American Medical Association Board of Trustees, which appeared in thousands of newspapers with more or less disturbing headlines, appears in full in this issue (page 1112) as does the carefully considered report from the Reference Committee back to the House of Delegates.

Read both reports carefully and realize that they were received and unanimously approved by the House with the same understanding and dignity with which Dr. Fishbein has since accepted the action.

DIETARY CHOLESTEROL AND ARTERIOSCLEROSIS

It is now well established that the development of arteriosclerosis is closely related to the metabolism of cholesterol. The detailed mechanisms of this relationship, however, have not been fully established. The accumulation of cholesterol in the arterial intima in the early stages of atherosclerosis is in part related to the level of the plasma cholesterol. For years it has been known that in chickens and rabbits dietary hypercholesteremia accelerates the development of arteriosclerosis. Quite recently these observations have been repeated in dogs.¹ Recognizing the relationship between plasma cholesterol levels and arteriosclerosis, many clinicians are currently recommending low cholesterol diets for the prevention of arteriosclerosis. Such dietary régimes are being advocated particularly for patients with coronary and cerebral arteriosclerosis.

While such low cholesterol régimes probably do no harm, they effect but little change in plasma cholesterol levels. Normally, more than 90 per cent of the cholesterol contained in the diet is absorbed from the gastro-intestinal tract. However, dietary cholesterol provides but a fraction of the daily cholesterol needs of the body and therefore the body normally synthesizes cholesterol from other materials. It has been shown² that the body readily uses acetic acid as a building block in the synthesis of cholesterol. As acetic acid is available through the metabolism of a variety of foodstuffs, many dietary substances may ultimately contribute to the plasma chole-

sterol levels. Therefore, one can anticipate little change in the level of plasma cholesterol by reduction in cholesterol intake alone. The development of successful measures for the prevention and treatment of arteriosclerosis demands a more complete understanding of the relationship between cholesterol metabolism and arteriosclerosis than is currently available. It is hoped that the research use of radioactive substances, particularly cholesterol and iodine, will provide information of vital importance in elucidating this relationship.

C. M.

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LOYALTY REPUTATION THREATENED

In many Pennsylvania county medical societies 85 to 100 per cent of members have paid the \$25 AMA membership assessment. In several county societies less than 60 per cent have paid.

A comparative report of all the sixty-one county societies is to be made to the 1949 House of Delegates of The Medical Society of the State of Pennsylvania and printed in the PENNSYLVANIA MEDICAL JOURNAL. Unless the tardy members of the several county societies send in

NOTICE OF AMA MEMBERSHIP ASSESSMENT

(Clip this form and mail with your check today if you have not already done so.)

The American Medical Association has requested your state medical society to collect this year a \$25 assessment. Please make check in favor of *American Medical Association—Assessment* and mail to The Medical Society of the State of Pennsylvania, 8104 Jenkins Arcade, Pittsburgh 22, Pa.

If your county medical society has combined this AMA assessment with its own dues for 1949, the bookkeeping of your county, state, and national medical societies will be greatly simplified if these two obligations are paid by separate checks.

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their checks, made payable to American Medical Association—Assessment, during the next few weeks, their society's rating in print may be far from the proud position that the average member should desire in such tests of unity and loyalty.

Officers of county medical societies should feel and implement their responsibility to bring their own society into line with the 90 to 100 per cent paid group.

Surely, with the AMA National Educational Campaign now well inaugurated and planned for the future, it is time for all AMA members to "stand up and be counted."

THE TREATMENT OF SYPHILIS COMPLICATED BY PREGNANCY

(EDITOR'S NOTE: This is the fifth of a series of guest editorials prepared by members of the Pittsburgh Syphilis and Venereal Disease Control Program, which is sponsored by the Venereal Disease Division of the Pennsylvania Department of Health, and the Department of Dermatology and Syphilology, University of Pittsburgh School of Medicine. They should refresh the minds of practicing physicians on the procedures necessary to establish a diagnosis of syphilis, the modern therapy, the follow-up of treated cases, and certain public health aspects.)

A syphilitic woman, untreated, has only one chance in six of bearing a live healthy infant, as compared with the normal woman's three chances in four. The incidence of syphilis in large obstetric clinics, depending on the race and general type of clientele, ranges from 3 to 23 per cent. It should be current practice, not only in clinic patients but in patients of the private class as well, to take a Wassermann test. No considerations of social level, expense, or confusion of moral with medical issues should be allowed to stand in the way of its performance in every pregnant woman.

There still persists a superstition, wholly unwarranted, that pregnancy is a frequent cause of false positive serologic reactions. This has been repeatedly demonstrated to be untrue. Pregnancy does not cause false positive serologic tests.

Infection of the fetus depends largely on the time relationships of infection of the mother. If the mother acquires syphilis shortly before, at the time of, or shortly after conception, the fetus is almost sure to be infected in utero. When infectious lesions are present in the mother at the time of delivery, the infant may acquire the disease at birth by contact with such lesions during passage through the birth canal, or later by contact with lesions on the breasts or elsewhere. The probability of the child being infected in utero diminishes somewhat as the duration of the mother's infection becomes longer. A woman who has had syphilis for many years may have

completely normal children, though it is not safe to count on this to the exclusion of treatment.

The best available evidence indicates that infection of the fetus probably does not occur until about the fifth month of pregnancy. Treatment of the syphilitic pregnant mother may therefore accomplish either one of two aims: (a) prevention of infection of the fetus if treatment is begun early, before the fifth month, by means of destruction of treponema in the mother's body and prevention of the wave of spirochetemia; or (b) if treatment is started later in pregnancy, after the fifth month, the actual early treatment of an already existing infection of the fetus, thus obtaining the same desirable result as the very early treatment of acquired syphilis in the adult.

One rule to which there is no exception and which is the explanation of Colles' law is that any woman who gives birth to an infected infant has syphilis herself, regardless of any serologic finding. The transmission of syphilis to the third generation is a rarity and is probably explained by the duration-in-infection factor. The woman who has the disease and bears normal children, in most cases, has been infected for more than twenty years before she becomes pregnant.

The advent of penicillin has modernized the treatment of syphilis. The advantages of this antibiotic over arsenicals and heavy metals are numerous, and make the use of penicillin particularly desirable in the treatment of syphilis in the pregnant woman. The total dose of penicillin should be not less than 2.4 million units administered in aqueous or saline solution at intervals of not less than two nor more than three hours night and day. The total duration of treatment should be not less than seven and one-half days.

The infant must be followed after birth for at least three months by means of (a) frequently repeated physical inspections, (b) quantitatively titered blood serologic tests, preferably every two weeks, and (c) roentgenograms of long bones taken preferably at the first and sixth weeks of life.

There is no satisfactory evidence that abortion, actual or threatened, is more frequent during penicillin treatment than during any other forms of antisymphilitic treatment.

The observations of three large groups combined give an over-all incidence of failure of 2.1 per cent to prevent prenatal syphilis by the use of penicillin as compared to 10 to 15 per cent failure by arsenotherapy.

The number of cases treated with penicillin in oil-beeswax studied thus far is too small to permit the drawing of definite conclusions. However there is some indication that it is somewhat

inferior to penicillin in aqueous solution in preventing congenital syphilis, particularly when treatment for early syphilis is begun late in pregnancy and there is a strong possibility that the fetus is already infected. It is especially necessary to maintain an effective level of blood and tissue penicillin in the mother if there is to be permeation of the placenta in sufficient amounts to cure the fetus in utero. In the total problem, however, penicillin in oil-beeswax seems to be almost as effective as aqueous crystalline penicillin, and superior to the arsenic-bismuth therapy previously employed.

Forty-five mothers were treated at the University of Pennsylvania with a total dosage of 4.8 million Oxford units of amorphous calcium penicillin in peanut oil and beeswax, given over a period of nine days. The over-all results were approximately equivalent to those following the use of aqueous solution. Two living syphilitic infants have resulted, or a failure rate of 4.9 per cent. It is not necessary for the woman to have a negative blood test to give birth to a perfectly normal child.

In treating congenital syphilis a distinction should be drawn as to the stage of the infection. The lesions typical of early congenital syphilis are entirely analogous clinically to those occurring in early acquired syphilis in adults with the exception that the infant suffers from a severe toxemia and concomitant lesions in the viscera. The constitutional disturbances are therefore more profound; the risk of death before the body's own defenses can be mobilized is grave. The mortality rate among infants with untreated congenital syphilis is high—from 25 to 50 per cent.

If the infant, unrecognized as syphilitic and therefore untreated, survives the first few months of life, opportunity is provided for a mobilization of his own body defenses, and he usually enters upon a period of latency of several or many years' duration, terminated by the development of lesions involving particularly four structures—the eye, the bones, the inner ear, and the nervous system.

In late congenital syphilis, on the other hand, as in late acquired syphilis, radical "cure" is probably no longer attainable. It is a well-known fact that under all conditions and during all kinds of antisymphilitic treatments a certain number of children will continue to show persistent positive serologic reactions many months after treatment. If these children continue to have a normal spinal fluid and fail to demonstrate any lesion of syphilitic character, but still continue to have a persistently low titer, they should not, under ordi-

nary circumstances, be subjected to any further treatment. They should be watched carefully for years.

Since it has been proved that maternal syphilitic reagin may appear in the blood of non-syphilitic infants for varying periods after birth, the results of the cord serologic test have become of little importance. When positive, the test may be merely evidence of maternal rather than infant infection.

In interstitial keratitis, when we consider the edema and massive infiltration in the cornea caused by the disease, dramatic results of treatment are not to be expected except in mild cases in which these pathologic processes are considerably attenuated. The absence of any striking result in the final visual acuity of penicillin-treated patients is consistent with clinical observation that penicillin does not uniformly exert an immediate favorable effect on active interstitial keratitis. Interstitial keratitis which is retrogressing at the time of treatment pursues a favorable course, and an occasional severe case of the disease seems to be benefited. On the other hand, other severe cases are definitely not improved by penicillin, nor indeed by any other method of treatment. Fever therapy appears to be the most effective form of treatment.

An adequate amount of penicillin for one course of treatment of an infant is 100,000 units of penicillin per kilogram of body weight, divided into approximately 120 intramuscular injections given at intervals not longer than three hours around the clock for a period of twelve to fifteen days. In debilitated infants, the initial dosage on the first day is reduced by about one-half.

JOSEPH J. HECHT, M.D.

THE AMERICAN CANCER SOCIETY AND THE EARLY DIAGNOSIS OF CANCER

The American Cancer Society has often been accused of doing more harm than good in its efforts to educate the lay public about the facts of cancer. Without attempting to praise or condemn its approach to this problem, the fact remains that any marked improvement in survival rates which is to be obtained through the use of the methods available for treatment today will be due chiefly to early diagnosis in a larger percentage of cases than is now the case. Early diagnosis depends not only on early consultation by the patient but equally so on early recognition

of the cause of the patient's complaint by the physician.

No one should have anything but praise for the Society's approach to the latter objective. This consists of a series of "Monographs for the Physician on the Early Recognition of Cancer" which are being sent to the medical profession through the mail without charge. These monographs are written by authorities who know

how to be brief and concise and are attractively printed and well illustrated. They may be read with profit by general practitioner and specialist alike and should be kept near at hand where they may be readily consulted.

If quality is maintained in the subsequent issues, the series of monographs will provide one of the best references on the early diagnosis of cancer that are available today. J. R. W.

TEST YOUR DIAGNOSTIC SKILL

At the request of Dr. William A. Bradshaw, chairman of the 1949 Committee on Scientific Work, we append case abstracts for the Clinicopathologic Conference called for Tuesday afternoon, September 27, in the Urban Room, Hotel William Penn, Pittsburgh.

The ambitious reader will familiarize himself with these case histories—jot down questions as they may occur; also, having completed an analysis of the evidence here presented, record his or her own diagnosis and complete plans to attend the convention and conference prepared to secretly applaud or requite himself as the whole picture is unfolded by the clinicians who conduct the conference.

CLINICOPATHOLOGIC CONFERENCE

3: 20-5: 00 p.m., Tuesday Afternoon, September 27

PATHOLOGIST: Dr. Elwyn L. Heller

CLINICIANS: Drs. William W. G. MacLachlan and Kendall A. Elsom

Case 1—White Male—Age 82 Years

Clinical History: An 82-year-old white male was admitted to the hospital on Feb. 12, 1949, complaining of mild intermittent abdominal pain of two weeks' duration and dysuria, with frequency and incontinence, of somewhat longer duration. Upon admission, a distended bladder reaching the level of the umbilicus was noted. The abdomen was distended and doughy to palpation; peristalsis appeared normal. There had been no bowel movement for three days. There had been a 40-pound weight loss associated with anorexia, slight nausea, and occasional vomiting during the preceding six months. The past medical history was irrelevant.

Clinical Findings: A massive fecal impaction was removed digitally during the first week of hospitalization, following which normal evacuation was established and the abdominal pain disappeared. A barium enema was not entirely satisfactory, but revealed diverticuli of the sigmoid colon. Because of signs of urinary retention, an indwelling catheter was inserted. Rectal examination revealed grade III prostatic enlargement. The gland was uniformly enlarged, soft, and not fixed. En-

doscopic examination on March 3 revealed enlargement of both lateral lobes, for which transurethral prostatic resection was planned.

In the afternoon, following cystoscopy, penile and lower abdominal pain, with nausea, vomiting, and diaphoresis developed. Operation was postponed and on March 4 and 5 the patient had nausea, vomiting, and anorexia. A gastric analysis revealed no free hydrochloric acid; the electrocardiogram showed no marked recent abnormalities. The patient retained very little food, but was free from pain. On March 7 churning peristaltic movements in the epigastrium moving from left to right were observed through the abdominal wall. There was slight abdominal distention with normal peristaltic sounds. A barium enema on March 8 revealed normal filling with numerous small diverticuli and a constricting deformity in the upper sigmoid colon suggestive of mild inflammatory changes around the bowel. There was abdominal distention and active visible peristaltic waves in the upper half of the abdomen, with occasional tinkling sounds. The following morning 70 cc. of reddish fluid was aspirated from the fasting stomach. It contained free hydrochloric acid.

Clinical Course: From March 5 to March 12 the patient had a consistent pattern of a good appetite for breakfast and lunch with increasing enlargement of his abdomen in the afternoon followed by vomiting during the evening, night, and early morning—never fecal in type and unassociated with pain. When vomiting had ceased toward morning, the patient obtained relief from the discomfort of distention. At no time was there abdominal pain, muscle splinting, or rigidity.

On March 12, after lavage, a one meal barium study revealed extreme dilatation of the stomach with 100 per cent six hour retention. No filling defect of the stomach was noted and the radiologic interpretation was one of pyloric obstruction.

On March 14 exploratory laparotomy was performed and the patient suddenly died six hours later, having reacted from anesthesia in a satisfactory manner.

The findings on physical examination were essentially negative except for those previously recorded. The blood pressure was 145/80; the chest was emphysematous; heart sounds were distant, but of good quality. The temperature and pulse fluctuated between normal and subnormal levels during the hospital course. Neurologic examination was entirely normal.

Laboratory Data:

Electrocardiogram: The heart rate was 60. Sinus mechanism was interrupted by occasional ectopic ven-

tricular contractions. The P-R interval measured about .18 sec. QRS complexes showed well-developed left axis deviation and marked slurring. The total QRS deflection time was about .12 sec. T waves were small and upright in leads I, II, and V-5 and better developed in V-2 and V-4. They were negative or diphasic in lead III.

Sedimentation rate (March 8): 32 mm. in 60 minutes (straight line).

Urinalyses: March 2, trace of albumin, few white blood cells; March 13, 10 to 14 white blood cells per high power field.

Phenolsulfonphthalein:

	March 3	March 9
First specimen	10 cc. 10%	150 cc. 10%
Second specimen ...	½ cc. 0%	55 cc. 25%

Blood count:

	March 2	March 13
Red blood cells	3,910,000	3,700,000
White blood cells	10,000	5,400
Hemoglobin	80	73
Polymorphonuclears ...	67	
Eosinophils	6	
Lymphocytes	27	

The mean red cell diameter on March 2 was 7 microns.

Chemistry:

March 2—Nonprotein nitrogen 32; sugar 112.

March 6—Total protein 6.06; albumin-globulin ratio 4.59/1.47.

March 8—Serum chloride 645 mg. per cent.

Serologic tests (March 4): Kline 4 plus, Kolmer 4 plus, cardiolipin 4 plus, quantitative Kolmer 44444-0.

Feces: Three examinations were negative for gross or occult blood.

Case 2—White Male—Age 16 Years

Clinical History: A 16-year-old white male was admitted to the hospital on July 26, 1948, complaining of dyspnea and swelling of the left ankle since May, 1948. The onset was preceded twenty to twenty-five days by a sore throat, associated with pain in thighs and calf muscles, most marked on the left. These symptoms cleared with medication.

At the onset there was painful swelling of the left ankle and foot to the extent that walking was impossible due to numbness and weakness. The patient was recently treated for three weeks at another hospital for a kidney and gastro-intestinal disturbance of uncertain type which cleared under therapy; the condition of the leg remained unchanged.

One week prior to this admission, pain and stiffness of the right shoulder developed with later involvement of both wrists. There was progressive weakness of the hands and forearms until at the time of admission he could barely extend the left arm, and had no use of the right hand. Dyspnea and tachycardia were constant, and he had become extremely pale.

Blood and mucus had been passed in the stools for three weeks prior to admission. He passed urine only once daily, having difficulty in initiating the stream by straining.

He complained also of fever and excessive perspiration without chills. There had been considerable loss of weight in the preceding three months.

Some blood had been coughed up the week before,

and the boy had noted some palpitation. He had been "very nervous" for four to five weeks and slept at night with difficulty.

Past History: He had had the usual childhood diseases and scarlet fever in infancy. His tonsils and adenoids were removed at age 6. The family history was non-contributory.

Physical Examination: Examination revealed a pale white youth propped up in bed, and quite dyspneic (24/min.). There was a noticeable facial pallor, but no ocular abnormalities. There was some nasal discharge and crusting. The tongue was red and furrowed. The throat showed slight inflammatory changes. The posterior cervical nodes were palpable, as were a few small axillary nodes, bilaterally.

Respiratory System: There was some retraction of the interspaces, also slight diminution of tactile fremitus in the bases together with percussion dullness and diminished breath sounds and rales. A very rough friction sound was heard just to the left of the cardiac apex, which was also heard to the right of the sternum in the third intercostal space.

Heart: The point of maximal impulse was in the sixth interspace—midclavicular line. The P₂ sound was greater than the A₂. The sinus mechanism rate was 120/min. There were no murmurs. The blood pressure was 108/92.

Abdomen: The liver edge was palpable three fingers below the costal border. There was an indefinite mass palpable in the left upper quadrant. These findings were confirmed by percussion. There was normal peristalsis.

There was pitting edema of the left foot, ankle, and leg. The feet were warm and the hands were moist.

Neurologic examination revealed profound flaccid paralysis of the arms and hands, slightly less in the legs and feet, and greater on the left side; pronounced muscle tenderness; loss of all tendon and abdominal reflexes, and loss of pain and diminution of touch sensation over the left hand and forearm, the left foot and foreleg, and to a lesser extent over the right foot and hand. There was slight impairment of vibratory sensation in the same regions. The cranial nerves were entirely negative.

X-ray examination on July 29 showed no bone lesions of the forearms or hands; chest study revealed pleural effusion on the right with accentuated hilar markings bilaterally.

Electrocardiogram, July 27, showed low voltage T waves with inversion in leads II and III, and contours of S-T segments suggested myocardial changes, possibly secondary to pericarditis. The possibility of coronary disease effects was to be considered.

Clinical Course in Hospital: During the hospital stay there was a constant tachycardia of 90-140. The temperature remained normal except for an abrupt terminal rise to 101.4° F. On July 27 the patient was critically ill. Enlargement of the heart was noted with ticktack rhythm, and gallop rhythm in the aortic area. The heart sounds were of poor quality.

On July 28, 240 cc. of clear yellow fluid was removed from the chest by tap. It formed a jelly clot after a few minutes. There was still dullness at the base of the right lung with diminished breath sounds.

On July 29, 400 cc. of fluid was removed from the chest. The optic fundi showed no arteriolar change or exudate. The disks were indistinct and pale.

On August 2 a pleuritic friction rub was present in the left lower portion of the chest anteriorly. Bronchial respirations with many moist rales were heard in the left upper portion anteriorly. A paravertebral block was done bilaterally with some relief of pain in the legs.

From August 3 until death on August 21, there was a progressively downhill course characterized by diffuse muscle tenderness, abdominal cramps, distention, and diminished peristalsis. Generalized edema of the upper and lower extremities developed and fluid from both pleural and pericardial cavities was aspirated. A biopsy of the gastrocnemius muscle on August 5 revealed small focal areas of perivascular inflammation of the fibrous septa and hyaline thickening of vessel walls.

There was gradual slowing of the pulse and respirations and a terminal rise in temperature shortly before death.

During his hospital course he had been given streptomycin in daily dosage of 1.8 Gm. for a total of 30 Gm. and a course of sulfadiazine totaling 165 grains.

Laboratory Studies:

Urinalyses

	July 27	August 4
Reaction	6.5	4.5
Specific gravity	1.027	1.030
Color	Amber	Amber
Albumin	4 plus	4 plus
Sugar	0	0
Microscopic findings ..	Few white and occasional red blood cells	Few each of white and red blood cells, epithelial cells, and granular casts

Blood counts

	July 27	August 2	August 6	August 16
Red blood cells	3,800,000	3,500,000	3,600,000	4,050,000
White blood cells	10,000	16,900	20,400	13,900
Hemoglobin	73	70	70	76
Polymorpho-nuclears ..	79	77	79	79
Eosinophils .	0	2	0	1
Lymphocytes	18	20	19	21
Monocytes .	3	1	2	0

Biochemistry

	Nonprotein Nitrogen	Sugar
July 27	31	85
August 16	39	

July 28—Pericardial fluid—total protein 2.14.

July 31—Total serum protein 6.63; albumin 4.23; globulin 2.40.

August 10—Total serum protein 5.5; albumin 3.16; globulin 2.39.

August 11—Pericardial fluid—total protein 2.2.

August 16—Cephalin-cholesterol flocculation test—3 plus in 24 hours, and 4 plus in 48 hours.

Bacteriology: On August 11 a smear of the pericardial fluid was negative for tubercle bacilli; culture showed *Streptococcus viridans*.

Serologic test: On July 27 the Kline test was negative.

Spinal fluid: Sugar 66; total protein 10; Wassermann test negative; colloidal gold 0001110000-0.

Sedimentation rate (July 27): 18 mm. in 45 minutes; 23 mm. in 60 minutes.

A - B - C RESTAURANTS

The American traveler, particularly in the South American countries, fully appreciates the meaning of environmental sanitation. After a siege of high fever, colic, and diarrhea, he knows what it means to have water and food supplies protected from disease-bearing organisms.

Although we in the United States know how we can protect the public from water-borne and food-borne disease, we do not always provide the administrative machinery whereby we can be positive that the public is protected.

Last September the City Council of Pittsburgh passed a restaurant grading ordinance which could accomplish this objective of protecting the customers of restaurants in this city. Under an ordinance of this type there are certain minimum standards which must be maintained. Maintaining these standards alone would rate a B. But, included also is an incentive for the restaurant to maintain the highest type of sanitary practices. Certain particular housekeeping items which make it easier for the restaurant owner to keep his place clean are included, and compliance with these will give him an A rating. By the use of A, B, and C grades the customer can

know just what kind of standards are maintained in the restaurant he patronizes. This type of ordinance gives the restaurant and its customers the incentive to want higher standards of restaurant sanitation.

The old method of policing and subsequent slow court action to close or fine a restaurant which does not maintain the standards required by law is ineffective. Fines can easily become a normal part of the overhead expense of the restaurant. In order to adequately protect the eating public, we must be assured that proper refrigeration is available and used; that dishwashing facilities and methods are such that the utensils are kept free from possible contamination. Many restaurant kitchens are located in basements with sewer lines overhead. Accumulated dirt on these pipes and condensation of moisture, due to poor ventilation, increase the hazards of possible food contamination. Structural defects are largely responsible also for infestation with vermin. Soft wood floors will absorb grease and food particles, leaving an excellent breeding place for micro-organisms. The A-B-C Restaurant Ordinance provides public health officials with a method of enforcing, through public opinion, standards of sanitation which should be maintained for the public protection.—*Pittsburgh Medical Bulletin*.

SKELETON TENTATIVE PROGRAM

NINETY-NINTH ANNUAL SESSION

Pittsburgh, September 25 to 29, 1949

SUNDAY, SEPTEMBER 25, 1949

(Campus of the University of Pittsburgh)

- 3:45 p.m. Religious Hour—Stephen Foster Memorial Auditorium
5:00 p.m. Tea—Faculty Club, 17th Floor, Cathedral of Learning (Subscription, \$1.00)

MONDAY, SEPTEMBER 26, 1949

(All scientific sessions and exhibits on 17th Floor, Hotel William Penn)

(Monday afternoon session in Urban Room)

- 1:00 p.m. Symposium—The Present Status of the Silicosis Problem
2:50 p.m. Intermission to view exhibits
3:10 p.m. Symposium—The Newer Aspects of Cardiovascular Disease
7:00 p.m. State Dinner, Pittsburgh Room (Subscription, \$5.00)

TUESDAY, SEPTEMBER 27, 1949

(Medicine in Urban Room; Surgery (simultaneously) in Monongahela Room)

- 9:00 a.m. Medicine—Symposium on Diabetes Mellitus
Surgery—Eye, Ear, Nose, and Throat Diseases
10:20 a.m. Intermission to view exhibits
10:40 a.m. Medicine—Symposium on Pediatric Endocrinology
Surgery—Symposium on Advances in Surgery
1:20 p.m. Medicine—Dermatology
Surgery—Symposium on Surgery of Trauma
3:00 p.m. Intermission to view exhibits
3:20 p.m. Medicine—Clinicopathologic Conference
Surgery—Obstetrics and Gynecology
8:30 p.m. Installation Meeting, Carnegie Music Hall

WEDNESDAY, SEPTEMBER 28, 1949

- 9:00 a.m. Section on Medicine—Miscellaneous
Surgery—Symposium on Pediatric Surgery
10:20 a.m. Intermission to view exhibits
10:40 a.m. Medicine—Symposium on Modern Therapy
Surgery—General, Fractures, Plastic, Bile Duct
1:20 p.m. Medicine—Mental and Nervous Diseases
Surgery—Clinicopathologic Conference
3:00 p.m. Intermission to view exhibits
3:20 p.m. Medicine—Symposium on Virus Diseases
Surgery—Urology
9:00 p.m. President's Reception (Pittsburgh Room)

THURSDAY, SEPTEMBER 29, 1949

- 9:00 a.m. Medicine—Symposium on Gross Gastro-intestinal Hemorrhage
Surgery—Symposium on Anesthesia
10:20 a.m. Intermission to view exhibits
10:40 a.m. Medicine—Preventive Medicine and Public Health
Surgery—Symposium on Surgery of Malignancy
1:00 p.m. Medicine—Symposium on Problems of the Newborn
Surgery—Pathology and Radiology

MAKE YOUR HOTEL RESERVATIONS EARLY

99th ANNUAL SESSION

THE MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA

September 25, 26, 27, 28 and 29, 1949, Pittsburgh

Hotel rooms are still at a premium, but the Pittsburgh hotels, in cooperation with the Pittsburgh Convention Bureau, have assured us that there will be available ample rooms for those attending our annual meeting if the reservations are made now. Make your plans now to attend the whole session and write directly to the hotel of your choice for reservations today.

HOTEL WILLIAM PENN—General Headquarters

William Penn Way

Single rooms	\$4.50	\$5.00	\$6.00	\$7.50
Double beds	6.75	7.50	9.00	10.00
Twin beds	7.75	9.00	12.00	13.00
Suites	15.00	18.00	22.00	27.00

ROOSEVELT HOTEL—Woman's Auxiliary Headquarters

607 Penn Avenue

Single rooms	\$4.00	\$4.50	\$5.00	\$5.25
Double beds	6.50	7.50	8.00	8.50
Twin beds	8.50	9.00	9.50	10.00
Suites	14.00	17.50	18.00	23.00

PITTSBURGHER HOTEL

428 Diamond Street

Single rooms	\$4.00	\$4.50	\$5.00	\$5.50
Double beds	6.00	6.50	7.00	7.50
Twin beds	8.00			
Suites	18.50			

FORT PITT HOTEL

Tenth Street and Penn Avenue

Single rooms	\$3.50	\$4.00	\$4.50	\$5.00
Double beds	5.00	5.50	6.00	7.00
Twin beds	6.00	6.50	7.00	8.00

SHERATON HOTEL

212 Wood Street

Single rooms	\$4.00	\$4.50	\$4.85	\$5.00
Double beds	5.00	5.50	5.75	6.00
Twin beds	7.00	7.50	8.00	
Suites	9.85	11.85		

WEBSTER HALL HOTEL

4415 Fifth Avenue

Single rooms	\$4.50	\$6.00	\$8.50	
Double beds	7.00	8.50	11.00	
Twin beds	7.00	8.50	11.00	

SCHENLEY HOTEL

Bigelow Boulevard and Fifth Avenue

Single rooms	\$4.50	\$5.50	\$7.00	\$9.00
Twin beds	7.00	8.00	9.00	11.00
Suites	15.00	16.00		

These are the tools . . .

Are you using them?

Every Medical Society member in the State has been provided with the following public relations tools. This is YOUR National Education Campaign, and your part in it takes only a few minutes a day. A few minutes is a small price to pay to preserve the freedom of American medicine.

* * * * *

Two Timely Pamphlets—Not long ago you received in the mail two pamphlets entitled “The Voluntary Way Is the American Way” and “Your Medical Program—Voluntary or Compulsory?” Have you distributed these personally, with a few well chosen words to each person who received them? Have you given twenty of each to your wife to use in the Auxiliary’s personal contact campaign? Have you used the green card to order extra copies for your waiting room and as bill inserts?

* * * * *

A Message to Patients—You also received, in quantity, a sticker to be attached to correspondence, statements, and prescriptions. This brief reminder serves to provoke interest in the issue and gives you an opportunity to answer questions which will arise. Order more of them!

* * * * *

The Powerful Poster—Is Sir Luke Fildes’ picture of “The Doctor” displayed in your waiting room, with its appropriate copy about sickness insurance? Two sizes, 35” x 35” and 19” x 20”, are available from your State Society. The larger poster is suggested for hospitals and drug store windows. Its message, “Keep Politics Out of This Picture,” is a powerful one. Take two minutes to order the poster and another two to tack it up.

* * * * *

A Reply to President Truman—AMA President-elect Elmer Henderson’s paper, “American Medicine Replies to President Truman,” is available for distribution in your waiting room or to people with whom you discuss the subject of socialized medicine. This is a doctor’s diagnosis—and none of the socializers has successfully challenged it!

Talking Points . . .

In answer to Oscar Ewing's contention that 325,000 people die needlessly every year, point out a recent statement by the Metropolitan Life Insurance Company that 267,000 lives were saved in 1947 alone because of the improvement in mortality statistics since 1940.

We quote James F. Byrnes, once Truman's Secretary of State and a Roosevelt era New Dealer: "If some of the new programs . . . should be adopted, there is danger that the individual, whether farmer, worker, manufacturer, lawyer, or doctor, soon will be an economic slave pulling an oar in the galley of the state."

General Eisenhower wrote to Congress: "In my own mind I am perfectly clear as to basic principle and have more than once made public statements to the effect that I definitely oppose every unnecessary intervention of the Federal authority and Federal Treasury in what should be **LOCAL BUSINESS AND LOCAL RESPONSIBILITY.**"

Dr. Ralph Campell, a young English physician who joined the National Health Service and, after seeing how it operated, refused to participate and came to America to practice, claims that there are three reasons why British medicine failed to fight:

- 1. British medicine's public relations were poor.
- 2. The average doctor did not know about the government plan until four months before it was put into effect.
- 3. British medicine has no alternate plan.

Let's profit by their mistakes—

- Improve our public relations as rapidly as possible.
- Make sure that not only every doctor but every layman knows the fallacies of socialized medicine.
- Support our voluntary insurance plans.

Compulsory health insurance is not really "insurance." It is gravely unfair to the people to pretend that it is. Though an arbitrary "premium" is collected, in the form of a payroll deduction, benefits are neither specified nor guaranteed. Sound insurance is based on sound actuarial standards and on contracts clearly setting forth both benefits and costs. Voluntary health insurance has such guarantees in writing. The government's proposal might justly be termed compulsory sickness taxation.

Campaign Material Available for Distribution

- Every message—every leaflet—exposing the threat of compulsory health insurance to the Nation's health is ammunition for the cause of America and American medicine. This munitions supply will win the fight against socialized medicine **IF IT IS USED EFFECTIVELY.**
- A variety of informative material is available for general distribution. Order what you can effectively use. On the form below check the items and note quantity desired, and mail to The Medical Society of the State of Pennsylvania, 230 State St., Harrisburg, Pa.

CHECK LIST	QUANTITY
☐ QUESTION AND ANSWER PAMPHLET , "The Voluntary Way Is the American Way"	_____
☐ ILLUSTRATED FOLDER : "Your Medical Program—Compulsory or Voluntary?" Reception room and mail enclosure piece	_____
☐ "COMPULSORY HEALTH INSURANCE—A Threat to Health—A Threat to Freedom!" (Basic speech in pamphlet form)	_____
☐ BLUEPRINT Plan of Campaign	_____
☐ ENVELOPE STICKERS	_____
☐ AMA 12-point program	_____
☐ "AMERICAN MEDICINE REPLIES TO PRESIDENT TRUMAN"	_____
☐ "THE DOCTOR" 19" x 20" color reproduction of Fildes painting, for office display	_____
☐ "THE DOCTOR" 35" x 35" blowup of Fildes painting, for large public display only	_____

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OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*

8104 Jenkins Arcade

Pittsburgh 22, Pa.

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

ACTIVITIES OF THE AMA JOURNAL EDITOR

(EDITOR'S NOTE: See editorial, "The Fishbein Incident," page 1101. The following is the supplemental report of the Board of Trustees to the AMA House of Delegates, June 6, 1949, and it in turn is followed by an excerpt from the report of the Reference Committee on Reports of Board of Trustees and Secretary.)

Dr. Henderson presented the following report, which was referred to the Reference Committee on Reports of Board of Trustees and Secretary:

The Board of Trustees is aware of the criticism of the Editor coming from within and from without the profession. The Board recognizes that the public has come to believe that the Editor is spokesman of the Association. The membership undoubtedly wishes the elected officials to speak authoritatively on all matters of medical policy.

Against the time when the Editor retires, Dr. Austin Smith has for some months been in training as the Assistant Editor and the talent of the Editor will be retained for the present under the control of the Board of Trustees.

In view of the increasing responsibility of the Editor and reorganization of the department, the Board of Trustees has decided on the following points:

1. The Editor will completely eliminate speaking on all controversial subjects both by platform and by radio. Approval of all speaking engagements will be made by the Executive Committee.

2. Elimination of all interviews, including press conferences, and statements by Dr. Fishbein except on scientific subjects.

3. Editorials on controversial subjects will be supervised by the Executive Committee.

4. Complete information as to these activities will be reported to the members of the House of Delegates.

5. There will be permanent elimination of the diary in Tonics and Sedatives.

6. Plans for the training of a new Editor in an orderly manner, including the retirement of the present Editor, will be formulated.

The Board of Trustees of the American Medical Association announces that plans have been formulated for the retirement of Dr. Morris Fishbein as editor of *The Journal of the American Medical Association* at an appropriate time. For thirty-seven years Dr. Fishbein has served the American Medical Association well and faithfully. *The Journal of the American Medical Association* is an enduring monument to his genius and devotion. His activities have extended far beyond his immediate duties as an editor, and the Board desires to pay tribute to his many accomplishments in other fields.

The Board finds that serious dislocation would result from any sudden replacement. With this in mind a reorganization of the editorial staff is under way so that his retirement, when consummated, will not result unfavorably for ventures of the Association.

Respectfully submitted,

ELMER L. HENDERSON, *Chairman*,
EDWIN S. HAMILTON, *Secretary*,
and all other Board members.

Gratitude Expressed

(Excerpt from report of Reference Committee on Reports of Board of Trustees and Secretary.)

7. ACTIVITIES OF EDITOR: Your Reference Committee on Reports of Board of Trustees and Secretary has considered the memorandum from the Board of Trustees on Activities of the Editor and recommends its adoption by the House of Delegates. The By-Laws provide that the functions of the Editor are a responsibility of the Board of Trustees. Your reference committee feels that this organization, together with the whole civilized world, owes Dr. Fishbein a debt of gratitude. His contributions to the advancement of medical science as Editor of *The Journal* have earned him international acclaim. *The Journal of the American Medical Association* is an enduring monument to his genius and devotion.

THOMAS A. FOSTER, *Chairman*.

STATE GRANTS FUNDS FOR GRADUATE COURSES

Open to Graduate Physicians at U. of P. Medical School

During the 1949-50 academic year, the School of Medicine of the University of Pennsylvania will present three special courses in the diagnosis and treatment of cancer for graduate physicians under a grant from the Division of Cancer Control of the State Department of Health at Harrisburg. Each of these courses will be of two weeks' duration, and they are scheduled as follows:

First course—November 7 to 19, 1949

Second course—January 16 to 28, 1950

Third course—April 17 to 29, 1950

Application blanks will be sent upon request to Dr. Robert C. Horn, secretary of the Cancer Commission, Hospital of the University of Pennsylvania, Philadelphia 4, Pa. These courses are limited to a small group of students, and applications must be received not later than four weeks before the opening date of the course applied for. Appointments will be made three weeks before the opening date.

Tuition fees and some compensation for time spent away from regular practice will be paid by the State.

OUTLINE OF THE HISTORY OF THE MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA 1848-1948

I. Title Page.

II. Frontispiece—photograph of Headquarters Building in Harrisburg.

III. Foreword—prepared by Dr. Edward L. Bortz.

IV. Table of Contents.

Chapter I. *The Society Is Conceived.*

A. Excerpts taken from text of Dr. William B. Atkinson's history of the first meeting.

B. The complete minutes of the first meeting.

C. The Constitution and By-laws as adopted at the first meeting.

D. Photograph of Methodist Episcopal Church in Lancaster and photographic prints of newspaper announcements and accounts of the first meeting.

Chapter II. *The First Forty-eight Years (1848-1896).*

A. Text to be taken from Dr. Atkinson's history of the yearly meetings.

B. Photographs of presidents for each year.

C. Reproduction of charter of MSSP granted in December, 1890.

Chapter III. *The Turn of the Century (1896-1915).*

A. Text to be taken from Dr. Walter F. Donaldson's history.

B. Photographs of presidents for each year.

Chapter IV. *A Generation of Progress (1915-1948).*

A. Text to be taken from Dr. Donaldson's history up to 1940. History from 1940 to 1948 to be written by Dr. Donaldson.

B. Photographs of presidents for each year.

Chapter V. *The Woman's Auxiliary.*

A. Introductory paragraph of Mrs. Frank P. Dwyer, historian.

B. History as prepared by Mrs. Dwyer.

C. Photographs of presidents for each year.

Chapter VI. *Histories of Committees and Commissions and Sections.*

Chapter VII. *Histories of Component County Societies.* Forty-nine counties have submitted histories.

Chapter VIII. *The Permanent Secretaries.*

A. Biographies of Drs. Atkinson, Stevens, and Donaldson.

B. Photographs of each.

Chapter IX. *The Publications.*

A. History and description of the ATLANTIC MEDICAL JOURNAL.

B. History and description of the PENNSYLVANIA MEDICAL JOURNAL.

C. Minutes of 1851 meeting, which include resolution for the creation of a Committee on Publications.

D. Photographs of covers and mastheads of ATLANTIC MEDICAL JOURNAL and PENNSYLVANIA MEDICAL JOURNAL.

Chapter X. *Executive Functions of 1948.*

A. Functions of the Board of Trustees.

B. Photographs of the Board of Trustees.

C. Functions of the committees and brief descriptions of their activities.

D. Functions of Pittsburgh and Harrisburg offices.

Chapter XI. *The Centennial Year—1948.*

A. Description of activities.

1. House of Delegates.

2. Scientific program.

3. Scientific exhibits.

4. Woman's Auxiliary.

5. Inauguration.

6. Religious service, etc.

B. Photographs of activities.

(The material on the Benjamin Rush Award is to be woven into this chapter.)

Appendix A—1948 Constitution and By-laws.

Appendix B—Roster for 1948—listed according to county with officers starred.

EXCERPTS FROM AMA SECRETARY'S LETTER

DEAR DR. DONALDSON:

The 98th annual session of the American Medical Association, held in Atlantic City, was a wonderful meeting. A total of 13,221 physicians was registered, which was second only to the record of 15,667 set at Atlantic City in 1947, which was the association's 100th anniversary year.

Dr. Elmer L. Henderson, Louisville, Ky., who has been active in AMA affairs for more than a decade, is the new president-elect. In his acceptance speech before the House of Delegates, he said: "If we are to endure as a free medical profession, we must stand united and present a solid front. We have just begun to fight. With the help of Almighty God, I pledge you that we will continue to fight and we will win."

Other officers elected at Atlantic City include: vice-president—James Francis Norton, Jersey City; secretary—George F. Lull, Chicago; treasurer—Josiah J. Moore, Chicago; speaker, House of Delegates—Francis

F. Borzell, Philadelphia; vice-speaker, House of Delegates—James R. Reuling, Bayside, N. Y.; trustees—Louis H. Bauer, Hempstead, N. Y., 1954, and F. J. L. Blasingame, Wharton, Tex., 1954; Judicial Council—Edward R. Cumiffe, New York, 1954, and Thomas P. Murdock, Mriden, Conn., 1953; Council on Medical Service—Elmer Hess, Erie, 1952, and Thomas A. McGoldrick, Brooklyn, 1952.

Scores of resolutions were introduced in the House of Delegates during the five-day session, but there were at least two that reflected a constructive and positive approach to some of the problems facing American medicine today.

The House of Delegates approved sponsorship of a National Health Conference in the late summer or early fall to implement the AMA's 12-point health program.

The AMA, through its Board of Trustees, will hold such a conference of "interested groups" to consider the 12-point health program and "such elaboration as may seem indicated in the public interest." The group will include, in all probability, farm and labor organizations. The date and site of the conference have not yet been decided.

In another resolution the House of Delegates took steps to recognize medical care plans operated by lay groups. Up to now, the AMA has approved only those medical care plans sponsored by county and state medical societies. There are 95 such plans, 70 of which have been granted the AMA seal of acceptance.

Lay medical plans are those sponsored by non-professional groups, such as labor, farm and consumer cooperatives.

GEORGE F. LULL, M.D.,

Secretary and General Manager, AMA.

June 20, 1949

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since April 30. Figures in first column indicate county society numbers; second column, State Society numbers.

May 2	Luzerne	350-357	10223-10230	\$120.00
	Chester	113-115	10231-10233	45.00
	Montgomery	334-337	10234-10237	60.00
	Crawford	52	10238	15.00
	Monroe	38-39	10239-10240	30.00
3	Northumberland	76	10241	15.00
	Blair	127	10242	15.00
	Clinton	26	10243	15.00
4	Philadelphia	2972-3056	10244-10328	1,282.50
	Lawrence	80-81	10329-10330	30.00
	Lackawanna	262-265	10331-10334	60.00
9	Fayette	116	10335	15.00
10	Luzerne	358-359	10336-10337	30.00
	Crawford	53	10338	15.00
	Montgomery	338-339	10339-10340	30.00
13	Jefferson	54-56	10341-10343	45.00
	Bucks	89	10344	15.00
	Washington	147-148	10345-10346	30.00
	Wayne-Pike	20	10347	15.00
16	Cumberland	46	10348	15.00
	Lackawanna	266-268	10349-10351	45.00
	Huntingdon	28	10352	15.00
	Butler	74-75	10353-10354	30.00
	Delaware	292-295	10355-10358	60.00

May 16	Clinton	27	10359	\$15.00
17	Cumberland	47	10360	15.00
	Bucks	90	10361	15.00
18	Tioga	27	10362	15.00
	Lebanon	66	10363	15.00
19	Lycoming	140	10364	15.00
20	Somerset	30	10365	15.00
	Lebanon	67	10366	15.00
	Lancaster	230-231	10367-10368	30.00
21	Tioga	28	10369	15.00
	York	168	10370	15.00
	Crawford	54-55	10371-10372	30.00
23	Lackawanna	269-275	10373-10379	105.00
	Cambria	165-167	10380-10382	45.00
	Fayette (1948)		10525	15.00
	Fayette	117-118	10383-10384	30.00
24	Northumberland	77	10385	15.00
	Venango	22, 24, 25	10386-10388	45.00
	Philadelphia	3057-3108	10389-10440	780.00
	Armstrong	42	10441	15.00
25	Lackawanna	276-280	10442-10446	75.00
	Mifflin	36-37	10447-10448	30.00
26	Centre	33-34	10449-10450	30.00
	Luzerne	360-363	10451-10454	60.00
	Lycoming	141-142	10455-10456	30.00
	Lebanon	68	10457	15.00
	Carbon	35	10458	15.00
	Mercer	90, 93	10459-10460	30.00
27	Allegheny	1619,		
		1629-1634	10461-10467	105.00

CONTRIBUTIONS TO MEDICAL BENEVOLENCE FUND

The Committee on Medical Benevolence makes grateful acknowledgment of the following contributions to the benevolence fund. These have also been previously acknowledged individually.

Woman's Auxiliary, Northampton County ...	\$350.00
a friend, in memory of Dr. Harry F. Leibert	5.00
Woman's Auxiliary, Clinton County	75.00
Woman's Auxiliary, Indiana County	110.00
Woman's Auxiliary, Indiana County, in memory of Dr. Joseph C. Lee	15.00
Woman's Auxiliary, Blair County (additional)	25.00
Woman's Auxiliary, Westmoreland County, New Kensington Branch (additional)	100.00
Woman's Auxiliary, Somerset County	75.00
Woman's Auxiliary, Washington County	80.00
Woman's Auxiliary, Lehigh County	518.30
Woman's Auxiliary, Lancaster County	200.00
Woman's Auxiliary, Armstrong County	50.00
Woman's Auxiliary, Centre County	55.00
Woman's Auxiliary, Lebanon County	150.00
Woman's Auxiliary, Lawrence County	75.00
Woman's Auxiliary, Beaver County, in memory of Mrs. Jefferson H. Wilson	10.00
two friends, in memory of Mrs. Wilson	15.00
Woman's Auxiliary, Montgomery county (additional)	96.90
Woman's Auxiliary, Luzerne County, a friend, in memory of Dr. Charles Long	10.00
Woman's Auxiliary, Allegheny County (additional)	544.50
Previously reported	4,599.18

Total contributions since 1948 report\$7,158.88

EXCERPTS FROM BOARD OF TRUSTEES
MINUTES

March 3, 1949

A regular meeting of the Board of Trustees of The Medical Society of the State of Pennsylvania was held Thursday morning, March 3, 1949, in the board room of the headquarters building, 230 State St., Harrisburg.

Members in attendance: Drs. John J. Sweeney (2d), Francis J. Conahan (3d), Charles V. Hogan (4th), James Z. Appel (5th), Joseph S. Brown (6th), George S. Klump (7th), James L. Whitehill (10th), Leard R. Altemus (11th), and Thomas R. Gagon (12th).

Officers present: Drs. Gilson Colby Engel, president; Walter F. Donaldson, secretary-treasurer; E. Roger Samuel, president-elect; Harold B. Gardner, first vice-president; and M. Louise Gloeckner, fourth vice-president.

Others present: Drs. C. L. Palmer, chairman, and Park A. Deckard, vice-chairman, Committee on Public Health Legislation; Howard K. Petry, chairman of Committee on Public Relations; Louis W. Jones, chairman of Committee on Medical Economics; Mr. Lester H. Perry, Executive secretary, and later Dr. John A. Daugherty, president of Medical Service Association of Pennsylvania, Messrs. Donald T. Diller, executive director, and George H. Hafer, legal counsel for the Medical Service Association.

In the absence of the chairman, Dr. Klump, vice-chairman, presided. The meeting was called to order at 9:35 a.m.

Dr. Klump stated that communications had been received from Chairman Lorenzo (9th) and Trustees Miller (1st) and Walker (9th) explaining their absence, and then introduced the fourth vice-president, Dr. Gloeckner.

SECRETARY DONALDSON: The several corrections received have all been made in the official minutes. Drs. Engel and Klump each called attention to specific errors.

It was moved (Dr. Altemus), seconded (Dr. Conahan), and unanimously carried that the minutes be approved as corrected.

Approval of Ballots by Mail

Dr. Donaldson reported that a ballot by mail regarding the selection of representatives to attend the Congress on Industrial Health in Chicago, Jan. 18-19, 1949, approved three members of the Commission on Industrial Health and Hygiene. Of these, only one—Dr. Daniel C. Braun, of Pittsburgh, who is co-chairman of the commission—was able to attend. Dr. Braun has submitted a report of the Congress in which he states that it was eminently successful, but makes the personal criticism "that management of industry was not represented to any extent throughout the entire program."

Authorization was also given by mail ballot to appoint a special committee to join with representatives of the Pennsylvania Bar Association, dental and engineering groups, in opposition to compulsory political insurance legislation. The committee, later appointed by President Engel, consists of Drs. James Z. Appel, chairman, William L. Estes, Jr., and William Harvey Perkins, with the officers of the State Medical Society as ex-officio members.

It was moved (Dr. Whitehill), seconded (Dr. Altemus), and unanimously carried that this mail ballot be approved.

*Reports of Board Committees**Finance Committee:*

Chairman Whitehill reported on the financial statement as of Jan. 31, 1949, previously mailed to board members, and stated that the official statement as of February 28 would be completed and distributed within the near future. His report included the statement that Mr. Perry reported that last year the Society spent \$1,100 for outside mimeographing and \$793 for overtime service in the Harrisburg office and advised employment of a girl to do all the stencil and mimeographing work.

It was moved (Dr. Whitehill), seconded (Dr. Altemus), and unanimously carried that Mr. Perry be authorized to employ another girl at a salary of approximately \$125 per month to assist in the library and do all the stencil and mimeograph work for the Harrisburg office, and that the report of the Finance Committee be approved.

Publication Committee:

The report was given by Chairman Gagon.

It was moved (Dr. Altemus), seconded (Dr. Brown), and unanimously carried that the report of the Publication Committee be approved.

Library Committee:

DR. KLUMP: The report of the committee is in your hands, and since you have taken care of the request for additional help, I think a motion is in order.

It was moved (Dr. Altemus), seconded (Dr. Conahan), and unanimously carried that the report of the Library Committee be approved as presented.

Building Maintenance Committee:

It was agreed to defer consideration of this report until after the architect had arrived with the plans for the proposed alterations in the property.

Medical Defense Cases

In the Second District, Case No. 376 is pending; in the Twelfth District, Case No. 368 is going to trial very soon.

Reports of Officers

It was agreed that the reports of the president, president-elect, and secretary-treasurer be deferred until later in the meeting.

Report of Executive Secretary

MR. PERRY: The Cancer Coordinating Committee has requested the services of Mr. Richards as its secretary, also that each participating organization contribute \$100 to cover the expenses of the committee. Mr. Richards feels that since the committee has now passed its organizational stage, the difficult part of that work is over.

(Read a summarization of requests—bottom of page 2 of report previously mailed to trustees.)

DR. GAGON: I disapprove. Mr. Richards says that we are at times very much pressed for stenographic assistance. They want not only Mr. Richards but stenographic assistance. We have just had to employ another stenographer to carry on our own business. I believe that we are reaching out through our employees to too many outside interests.

DR. ALTEMUS: Is this a combined commission of the State Medical Society Cancer Commission with other groups?

DR. KLUMP: It is composed of the State Medical Society Cancer Commission, the Division of Cancer Control of the State Health Department, and the Pennsylvania and Philadelphia Divisions of the American Cancer Society.

DR. ALTEMUS: I am opposed also to the Society providing full stenographic and secretarial service for them, since I think they have other sources from which they can obtain it.

SECRETARY DONALDSON: Can Mr. Richards' point of view be interpreted as meaning that the others are perfectly willing to pay their share if we bill them for service rendered?

MR. PERRY: Yes, for all except that of Mr. Richards, which they request as a contribution. They are prepared and planning to pay for stenographic service, postage, paper, and mimeograph expense. Mr. Richards through his work for our Cancer Commission was one of the prime movers in getting this coordinating group started and has cooperated up to this time.

SECRETARY DONALDSON: Instead of us giving a blunt negation, might it not be wise to consider appointing a conference committee, consisting of the chairman and two members of this board, to confer with Messrs. Perry and Richards before coming to a decision?

It was moved (Dr. Altemus) and seconded (Dr. Whitehill) that the chairman appoint a committee to investigate the duties of the secretary of the Cancer Coordinating Committee—this committee to meet with the chairman of the Cancer Commission, a representative from the Pennsylvania Cancer Society, a representative of the State Department of Health, Division of Cancer Control, and Mr. Richards, and report back to the Board of Trustees by mail within two weeks.

Drs. Gagon, Hogan, and Sweeney opposed the motion. Drs. Appel, Brown, Conahan, and Whitehill were in favor of it.

Dr. Klump then appointed Drs. Whitehill and Sweeney to serve on the committee and arrangements were made for a conference to be held March 3 with the various representatives.

It was moved (Dr. Gagon), seconded (Dr. Altemus), and unanimously carried that the State Medical Society continue as a member of the Pennsylvania Chamber of Commerce at a fee of \$100 per year.

DR. KLUMP: Mr. Perry's report before you states that Messrs. Brown, Richards, Stewart, and Perry had been authorized to attend previous AMA conventions.

It was moved (Dr. Sweeney), seconded (Dr. Hogan), and unanimously carried that this request be tabled until the May meeting of the Board of Trustees, Mr. Perry in the meantime to gather more definite information to present at that time.

MR. PERRY: The next section of my report deals with the 25-year-old National Institute of Trade Association Executives. I recommended that the Board authorize two of our employees to attend the 1949 institute, leaving the selection to the secretary or the executive secretary.

DR. GAGON: I looked over the program very carefully and it includes nothing that has to do with health.

After further discussion, it was moved (Dr. Sweeney), seconded (Dr. Gagon), and unanimously carried that this request contained in Mr. Perry's report be not approved.

MR. PERRY: The last section of the report deals with vacation problems. You will notice in the last sentence that I make a recommendation. Do you want some more facts about this?

It was moved (Dr. Whitehill), seconded (Dr. Altemus), and unanimously carried that Mr. Perry prepare a further report on this matter.

Recess

(At this point the meeting was recessed for twenty minutes in order that the Board might view the plans for remodeling as drawn up and displayed by the architect, Mr. Edwin Green.)

Reconvened

DR. KLUMP: Mr. Perry has one or two other matters which may be deferred. Dr. Palmer wants to present his report of the Committee on Public Health Legislation and Dr. Petry has one item of his report that he wishes to place before you this morning.

Report of Committee on Public Health Legislation

DR. PALMER: Important in the report are the actions of the Committee on Public Health Legislation, which indicate that unless there is agreement between all parties concerned regarding the transfer of state mental health and state-headed and state-owned hospitals from the Welfare Department to the Department of Health, the committee believes that it would be inadvisable to introduce or support a bill providing for such a transfer.

DR. KLUMP: Dr. Palmer, has this bill been introduced?

DR. PALMER: It has not.

It was moved (Dr. Gagon), seconded (Dr. Altemus), and unanimously carried that the Board approve that section of Dr. Palmer's report dealing with the introduction of the Mental Health Bill.

DR. PALMER: The other bills you have before you were more recently drafted; therefore, I will discuss briefly the bill providing for a Board of Psychologists.

It was moved (Dr. Gagon), seconded (Dr. Sweeney), and unanimously carried that this part of Dr. Palmer's report be approved.

DR. PALMER: The next bill before you proposes to amend the Medical Service Association corporation act to eliminate the income limitations. The vote by mail on that returned by members of your Board of Trustees was *six* in favor and *three* against. The Board of Directors of MSAP passed on this at their January 6 meeting and copies of their resolution were sent later by Dr. Donaldson to each of you.

DR. ALTEMUS: I didn't vote because I wanted to know more about it.

DR. GAGON: I would like to be recorded by name as voting against it.

DR. ALTEMUS: I would like to know what change in the income groups is to be made.

DR. PALMER: That will depend on changing economic conditions.

DR. ALTEMUS: How are you going to base the recommendation?

DR. PALMER: On the reports of the Bureau of Labor and of Pennsylvania State College. When marked changes in economic conditions of the country develop,

the Board of Directors of MSAP can request the Bureau and College for advice as to a proper income level. That is what the Medical Service Association seems to want.

DR. ALTEMUS: I want to be recorded as voting against it.

DR. KLUMP: I don't believe that MSAP wants this. I think the people want it and the demand is growing to the point where Blue Cross and MSAP recognize the fact. This Board of Trustees has approved the general philosophy by mail vote. It hasn't approved the proposed legislation.

There is a new suggestion here as to a method for determining income limitations.

It was moved (Dr. Whitehill), seconded (Dr. Altemus), and unanimously carried that this matter be left in the hands of the Committee on Public Health Legislation.

DR. PALMER: We have a bill providing for the reporting of incipient blindness. It was fostered by the Pennsylvania Association for the Blind. I polled our Committee on Conservation of Vision and the majority of them voted in favor of it.

It was moved (Dr. Whitehill), seconded (Dr. Altemus), and unanimously carried that this matter be referred to the Committee on Public Health Legislation.

State Speakers' Bureau

DR. PETRY: Each county society has its own speakers' bureau, but there is a need for a certain group who will cross county lines or be available for meetings that require such service. The Committee on Public Relations would like to recommend that "the trustee and councilor of each of our twelve districts select ten speakers from his councilor district who are adequately qualified and willing to accept speaking engagements in his or adjacent districts."

DR. GAGION: If the councilor makes such trips, he charges them against his councilor expense. The expenses of other speakers should be charged to the budget of the Committee on Public Relations.

It was moved (Dr. Whitehill), seconded (Dr. Altemus), and unanimously carried that the Board accept the recommendation of the Committee on Public Relations to set up a State Speakers' Bureau gathered from each councilor district, and that the councilor shall be responsible for the filling of requests for speakers.

Discussion in Regard to Amending the Medical Service Act to Permit Payment of Osteopaths

PRESIDENT DAUGHERTY (MSAP): The board of directors of the Medical Service Association recently transmitted two resolutions through Dr. Donaldson to the Board of Trustees. The one states that the MSAP board is offering to the people of Pennsylvania a plan for prepaying their medical care under which it is unable to fully discharge its obligation for the reason that it cannot legally pay licensed osteopaths for service rendered to subscribers. The MSAP board, therefore, believes that the act should be amended. The second resolution was concerned with amending the act to make the subscriber income level flexible. Subsequent to sending the resolutions to you, bills H. 450 and H. 451 were introduced in the State Legislature by the attorney for the Osteopathic Association, Mr. Parnell.

(SECRETARY'S NOTE: A discussion ensued, lasting for two hours, which was participated in briefly by a few members of the Board of Trustees but principally by

Mr. George Hafer of Harrisburg, attorney for MSAP, and by Dr. Palmer. Before adjourning it was agreed that certain amendments to H. 451 as proposed by Dr. Palmer would be transcribed and available for action by the Board when it convened at 1:00 p.m. on March 4.)

The meeting adjourned at 1:15 p.m. to reconvene at 1:00 p.m., March 4, 1949.

GEORGE S. KLUMP, *Vice-Chairman*,
WALTER F. DONALDSON, *Secretary-Treasurer*.

Special Meeting—March 3, 1949

A special meeting of the Board of Trustees of The Medical Society of the State of Pennsylvania was held Thursday evening, March 3, 1949, in the Assembly Room of the Penn-Harris Hotel, Harrisburg.

Members in attendance: Drs. John J. Sweeney (2d), Francis J. Conahan (3d), Charles V. Hogan (4th), James Z. Appel (5th), Joseph S. Brown (6th), George S. Klump (7th), James L. Whitehill (10th), Leard R. Altemus (11th), and Thomas R. Gagon (12th).

Officers present: Drs. Gilson Colby Engel, president; Walter F. Donaldson, secretary-treasurer; E. Roger Samuel, president-elect; Park Berkleimer, assistant secretary-treasurer; Harold B. Gardner, first vice-president; and M. Louise Gloeckner, fourth vice-president.

Others present: Drs. Howard K. Petry, chairman of Committee on Public Relations; Louis W. Jones, chairman of Committee on Medical Economics; Francis F. Borzell; Joseph W. Post. Mr. Lester H. Perry, executive secretary, Alex H. Stewart, Jr., convention manager, and Robert L. Richards, staff secretary, all of the Harrisburg office, were also in attendance.

The meeting was called to order at 9:35 p.m., by the vice-chairman, Dr. Klump, who stated that the main reason for the special meeting was further consideration of the osteopathic question. However, inasmuch as a few regularly scheduled reports had been passed over at the morning meeting, they would be considered at this meeting before discussion was reopened on the osteopathic question.

Report of Convention Manager

Inasmuch as this report was purely informative, Dr. Klump stated that it would be received.

Reports of Chairman of State Healing Arts Advisory Committee, Conference of Professional Licensures, Advisory Committee to the Bureau of Rehabilitation, and Committee on Rural Medical Service

Inasmuch as these reports were purely informative, the chairman stated that they would be received.

MR. PERRY: I have one additional section to my report and that is the analysis of our insurance coverage.

It was moved (Dr. Gagon), seconded (Dr. Whitehill), and unanimously carried that the study be continued and that Mr. Perry report further to the Board at the next regular meeting.

Mr. Perry mentioned the paying of an honorarium to speakers on the afternoon program at the Secretaries and Editors Conference, and it was agreed that the payment of such honoraria be left to the committee in charge of the conference, in consultation with Dr. Donaldson.

Discussion of MSAP Request

DR. APPEL: MSAP has requested that you initiate the amending of the enabling act of the Medical Serv-

ice Association of Pennsylvania. Amending legislation has been introduced by the osteopaths. A public hearing has been asked. The Medical Service Association is on record, and has formally expressed to this Board a desire for authority to pay osteopaths. As far as I know, the Medical Service Association has determined never to take any policy-making step that might affect the medical profession without the approval of this board. You could modify the osteopaths' amendments with the language suggested by Dr. Palmer this morning.

SECRETARY DONALDSON: After the Board adjourned today, Dr. Palmer and Mr. Hafer met and inserted in H. 421 as amendments the recommendations made by Dr. Palmer this morning. They then visited Commissioner of Insurance Malone, whose reaction to the last changes is expressed in this letter addressed to Dr. Palmer.

(Dr. Klump then read the letter from Commissioner Malone.)

DR. KLUMP: As I interpret this letter, the Insurance Commissioner would be in favor of legislation enabling payment to osteopaths by MSAP, but would not be in favor of legislation which would broaden in any sense their legal field of practice.

It was moved (Dr. Whitehill) and seconded (Dr. Gagon) that this matter remain in the hands of the Committee on Public Health Legislation.

DR. ENGEL: I suggest "*with the power to act.*"

DR. WHITEHILL: That will be understood.
The motion was unanimously carried.

Report of President

DR. ENGEL: First, I might report that Dr. Rutherford, president of the Pennsylvania Psychiatric Society, Mr. Elwood, president of the Public Charities Association, and myself met with Governor Duff on February 3 to discuss the transfer of the Welfare Department to the Department of Health, including the transfer of the voluntary hospitals and the state-owned general hospitals.

I want to report also that a meeting was held in Harrisburg in January with two representatives of the American Federation of Labor and one representative of the United Mine Workers. Present from the State Society were Drs. Lucchesi, Dudley P. Walker, Everts, Palmer, Petry, and myself. There was a frank discussion of problems which I believe was very worth while. We consider it the first step toward closer relations with labor in the State, and I believe that it should be developed further.

Dr. Engel discussed at considerable length his ten-point program, stating that the AMA is behind the program now, and Drs. Henderson and Lull both agreed to its presentation to U. S. Senator Lister Hill of Alabama. Dr. Engel had with him the second draft of his bill to be presented to Congress.

After Dr. Engel had discussed numerous points in the proposed Hill bill and had answered questions, it was moved (Dr. Appel), seconded (Dr. Whitehill), and unanimously carried that President Engel be rendered a vote of unqualified confidence.

Dr. Borzell, former president, spoke in praise of Dr. Engel and emphasized the AMA's approval of his program in principle. He also cited their comments on his points six and seven.

Report of Building Maintenance Committee

DR. CONAHAN: Most of the Board members saw the drawings for the proposed building alterations this morning. Tonight Dr. Sweeney and I talked to Dr. Lavery regarding the possible inconvenience to him, and his reply was that he would consult with Mr. Perry and the architect. The architect promised more specific information with drawings, so that we should be able to give a detailed report with recommendations at our May meeting.

MR. PERRY: Do I understand that Architect Green is authorized to proceed with detailed plans and specifications insofar as it is possible to complete alterations in line with the terms of Dr. Lavery's lease?

It was moved (Dr. Appel), seconded (Dr. Altemus), and unanimously carried that the report of the Building Maintenance Committee be accepted.

The meeting was adjourned at 11 p.m.

GEORGE S. KLUMP, *Vice-Chairman*,
WALTER F. DONALDSON, *Secretary-Treasurer*.

March 4, 1949

A meeting of the Board of Trustees of The Medical Society of the State of Pennsylvania was held Friday, March 4, 1949, in the board room of the headquarters building, 230 State St., Harrisburg.

Members in attendance: Drs. John J. Sweeney (2d), Francis J. Conahan (3d), Charles V. Hogan (4th), James Z. Appel (5th), Joseph S. Brown (6th), George S. Klump (7th), James L. Whitehill (10th), Leard R. Altemus (11th), and Thomas R. Gagon (12th).

Officers present: Drs. Walter F. Donaldson, secretary-treasurer; Park Berkheimer, assistant secretary-treasurer; and Harold B. Gardner, first vice-president.

Others present: Drs. Howard K. Petry, chairman of Committee on Public Relations; Louis W. Jones, chairman of Committee on Medical Economics; and Joseph W. Post, executive assistant to Dr. Hugh M. Miller (1st); Dr. George F. Stoney, chairman of Commission on Diabctes; Messrs. Lester H. Perry, executive secretary; Leo E. Brown, public relations assistant; Robert L. Richards, staff secretary; and Alex H. Stewart, Jr., convention manager.

The meeting was called to order at 1:15 p.m., by the vice-chairman, Dr. Klump.

Report of Committee Appointed Thursday Morning to Review the Request of the Cancer Coordinating Committee

DR. WHITEHILL: The committee consisting of myself, Dr. Sweeney, and Dr. Klump met with Mr. Richards yesterday and we recommend to the Board of Trustees that it permit Mr. Richards to be retained, as formerly, by the Coordinating Committee until July 1, 1949, provided the Coordinating Committee will furnish sufficient stenographic services; but at the end of this period Mr. Richards should relinquish his secretaryship. It was the consensus of the committee, after conference with Dr. Leverett D. Bristol, director of the Division of Cancer Control of the State Department of Health, that the only permanent solution to this problem is the employment of a full-time executive secretary by the Coordinating Committee. Dr. Bristol advised that, since a plan was in the process of formation, to cut them off abruptly would throw them into turmoil. So we advise a four-month extension.

It was moved (Dr. Altemus) and seconded (Dr. Hogan) that this report be accepted.

Vote on the motion: Dr. Gagion was *opposed* and the majority were *in favor*.

Report of Committee on Public Relations

DR. PETRY: Our committee believes that we are losing a large part of the publicity value inherent in the presentation annually of fifty years in practice testimonials by burying it in our councilor district meetings. Frequently the award of that citation arranged as a community event would give many laymen a chance to honor a doctor and thus focus the attention of the entire community on the services of medicine. In some cases this might not be feasible, but we hope the Board will approve it in those instances where a county society or councilor district does wish to award the testimonials in a local ceremony.

DR. GAGION: I have often felt that when such members received their certificates at councilor district meetings, the procedure was passed over as a small item of business.

SECRETARY DONALDSON: I think it may, on occasion, be a wonderful event, but if in 1949 we have members entitled to that certificate in forty of our counties, there will be twenty in which you cannot depend on such a local event being successful.

DR. GAGION: Each councilor should decide when, where, and how the fifty-year presentation shall be arranged.

It was moved (Dr. Gagion), seconded (Dr. Altemus), and carried that the section of the report of the Committee on Public Relations regarding the presentation of fifty-year certificates be adopted. (NOTE: Dr. Whitehill voted *against* the motion.)

Discussion Regarding Advances on Expense Accounts for Public Relations Employees

DR. WHITEHILL: The Harrisburg office has a revolving petty cash account. Why should we not increase that account to provide travel expense advances therefrom to be charged against the Public Relations Committee budget?

It was moved (Dr. Gagion), seconded (Dr. Altemus), and unanimously carried that decision as to the portion of the Public Relations Committee report regarding advances for expense accounts be left to the discretion of the Finance Committee.

Discussion Regarding New Employees in Public Relations Department

Dr. Petry read that section of his report regarding the two new employees in the Public Relations Department, Mr. Keith R. Hutchison and Miss Suzanne Treadwell.

DR. GAGION: Are Miss Treadwell's expenses for traveling for the Woman's Auxiliary charged against the Auxiliary?

DR. PETRY: She is our employee and I assume the charge is to our committee.

DR. GAGION: I would like to know next year how much we are to provide for the Woman's Auxiliary if we are to carry on this same line of business.

DR. DONALDSON: We not infrequently originate vouchers for one employee who has rendered services to two or three committees, but the division of service is

distinctly set forth on the voucher and so entered in the books of the secretary-treasurer.

Supplementary Report of Committee on Public Relations

DR. PETRY: The implementation of the AMA National Education Campaign is planned so as to make shipment of its printed material to the county society and not to individual members. Most county societies have no organized facilities and much of the AMA publicity material will not get into public hands promptly if at all.

DR. KLUMP: It is a decision for the committee to make.

DR. PETRY: Our committee has been asked by the Governor's Highway Safety Advisory Committee to designate one member in each of four areas to act as members of a subcommittee.

It was moved (Dr. Gagion), seconded (Dr. Hogan), and unanimously carried that the appointments to the Governor's Highway Safety Advisory Committee be made by the president. (SECRETARY'S NOTE: President Engel appointed the following: Drs. Constantine P. Faller, chairman, Luther I. Fisher, William G. Leaman, Jr., William L. Mullins, and Wilfred H. Winey.)

Dr. Petry then read the second request of the Public Relations Committee regarding additional temporary personnel.

Report of Committee on Medical Economics

Dr. Jones reported on two VA fee schedule items and VA physicians engaging in private practice (see p.r.).

It was moved (Dr. Gagion), seconded (Dr. Altemus), and unanimously carried that the report of the Committee on Medical Economics be adopted, including the recommendation that the fee of \$3.00 for item 8827 and the fee of \$5.00 for item 9136 be inserted in the VA fee schedule.

Report of Commission on Graduate Education

It was moved (Dr. Gagion), seconded (Dr. Hogan), and unanimously carried that the Board approve the recommendation of the Commission on Graduate Education that any member of the AMA may register in the Graduate Education Institute for the fee of \$25.

It was moved (Dr. Hogan), seconded (Dr. Gagion), and unanimously carried that the request of the Commission on Graduate Education regarding introduction of a course in electrocardiography to be given in Harrisburg on a trial basis be approved.

Report of Commission on Preventive Medicine and Public Health

This commission met Feb. 4, 1949. After some discussion of the unreleased but printed Public Health Survey Report, the commission unanimously approved the following motion: "That the matter of securing a copy of the Public Health Survey Report be referred to the Board of Trustees of the State Society for any action they may deem advisable."

It was moved (Dr. Whitehill), seconded (Dr. Sweetney), and unanimously carried that this matter be tabled with the understanding developed in the discussion.

Letter from Commission on the Control of Syphilis and Venereal Diseases

Secretary Donaldson read a letter from Dr. Samuel Grossman, chairman of the Commission on the Control

of Syphilis and Venereal Diseases, requesting the Board of Trustees to authorize payment of the sum of \$513.10 to cover one-half the cost of printing 11,000 copies of a booklet on the control of syphilis which the commission is preparing.

It was moved (Dr. Altemus), seconded (Dr. Whitehill), and unanimously carried that Dr. Grossman be advised that his commission still has sufficient funds in the budget to proceed as proposed with the publication and distribution of their instruction in booklet form.

Consideration of "Practice of Medicine by Hospitals"

SECRETARY DONALDSON: This Board has been requested to make a report on this subject to the 1949 House of Delegates. We have furnished you with all AMA records on the question, so it would be well to have a Board committee delegated to bring in a recommendation at the May meeting.

DR. JONES: You authorized our Committee on Medical Economics to turn this material over to the Committee on Hospital Relations.

It was agreed that the Committee on Hospital Relations (Dr. Hess, chairman) be instructed to bring in a report at the May meeting of the Board of Trustees.

Report of Councilor Hogan on the Sunbury Hospital Situation

Secretary Donaldson read a report from the district censors of the Fourth Councilor District to Trustee and Councilor Charles V. Hogan (*Appendix A*).

DR. HOGAN: I hope that closes the complaint. They met in my office with both sides represented and spent about two hours in open discussion.

It was moved (Dr. Whitehill), seconded (Dr. Sweeney, and unanimously carried that this report be accepted.

Resolution from Lancaster County Medical Society

DR. KLUMP: (Read last paragraph of the resolution.) I understand there has been some acknowledgment of this, but I don't know how much action.

SECRETARY DONALDSON: The resolution mailed to all present on January 19 is discussed editorially in the February PENNSYLVANIA MEDICAL JOURNAL, and also printed in full therein.

It was moved (Dr. Whitehill), seconded (Dr. Brown), and unanimously carried that the resolution of the Lancaster County Medical Society be accepted and referred to the Committee on Public Relations.

Request from MSAP

Secretary Donaldson presented a request from MSAP recommending that the Board of Trustees enter into a plan with MSAP to orient representatives from county medical societies in the administrative details of MSAP, the cost for bringing such individuals to Harrisburg for a day to be shared by MSAP and MSSP.

DR. APPEL: MSAP has no public relations department of its own, so the MSAP board members have asked us to bring a member from each county society to the MSAP Harrisburg office for a day's course of indoctrination in the workings of the Blue Shield insurance plan.

It was moved (Dr. Whitehill), seconded (Dr. Conahan), and unanimously carried that the matter be laid on the table for further investigation and report at the next meeting.

Report from Delegates to 9th Annual Congress on Industrial Health

SECRETARY DONALDSON: I have Dr. D. C. Braun's report with me. It is an indication of good faith that the delegate attended and reported to his commission.

Report on Attendance Upon Course on "The Medical Aspects of Special Weapons and Radioactive Isotopes"

SECRETARY DONALDSON: Dr. Irwin W. Pochapin, of Pittsburgh, was accepted for a course at Bethesda. He was the only civilian taking the course with 150 Navy doctors in uniform. He prepared a report for our Committee on Disaster Emergency Medical Service. The total expense for the course was \$116.68.

DR. APPEL: I am connected with the National Guard and I received a communication concerning this course in which it was stated that the only civilian organization that sent a student to the course was MSSP and same was noted in a very complimentary way.

Delegates to 1950 U. S. Pharmacopeial Convention

SECRETARY DONALDSON: We were represented in 1940 by Dr. Edward J. Beardsley, of Philadelphia, and Dr. Harold B. Gardner, of Pittsburgh. They (U. S. Pharmacopeial convention) want to know by next December who our delegates will be, although the meetings do not take place until May 9 and 10, 1950.

Election of Associate Members

SECRETARY DONALDSON: The reference to county medical society officers in the revision of Section 2, Article IV, of the Constitution dealing with forms of membership has occasioned an unusual reaction.

In the first place the adoption of Associate Membership as the title covering the benefits previously available since 1923 under the title Affiliate Membership has served to call attention to an avenue of escaping the payment of county and state society dues.

We have received as many nominations for Board consideration in the last four months as we ordinarily do in twenty-four months. This considerable increase will doubtless not be duplicated soon, but it has brought a complaint from two county society secretaries, voiced about as follows:

"I wonder if the House of Delegates appreciated the tremendous financial loss the county societies with small membership will suffer as the result of this action."

One member writes to our office:

"I was notified today that I had been voted at a meeting, which I did not attend, to a form of membership excusing me from payment of dues. Do I receive medical defense under that form of membership?"

A second form of enthusiasm on the part of county society secretaries to "bring financial benefits to the members" is expressed by the action that nominates two members "for Associate Membership for 1949 only."

Needless to state, the latter will be clarified by requiring the completion of a formal request for Associate Membership "on the basis of disability preventing continuation in practice."

Dr. Donaldson then read the lists of active members proposed for Associate Membership (69 names from 16 component societies—see p.r.).

It was moved (Dr. Gagon), seconded (Dr. Hogan), and unanimously carried that the first list read become associate members on the basis of age and continued membership, and that the second list be elected as associate members on the basis of disability preventing continuation in the practice of medicine.

It was announced that the available (hotel) dates for the next Board meetings would be Thursday evening, May 19, and Friday morning, May 20, 1949.

It was moved (Dr. Whitehill), seconded (Dr. Altemus), and unanimously carried that the meeting be adjourned to reconvene May 19, 1949, at 6:30 p.m.

The meeting was adjourned at 3:05 p.m.

GEORGE S. KLUMP, *Vice-Chairman*,
WALTER F. DONALDSON, *Secretary-Treasurer*.

May 19, 1949

A regular meeting of the Board of Trustees of The Medical Society of the State of Pennsylvania was held Thursday evening, May 18, 1949, in the Governor's Room of the Penn-Harris Hotel, Harrisburg.

Members in attendance: Drs. Hugh M. Miller (1st), John J. Sweeney (2d), Francis J. Conahan (3d), Charles V. Hogan (4th), James Z. Appel (5th), George S. Klump (7th), Herman H. Walker (8th), Frank A. Lorenzo (9th), James L. Whitehill (10th), Leard R. Altemus (11th), and Thomas R. Gagon (12th). Joseph S. Brown (6th) was unavoidably detained.

Officers present: Gilson Colby Engel, president; Walter F. Donaldson, secretary-treasurer; E. Roger Samuel, president-elect; Harold B. Gardner, first vice-president; and Park Berkheimer, assistant secretary-treasurer.

Others present: Drs. C. L. Palmer, chairman of Committee on Public Health Legislation; Howard K. Petry, chairman of Committee on Public Relations; Louis W. Jones, chairman of Committee on Medical Economics; Mr. Lester H. Perry, executive secretary; and Mr. Leo E. Brown, executive assistant, public relations Department.

Chairman Lorenzo called the meeting to order at 7:45 p.m.

Secretary Donaldson explained that a number of minor changes and corrections had been submitted by Drs. Klump, Appel, Brown, and Conahan to the minutes of the March 3 and 4, 1949 meetings and that the corrections had been entered on the copies of the minutes in the Secretary's office.

It was moved (Dr. Gagon), seconded (Dr. Altemus), and unanimously carried that the minutes of the March 3 and 4, 1949 meetings of the Board of Trustees be accepted as circulated to and corrected by the various members of the Board.

Reports of Board Committees

Finance Committee:

Chairman Whitehill reported the following investments:

Medical Benevolence Fund—\$30,000 invested in United States G Savings Bonds.

Endowment Fund—\$5,000 invested in United States G Savings Bonds.

Educational Fund—\$20,000 to be invested in U. S. Treasury 1½ Certificates of Indebtedness.

The committee then recommended that the reimbursement for mileage incurred by representatives of the State Society while on State Society business be increased from 6 to 7 cents per mile.

It was moved (Dr. Miller), seconded (Dr. Sweeney), and unanimously carried that the report of the Finance Committee be accepted, that approval be given to the recommendation of the Finance Committee regarding the purchase of securities with the money in the Educational Fund, and that the mileage be raised to seven cents per mile beginning June 1, 1949.

Library Committee:

Chairman Klump discussed the report of the Library Committee mailed earlier to each member of the Board.

It was moved (Dr. Gagon), seconded (Dr. Hogan), and unanimously carried that the report of the Library Committee be accepted.

No new medical defense cases were reported.

Report of Secretary-Treasurer

Secretary Donaldson reported that approximately 100 per cent of 1949 dues has been paid by more than 10,500 active members.

He reported also that 68 per cent of the membership have paid the \$25 AMA membership assessment. Although a great many county societies were paid up 70 to 100 per cent, he said there were about a dozen societies, both large and small, with approximately only 50 per cent or less of active members paid. He earnestly solicited the interest and assistance of all trustees and councilors in this final and most difficult task of collecting the balance.

The Secretary then announced recent appointments made by President Engel (see pages 995-996, June PENNSYLVANIA MEDICAL JOURNAL).

It was moved (Dr. Altemus), seconded (Dr. Klump), and unanimously carried that the report of the Secretary-Treasurer be accepted with the correction that a new appointee be chosen in place of Dr. Edward Lyon to the Committee to Nominate Delegates and Alternates to the AMA. (SECRETARY'S NOTE: President Engel appointed Dr. Louis W. Jones, who resigned from the Advisory Committee to the Woman's Auxiliary.)

Report of President

PRESIDENT ENGEL: I have attended the First, Seventh and Fifth Councilor District meetings and each had a good attendance.

Dr. Harold B. Gardner attended the Sesquicentennial of the Maryland State Society and sent me a marvelous report which I will turn over to Secretary Donaldson.

Dr. Catharine Macfarlane sent a telegram from Savannah, Ga., stating that they were most enthusiastic over and grateful for the artistic scroll sent by our State Society.

The Philadelphia County Medical Society centennial was well attended and U. S. Senator Lister Hill gave an address which I thought was outstanding. It should be read by every doctor in the country. It appeared in the May 21 issue of *Philadelphia Medicine* and I sent a copy to Secretary Donaldson.

President Engel then gave a complete report of his legislative conferences with AMA representatives in Washington, in which they planned a good bill to combine certain features of bills previously introduced by Senator Hill and Senator Taft. President Engel also discussed correspondence with Senator Wayne Morse.

It was moved (Dr. Hogan), seconded (Dr. Conahan), and unanimously carried that the report of President Engel be accepted.

Report of Executive Secretary

MR. PERRY: The first section of my report deals with the question of office staff members attending the AMA convention. I have checked the programs of the various meetings and find that the meetings on Sunday and Wednesday set up for employees of medical societies deal with public relations problems. With that in mind, I think it is important for Mr. Brown to be present at those sessions, which would keep him in Atlantic City from Sunday morning until Wednesday night. I also report that Mrs. Craig spoke to me about the possibility of Miss Treadwell attending the meetings of the AMA Auxiliary.

DR. ENGEL: I believe that sending people from this State Society to the AMA meetings is educational and a good investment and that those who are in key positions should go there and find out what they are all about.

DR. GAGION: Would Miss Treadwell's expenses be charged against the Public Relations Committee's budget, the Woman's Auxiliary, or ours?

DR. WHITEHILL: They should be charged to public relations.

SECRETARY DONALDSON: As I have said before, economy suggests that some staff members stay at the convention but two days to get what they want rather than four or five days.

MR. PERRY: I will take all these factors into consideration as to when they should come and go.

DR. GAGION: I would not be in favor of putting a limit on what they should spend.

It was moved (Dr. Altemus), seconded (Dr. Appel), and unanimously carried that Messrs. Perry, Brown, Richards, and Stewart and Miss Treadwell of the Harrisburg office be authorized to attend the AMA meetings in Atlantic City, to be sent at Mr. Perry's discretion.

It was moved (Dr. Miller), seconded (Dr. Walker), and unanimously carried that, if necessary, a hotel room be rented in Harrisburg for Board of Trustees meetings while the board room at 230 State Street is being used for office space by the employees during building alterations.

Telephone Recordings:

It was moved (Dr. Gagon), seconded (Dr. Hogan), and unanimously carried that Executive Secretary Perry keep the voice recorder attached to his telephone to be used at his discretion for State Society business purposes.

Request from Governor's Highway Safety Advisory Committee

It was moved (Dr. Whitehill), seconded (Dr. Miller), and unanimously carried that President Engel appoint a committee for the purpose of studying the problem of the driver who is suffering from a heart ailment, as requested by the Governor's Highway Safety Advisory Committee. (SECRETARY'S NOTE: A committee was appointed as follows: Drs. Constantine P. Faller, chairman, Luther I. Fisher, William G. Leaman, Jr., William L. Mullins, and Wilfred H. Winey.)

Insurance Analysis

MR. PERRY: Mr. Hafer recommended the analyst who made the report of the Society's insurance coverage.

It was agreed that discussion of the insurance problem be postponed until the Friday morning meeting.

VA Contracts with Hospitals

MR. PERRY: Since I mailed you my report, Superintendent Kohlhaas of the Harrisburg Hospital called, saying they had earlier canceled their contract with the Veterans Administration but that VA was now seeking to renew its contract with the hospital. His question was this: Is he supposed to collect fees from the VA for the physicians who are rendering services to VA patients in the hospital? I thought perhaps this should be referred to the Committee on Medical Economics.

CHAIRMAN JONES: In the agreement we now have with VA, the hospital has no right to collect fees for any services that a doctor renders. X-ray and laboratory services rendered in the hospital are still considered hospital services. If the VA authorizes an x-ray, the authorization is sent beforehand. That can be collected by the hospital if the physician is paid a salary or a salary plus commission.

It was the consensus that this matter be marked finished.

Report of Convention Manager

It was moved (Dr. Gagon), seconded (Dr. Miller), and unanimously carried that this report as distributed be accepted and that Mr. Stewart be authorized to attend the exhibit meeting in New York.

Report of Committee on Public Health Legislation

This report elicited considerable discussion on the values of closer cooperation between the Public Health Legislation and the Public Relations Committees.

It was moved (Dr. Miller) that there be a joint meeting of the Committee on Public Health Legislation and the Committee on Public Relations at least twice yearly, or more frequently if the chairmen deem it necessary.

DR. KLUMP: I would like to report what I have gathered in looking over this report and some adjunct material. This report of the Committee on Public Health Legislation discusses the action on the mental health bills. I think the Board should know what is going out to the public on that in an editorial. (Read editorial in criticism from the Public Charities Association *Herald*.) We spent between \$30,000 and \$50,000 this year on our program of public relations, and if we failed on Capitol Hill, it seems to me we should take some cognizance of that. We see in the April report of the Finance Committee that the Committee on Public Health Legislation spent over \$2,000 for antivivisection pamphlets. The average county society committee member receives some wires from this committee without information on how he can impress his legislative representatives. I would like Dr. Palmer to request action from his committee or a special committee toward making more positive recommendations. I am not satisfied with our progress this year.

DR. PALMER: We have made certain recommendations, with information, to every member of the State Medical Society on all these questions. The chiropractors state widely that they are unable to obtain a license

in Pennsylvania. They definitely can, but our members forget this truth when talking to their legislators.

Dr. Klump then seconded Dr. Miller's motion, which was carried.

DR. APPEL: I believe our greatest fault has not been with the Committee on Public Health Legislation. The committee's primary duty with the Legislature in session is to speak for us before the legislators and they have done an excellent job. Where we have failed is in our own membership. I would urge that somehow an educational campaign be carried on through our county societies to teach the doctors the importance of carefully digesting information sent them and then to work in cooperation with the Committee on Public Health Legislation.

DR. PETRY: We must remember that a fair proportion of our trouble on Capitol Hill this year springs from a national campaign against doctors during the past year. I think there is a province for the Public Relations Committee to conduct a long-range educational program not only for the public but our own profession.

DR. SWEENEY: Dr. Palmer's program is difficult to formulate in advance because he is on the defensive and must work from scratch as unexpected bills are introduced.

DR. PALMER: The purposes of the State Board of Medical Education and Licensure should be emphasized. We should also analyze a summary of the recently released survey of the State Health Department and then emphasize what is needed in that state department. The Woman's Auxiliary, during this last session, was a tremendous help.

The question on Dr. Miller's motion was unanimously carried.

Report of Committee on Public Relations

Part I—Public Relations Counsel

It was moved (Dr. Gagon), seconded (Dr. Altemus), and unanimously carried that the Public Relations Committee, if they deem Ketchum, Inc.'s services are necessary, may have a survey made providing it can be paid for out of the committee's current budget.

Part II—National Speakers' Bureau

It was moved (Dr. Gagon), seconded (Dr. Hogan), and unanimously carried that the chairman of the Board of Trustees appoint the two speakers as requested by the AMA.

Part III—Benjamin Rush Awards

DR. PETRY: We would suggest that the chairman appoint a committee of the Board to review the nomination submitted and that their report be distributed for a mail vote of confirmation to be in the committee's hands by July 15.

It was moved (Dr. Hogan), seconded (Dr. Gagon), and unanimously carried that the chairman appoint a committee of three to consider the Benjamin Rush Awards.

(Chairman Lorenzo then appointed Drs. Klump, Gagon, and Appel on the committee, instructing them to select their own chairman.)

Part IV—AMA General Practitioner Award

DR. WHITEHILL: I would like to make the suggestion that the Committee on Public Relations watch this

AMA project for awhile and not get too excited about it.

(It was so agreed.)

Part V—(Informatory)

Part VI—Petty Cash 1949 Convention Account

It was moved (Dr. Whitehill), seconded (Dr. Gagon), and unanimously carried that the request for \$250 be granted.

Part VII—National Sales Foundation

It was moved (Dr. Gagon), seconded (Dr. Appel), and unanimously carried that such approval be granted under the circumstances.

Part VIII—Promotion of AMA National Education Campaign

DR. GAGON: If the county society's speakers' bureau could enlist the aid and cooperation of laymen as speakers and the bureau would educate the laymen, our cause would have a much finer service. Too often the only man to speak for voluntary insurance is a doctor, and he is immediately accused of selfish interests.

DR. PETRY: I agree with you absolutely. I would like to have lay speakers, but I think it would be a difficult undertaking unless we are prepared to subsidize them.

Parts IV, X, XI, and XII (Informatory)

Part XIII—Film Booklet

The remainder of the report was purely informative.

It was moved (Dr. Hogan), seconded (Dr. Miller), and unanimously carried that the report of the Public Relations Committee be adopted with a vote of thanks.

Chairman Lorenzo then announced the appointments to the national Speakers' Bureau—Dr. Alfred E. Chadwick, New Brighton, and Dr. Richard A. Kern, Philadelphia.

Report of Committee on Medical Economics

Part I—VA Fee Schedule Amendment—previously mailed (see June PENNSYLVANIA MEDICAL JOURNAL).

It was moved (Dr. Sweeney), seconded (Dr. Miller), and unanimously carried that Part I be approved.

Part II (A, B and C)—United Mine Workers—previously mailed (see July PENNSYLVANIA MEDICAL JOURNAL).

It was moved (Dr. Altemus), seconded (Dr. Sweeney), and unanimously carried that the report of the Committee on Medical Economics be accepted.

DR. PALMER: I recognize that the Committee on Medical Economics and the Commission on Industrial Health and Hygiene are very careful in their recommendations. However, the other day I received, as did most all doctors, from the area administrator of the United Mine Workers Fund a statement to be signed as agreeing to participate in this program. That is something to be careful about. Their program is not the same as it was a few months ago. I am concerned about approving economic philosophies of that type. Consumers of coal are paying for this service rendered to a group of individuals who do not help to pay for it and it is administered by a labor group. Our committee has done an excellent job, but I don't know whether we should come right out and endorse this.

DR. JONES: Our committee realizes that many of the people in the soft coal areas are taken care of under the Department of Public Assistance program. A miners' fund now comes forth which offers to pay for medical service and hospital care for those people at the recognized fees in the local areas. We did not approve the Fund. We approved the operation of its medical program. Most of the representatives of county medical societies attending our conference were in accord with the program for the operation of the medical phase of the Fund as it was presented.

The Area administrators present were unaware of the medical part of the recommendations which the Commission on Industrial Health and Hygiene and the Committee on Medical Economics jointly made to this Board in March, 1947. I would ask permission of the Board to send them a copy of that.

It was moved (Dr. Hogan), seconded (Dr. Altemus), and unanimously carried that Dr. Jones be given permission to send this material.

DR. ALTEMUS: There were several of our members present who represented different county societies. Dr. Jones wishes the Board to approve of reimbursing them for travel expense in attending his committee meeting on Sunday, May 15, same to be charged to the budget of the Committee on Medical Economics.

It was moved (Dr. Altemus), seconded (Dr. Conahan), and unanimously carried that the expenses incurred by the county society representatives who attended the May 15 meeting of the Committee on Medical Economics be paid out of the budget of the committee.

VA Contract—1949-50

Dr. Donaldson then advised that he had received a copy of the contract with the Veterans Administration for the year beginning July 1, 1949 and ending June 30, 1950.

Dr. Jones advised that it was the opinion of the Committee on Medical Economics that the contract should be renewed for the coming year.

It was moved (Dr. Sweeney), seconded (Dr. Gagon), and unanimously carried that the VA contract for the coming year be approved.

Chairman Lorenzo declared the meeting adjourned until 9:30 a.m., Friday morning.

The meeting adjourned at 11:30 p.m.

FRANK A. LORENZO, *Chairman*,
WALTER F. DONALDSON, *Secretary*.

May 20, 1949

A regular meeting of the Board of Trustees of The Medical Society of the State of Pennsylvania was held Friday, May 20, in the board room of the headquarters building, 230 State St., Harrisburg.

Members in attendance: Drs. Hugh M. Miller (1st), John J. Sweeney (2d), Francis J. Conahan (3d), Charles V. Hogan (4th), James Z. Appel (5th), George S. Klump (7th), Herman H. Walker (8th), Frank A. Lorenzo (9th), James L. Whitehill (10th), Leard R. Altemus (11th), and Thomas R. Gagon (12th). Joseph S. Brown (6th) was unavoidably detained.

Officers present: Drs. Gilson Colby Engel, president; Walter F. Donaldson, secretary-treasurer; E. Roger Samuel, president-elect; Harold B. Gardner, first vice-president; and Park Berkheimer, assistant secretary-treasurer.

Others present: Drs. C. L. Palmer, chairman of Committee on Public Health Legislation; Howard K.

Petry, chairman of Committee on Public Relations; and Louis W. Jones, chairman of Committee on Medical Economics. Messrs. Lester H. Perry, Leo E. Brown, Robert L. Richards, and A. H. Stewart, of the Harrisburg office, were also present.

Chairman Lorenzo called the meeting to order at 9:40 a.m.

Practice of Medicine by Hospitals

Secretary Donaldson read a progress report dated May 2, 1949, from Dr. Elmer Hess, chairman of the Committee on Hospital Relations.

SECRETARY DONALDSON: This Board of Trustees has a definite responsibility to our 1949 House of Delegates to give them something helpful on this problem of hospitals practicing medicine.

It was moved (Dr. Whitehill), seconded (Dr. Altemus), and unanimously carried that the subject of the practice of medicine by hospitals be laid on the table until the July meeting of the Board, at which time the Board must evolve a progressive resolution to be presented to the 1949 House of Delegates.

1949 Councilor District Meetings

Secretary Donaldson then read information concerning the dates and places of the 1949 meetings held or to be held by all councilor districts except the Eighth.

DR. GAGON: In the coming year may the councilor use his discretion about how the 50-year awards will be given?

CHAIRMAN LORENZO: I think that is proper.

MSAP Orientation of a County Medical Society Representative

SECRETARY DONALDSON: Since that item went into today's agenda, I received a communication from President Daugherty of MSAP in which he gave one or two reasons why it should not be taken up at this time.

DR. APPEL: The Associated Medical Care Plans has just issued in pamphlet form the outline of a public relations program for the various state Blue Shield organizations. This arrived in the Harrisburg headquarters of Blue Shield too late for the members of the Board to thoroughly study it. They would like to defer discussion of the proposal.

It was moved (Dr. Appel), seconded (Dr. Klump), and unanimously carried that discussion on this subject be postponed until the Board of Directors of MSAP has a chance to look over the AMCP program.

Distribution of APHA Public Health Survey of Pennsylvania Public Health System

DR. KLUMP: I was unable to be present at the meeting of the Commission on Preventive Medicine and Public Health in April, and requested that Mr. Richards be allowed to present the matter.

MR. RICHARDS: The Commission on Preventive Medicine and Public Health is interested in your approval of the proposed distribution of 900 copies of the American Public Health Association's survey report. The commission would like you to approve of spending approximately 21 cents per copy for that distribution. It estimates that the immediate distribution would total about 500 copies, and the other 400 would be retained to meet future demands.

DR. KLUMP: I think that Dr. Vaux's offer allowing us to distribute the 900 copies offers an opportunity in public relations that we couldn't possibly buy with any amount of money. The report should be sent only to people who are interested. We should draft an appropriate covering letter emphasizing our original sponsorship of the survey.

DR. PETRY: I agree with you in general. But you are going to have 900 copies to deliver and it may resemble that old question of patronage.

DR. KLUMP: There is an unlimited supply of the 40-page summary which could be used to supplement the supply of reports. The report should be given to responsible executives of organizations interested in health problems.

DR. MILLER: This may well serve as the basis of legislation two years from now. If we can follow Dr. Klump's suggestion, I think it is worth while for the Public Relations Committee to spend a week in making up a list and a letter of transmittal.

DR. KLUMP: The commission has been asked by Dr. Vaux to distribute the report.

MR. RICHARDS: We have received many requests from all types of state-wide organizations interested in public health and from individuals. Dr. Vaux refers the requests to the State Medical Society.

DR. KLUMP: This report was made at the request of the Medical Society through proper action of our House of Delegates and we are not responsible for what the American Public Health Association says. We simply requested that they make a report, and frankly I was very pleased that the Secretary of Health wanted us to distribute it. This is a progressive move. All of the county community chests that have social planning councils are very much interested in the report.

MR. PERRY: Dr. Vaux plans to keep 100 copies to distribute to other state health officers throughout the nation plus key men in his own department. We have had requests from the newspaper correspondents in the Capitol newsroom. We should guard against the possibility of criticism against the State Society for bottling up the report.

DR. PALMER: Dr. Vaux has talked to me considerably about the subject of this discussion. I think that it is perfectly right for the Medical Society to distribute this report. You should list those whom you wish to receive a copy. In our committee's files in the Secretary's office we have a list of the names of the people whom Dr. Vaux and the Governor had in mind as an advisory committee before this report was to be released. These individuals represent many different organizations interested in health matters. We also have a list in the Secretary's office of the officers of the various organizations who are willing to come into the proposed General Health Council. I think that we can develop a list of key members of the Medical Society who should have a copy of this report. I believe that the Board of Trustees, the Committees on Medical Economics, Public Relations, and Public Health Legislation and some of the key men in the various county societies should have a copy as a source of reference. The resolution adopted by our House of Delegates recommended that this survey be made by a state group. It wasn't made by a state group, so they didn't adhere entirely to our recommendation.

It was moved (Dr. Gagon), seconded (Dr. Miller),

and unanimously carried that the State Medical Society pay for the distribution of this report to a list of recipients, the list to be supervised by Chairmen Palmer, Petry, Jones, and the Secretary and referred to Mr. Richards.

MR. RICHARDS: Members of the Commission on Preventive Medicine and Public Health are from time to time called upon to speak before lay groups, and they would like to know whether or not the Board of Trustees will approve of paying for traveling expenses from the budget of the commission in the event that certain lay organizations don't pay the travel expenses connected with speaking engagements.

It was moved (Dr. Whitehill), seconded (Dr. Gagon), and unanimously carried that expenses for speakers from the Commission on Preventive Medicine and Public Health only be charged against the budget of the commission.

SECRETARY DONALDSON: Doubtless all of you have had a chance to become members of the World Medical Association. They are now suggesting to state medical societies that they become organization members. They mention some figures which organizations, dependent on size, have contributed. I suggest that this proposal be referred for study by the Finance Committee to report at the July meeting.

It was moved (Dr. Hogan), seconded (Dr. Altemus), and unanimously carried that the subject of joining the World Medical Association be referred to the Finance Committee for a report at the July meeting of the Board.

Pennsylvania Academy of General Practice

Secretary Donaldson read a communication from Dr. J. Franklin Karcher, chairman of the Convention Committee of the Pennsylvania Academy of General Practice, asking for space where someone could answer questions and sell tickets for their Wednesday evening dinner meeting 5 to 8 p.m.

It was moved (Dr. Whitehill), seconded (Dr. Altemus), and unanimously carried that this communication be referred to Mr. Stewart.

Trustees' Reports on National AMA Education Campaign

DR. WHITEHILL: In the Tenth District we are organizing the various county society committees as recommended by Whittaker & Baxter. Two of our counties are organized and ready to go. The other two are working at it.

A similar report was made by Dr. Altemus (11th District). Mr. Hutchison, of public relations, has been active in this work.

DR. SWEENEY: In the Second District each county society has appointed a speakers' bureau.

DR. ALTEMUS: I would like to have a list of the active members in the Eleventh Council District who have not paid the AMA membership assessment.

SECRETARY DONALDSON: Each board member may receive that information on request to the office of the Secretary-Treasurer.

Election of Associate and Affiliate Members

It was moved (Dr. Gagon), seconded (Dr. Altemus), and unanimously carried that the list submitted by the Secretary be approved for associate and affiliate members (see p.r.).

Organization of Medical Bureau in Lancaster

Dr. Appel read a communication sent to him by Dr. Joseph Appleyard, of Lancaster, who is president of the newly formed Medical Bureau in Lancaster. The \$2,500 asked for is to comprise a budget to be drawn against only when the Medical Bureau of Lancaster feels the need of a loan.

DR. SWEENEY: I don't see why this Board of Trustees should underwrite a cushion for it.

DR. APPEL: The idea sprang from the knowledge that the State Society originally aided the Harrisburg Bureau.

SECRETARY DONALDSON: The Society advanced them \$3,500, all of which has finally been repaid in installments after many years.

It was moved (Dr. Whitehill), seconded (Dr. Miller), and unanimously carried that the Secretary reply to the letter from the Lancaster Medical Bureau advising that they ask the Lancaster County Medical Society for assistance and if their organization later has financial difficulty, they may again contact the Board of Trustees, who may reconsider their action. The reason the Board deems it unwise to support them directly is that there are sixty other counties which may ask for this type of assistance.

There was a short recess at 11:15 a.m. in order that the members of the Board could review with the architect the building plans.

The meeting reconvened at 11:30 a.m.

Discussion of Architect's Building Plans

DR. GAGION: It is impossible for more than two men to view those plans at one time as they lay flat on the table. Would it be possible to put them on slides for projecting so we could sit down as Mr. Green explains them?

MR. GREEN: I could have prints made and distribute them.

DR. CONAHAN: May our committee have your approval of Mr. Green's proposal to have everything ready for our July meeting?

It was moved (Dr. Conahan), seconded (Dr. Whitehill), and unanimously carried that bids should be secured so that the contract can be awarded in July.

Communication from Erie County Medical Society

Secretary Donaldson then read a communication from the Erie County Medical Society accompanying a resolution which proposed an amendment to Article IV, Section 1, of the Constitution and By-laws deleting citizenship as a qualification for election to active membership.

Additional Amendments to Constitution and By-laws

SECRETARY DONALDSON: I will read other amendments in which I hope the Board of Trustees may express interest. (Read proposed amendment to *Chapter II, Section 1, of the By-laws.*) For many years the first day of the annual session was Tuesday and the House of Delegates convened on Monday. Now we have scientific sessions on Monday, so that really the session lasts through Monday, Tuesday, Wednesday, and Thursday. If it stands as it is now, it will be mandatory that the House of Delegates first meet on Sunday. It should be changed to read "the House of Delegates shall meet on the morning of the day fixed

as the first day of the annual session." Will the Board of Trustees accept the responsibility of offering that amendment?

It was moved (Dr. Gagon), seconded (Dr. Miller), and unanimously carried that the Board offer to the 1949 House of Delegates this proposed amendment to Chapter II, Section 1, of the By-laws and that it be published in the June JOURNAL.

Secretary Donaldson then read an amendment to Chapter V, Section 2, of the By-laws which proposes to change the word *second* in the third line to the word *third*.

It was moved (Dr. Miller), seconded (Dr. Klump), and unanimously carried that the Board offer to the House of Delegates this proposed amendment to Chapter V, Section 2, of the By-laws and that it be published in the June JOURNAL.

Secretary Donaldson then read an amendment to Chapter VII, Section 11, of the By-laws which proposed changing the second sentence to read: "They shall act in an advisory capacity to the Woman's Auxiliary, and shall hold meetings whenever called upon by the Woman's Auxiliary regarding its functions or changes in its constitution and by-laws."

It was moved (Dr. Hogan), seconded (Dr. Conahan), and unanimously carried that the Board offer this amendment to Chapter VII, Section 11, of the By-laws and that it be published in the June JOURNAL.

DR. WHITEHILL: I would like to bring up a by-law that lacks clarity. (Read Chapter VII, Section 1-c, of the By-laws.) As it reads now, if the chairman of the Board of Trustees appoints its Finance Committee and a Building Maintenance Committee, they should report to the House of Delegates, which they never do.

SECRETARY DONALDSON: These are committees of the Board.

DR. WHITEHILL: But it needs to state that each committee report back to the body which created it.

Dr. Klump then read from Section 7, Chapter VI, of the By-laws which provides that the trustees have charge of the Society's finances and its real estate.

DR. PETRY: There was no intent that it should cover special committees of the Board of Trustees.

It was moved (Dr. Miller), seconded (Dr. Altemus), and unanimously carried that Dr. Whitehill prepare an amendment in accordance with the discussion (Section 1-c, Chapter VII, of the By-laws).

It was moved (Dr. Whitehill), seconded (Dr. Altemus), and unanimously carried that the Board of Trustees produce a resolution to change the By-laws so that the committees appointed by the Board of Trustees report back to the Board rather than to the House of Delegates. (SECRETARY'S NOTE: At a later meeting Dr. Whitehill moved for rescindment of this motion.)

Report of Commission on Cancer

(Request for Approval to Mail the Texas Cancer Bulletin to Membership)

DR. MILLER: I reviewed the Texas Bulletin, and even though they propose to make a great many changes, I can't see its usefulness in the State of Pennsylvania.

DR. ALTEMUS: We have been trying to get a good cancer program going in Pennsylvania and we ought to be careful. We should analyze the proposal very thoroughly before we oppose anything connected with the

educational program for cancer control. The Pennsylvania Department of Health is paying for the pamphlets from the Texas Society, but our society is to pay for their mailing.

MR. RICHARDS: The editor of this magazine has said that he has other state societies participating, and that he will have a second-class mailing permit within a month. At the end of the year the State Department of Health will send a card to all physicians to get their expressed reactions to this bulletin. If the response is good, they may return to your Board next year with a similar request.

DR. ENGEL: I feel that there is a duplication of effort in this whole program. I don't believe we ought to turn down this offer, but we should studiously attempt to make a wise choice.

It was moved (Dr. Altemus) and seconded (Dr. Klump) that the suggestions from the Commission on Cancer be approved along with the request to pay for the distribution of the pamphlets.

QUESTION ON THE MOTION: Four voted in favor. Dr. Gagion wished to be recorded by name as having opposed the motion. The motion lost.

Attorney Hafer appeared at this time to discuss the property.

MR. HAFER: I would like to say that since I was here the last time and discussed legislation, Dr. Palmer has worked very well with me. We soon figured out what our difficulties and differences were and I want to say again that, as far as I was concerned, he did a wonderful job.

It was moved (Dr. Conahan), seconded (Dr. Sweeney), and unanimously carried that the agreement be accepted as read and explained by the attorney and Mr. Perry for the purchasing of property in the amount of \$3,950 and that a check be drawn for the amount of \$4,050 which will pay for the property plus the insurance and other incidentals that may develop in the transaction.

It was moved (Dr. Sweeney), seconded (Dr. Conahan), and unanimously carried that the blanket liability insurance proposition of the Dauphin Deposit Trust Company be accepted, premium \$2.00, and that \$5,000 fire insurance coverage be carried on a five-year term.

MR. PERRY: We have the insurance analysis. The present cost of coverage is \$300 a year for all types. Insurance proposed for securities held in the bank costs \$450 a year. (SECRETARY-TREASURER'S NOTE: Upon specific inquiry it is learned that as long as the Society's securities remain "for safe keeping" in the vaults of the Peoples First National Bank & Trust Company, the latter institution is bonded to return them to us on properly executed formal demand. The continued presence in the vault of each individual security is checked annually by two representatives of the bank with the Society's auditor and its secretary-treasurer.)

Water damage insurance on the building costs \$100, with approximately \$100 on the contents. Additional fire insurance involved depends on increases on 230 State Street and on furniture; equipment in the Pittsburgh office is estimated to cost an additional \$50. For all other items the reviewer suggested another \$100 premium. He recommended a complete inventory of all furniture, fixtures, and supplies in both the Pittsburgh and Harrisburg offices to be made by an expert in that line.

On the question of non-ownership automobile liability coverage, Mr. Hafer will be glad to clarify that problem.

MR. HAFER: When the report was first made, the company recommended a comprehensive policy. But at the time any member of this Society on business of the Society was receiving mileage for the use of his car, the Society could be made a liable co-defendant with the individual doctor member. With a verdict against the doctor and the Medical Society, the plaintiff would have his option of collecting against either or both. I find you have five staff persons in Harrisburg regularly using their cars for Society business.

In the buying of such insurance there are two classes: Class 1—those who regularly use their own cars; Class 2—officers, committee members, and others who occasionally use their cars on Society business. I would recommend that you buy it on a comprehensive basis.

My recommendation also is that you cover your staff, general officers and trustees, your committee members, and representatives at the annual Secretaries and Editors Conference.

It was moved (Dr. Gagion), seconded (Dr. Walker), and unanimously carried that a comprehensive policy be purchased covering the individuals whom the Executive Secretary feels should be covered.

It was moved (Dr. Gagion), seconded (Dr. Hogan), and unanimously carried that Mr. Perry continue the survey of our insurance position, contacting during his study the Building Maintenance Committee and that they bring in their recommendations at the next regular meeting of the Board.

It was moved (Dr. Gagion), seconded (Dr. Hogan), and unanimously carried that the workmen's compensation, fire, and other insurance features be placed on a binder.

It was moved (Dr. Hogan), seconded (Dr. Gagion), and unanimously carried that Mr. Perry get the advice of an insurance expert to estimate the value of the contents of the building and prepare an inventory.

It was agreed that the next meetings should be held July 14 and 15, 1949.

Letter from Tennessee State Medical Association

SECRETARY DONALDSON: The Tennessee State Medical Association writes regarding future hospital service for veterans. (Read letter.) Shall it be limited to VA hospitals or permit free choice by veterans of doctor and hospital (home town)? I believe the Board might take action leaving it to the judgment of our AMA delegates.

It was moved (Dr. Gagion), seconded (Dr. Hogan), and unanimously carried that this proposal be left to the judgment of the AMA delegates.

Letter from Dr. Ralph Mulligan

Secretary Donaldson read a letter which he had received from Dr. Ralph Mulligan, Philadelphia, regarding pertussis.

It was moved (Dr. Gagion), seconded (Dr. Altemus), and unanimously carried that Dr. Mulligan's letter be referred to the Committee on Child Health.

It was moved (Dr. Gagion), seconded (Dr. Altemus), and unanimously carried that the meeting be adjourned.

The meeting adjourned at 1:10 p.m.

FRANK A. LORENZO, *Chairman*,
WALTER F. DONALDSON, *Secretary-Treasurer*.

CHANGES IN MEMBERSHIP OF COUNTY SOCIETIES

New (62) and Reinstated (2)

ALLEGHENY COUNTY: James R. Dornenberg, Pittsburgh; Richard T. Turfley, Woodville.

BUCKS COUNTY: Edward E. Everts, Langhorne.

BUTLER COUNTY: C. Y. Veenis, Butler; Frederick F. Young, Chicora.

CAMBRIA COUNTY: John F. Brierton, Johnstown.

CARBON COUNTY: George P. Thomas, Jr., Mauch Chunk.

CENTRE COUNTY: B. E. Durgin, Bellefonte.

CHESTER COUNTY: Toye G. Davis, Lincoln University; Robert K. Irvine, Coatesville; Henry S. Thomas, East Orange, N. J.

CRAWFORD COUNTY: Richard Jessup, Meadville.

DELAWARE COUNTY: Edward A. Kelly, Drexel Hill; Henry M. Tracy and Joseph E. Turner, Jr., Chester; William Charles Wood, Philadelphia.

FAYETTE COUNTY: Matthew B. Moore, Connellsville.

HUNTINGDON COUNTY: Merrill D. Cunningham, Mt. Union.

JEFFERSON COUNTY: A. E. Devlin, Brockway.

LACKAWANNA COUNTY: John M. Loftus and Elmo F. Masucci, Scranton.

LANCASTER COUNTY: John S. Gates, Baltimore, Md.; Joseph X. Medwick, Lancaster.

LEBANON COUNTY: Anthony M. Tanno, Lebanon.

LEHIGH COUNTY: David S. Bachman, Allentown.

MIFFLIN COUNTY: Harry R. Cramer, McClure.

MONROE COUNTY: Theodore S. Hsu, E. Stroudsburg; Howard Ott, Portland.

MONTGOMERY COUNTY: Manuel A. Bergnes and Joseph S. Puleo, Norristown; Harry A. Fisher, Jr., Hatboro; Theodore H. Durr, Jr., Glenside; Francis F. Hart, Ambler.

PHILADELPHIA COUNTY: George M. Austin, Jr., Horace G. Butler, Elton M. Cannon, James E. Ecknehoff, Thomas V. Finch, Sol A. Goldberg, Mortimer B. Hermel, Karl C. Jonas, Leroy W. Krumperman, Edward L. Keyte, Milo D. Leavitt, Jr., Robert L. Leopold, Cyril C. Stapinski, Alfred Trosow, Chester M. Trossman, George R. Wade, James Franklin Ward, and William M. Wilson, Jr., Philadelphia; Bryan A. Dawber, Bethayres; Guerrant H. Ferguson, Jr., Bala-Cynwyd; Edward M. Kavjian, Upper Darby; Richard S. Monheit, Melrose Park; Norbert J. Schulz, Moylan. (Reinstated) Charles R. Perryman, Baton Rouge, La.

TIOGA COUNTY: Stuart M. Davis, Westfield. (R) John R. Davies, Blossburg.

WASHINGTON COUNTY: Frank R. Raynak, Canonsburg.

WESTMORELAND COUNTY: William D. Levinson, Mount Pleasant; Philip J. Skirpan, Monessen; Thomas M. Sproch, Latrobe.

YORK COUNTY: Frederick D. Reardon, Jr., York.

Resignations (10), Transfers (2), Deaths (20)

ALLEGHENY: *Resignations*—Edward R. Kielman and Harvey W. Rosenberg, Pittsburgh. *Deaths*—Isaac N. Lear, Vandergrift (Univ. Pgh. '96), March 18, aged 82; Alfred S. Sigmann, Bellevue (Univ. Austria '97), May 7, aged 81.

CHESTER: *Death*—George W. Sharshon, Phoenixville (Hahn. Med. Coll. '25), April 9, aged 50.

ERIE: *Death*—Fred E. Abbott, Erie (Hahn. Med. Coll. '21), May 8, aged 55.

FAYETTE: *Death*—Paul Staman, Uniontown (St. Louis Univ. '33), April 18, aged 41.

INDIANA: *Death*—Medus M. Davis, Indiana (Jeff. Med. Coll. '93), May 9, aged 81.

JEFFERSON: *Resignation*—Carl T. Korsmo, Akron, Ohio.

LANCASTER: *Deaths*—Willis Hess Lefevre, Lancaster (Univ. Va. '13), April 29, aged 59; Herman H. Levin, Lancaster (St. Louis Univ. '37), May 4, aged 36; Silas R. Posey, Lititz (Jeff. Med. Coll. '11), May 5, aged 69.

LUZERNE: *Transfer*—Lucian L. Rinaldi, Scranton, to Lackawanna County Society. *Deaths*—William J. Doyle, II, Wilkes-Barre (Jeff. Med. Coll. '32), May 23, aged 42; Percival M. Kerr, Wilkes-Barre (Temple Univ. '06), April 11, aged 64.

MERCER: *Death*—Caroline J. Gilliland, Sharon (Woman's Med. Coll. '06), recently, aged 83.

NORTHAMPTON: *Resignation*—Leslie A. Freeman, Somerville, N. J. *Death*—Fred E. Ward, Easton (Med.-Chi. Coll. '06), May 3, aged 67.

PHILADELPHIA: *Transfer*—Richard B. Eisenberg, Erie, to Erie County Society. *Resignations*—Leonard Averett, Los Angeles, Calif.; Willard S. Hastings, Canandaigua, N. Y.; Lewis Lehrer, Cleveland, Ohio; Stanley Miller, Baltimore, Md.; Joseph J. Shebl, Salinas, Calif. *Deaths*—Maximilian D. Bloomfield, Philadelphia (Jeff. Med. Coll. '05), May 5, aged 69; Daniel Longaker, Philadelphia (Univ. Pa. '81), April 30, aged 91; Christian G. Yaeger, Philadelphia (Univ. Pa. '95), May 6, aged 77; Anne Heath Thomas, Colorado Springs, Col. (Woman's Med. Coll. '05), May 21, aged 77.

SOMERSET: *Death*—Robert J. Heffley, Berlin (Med.-Chi. Coll. '98), May 9, aged 78.

SUSQUEHANNA: *Death*—Warren W. Preston, Montrose (Hahn. Med. Coll. '07), May 8, aged 70.

WASHINGTON: *Resignation*—Joseph J. McMullin, Catlettsburg, Ky.

WESTMORELAND: *Death*—Philip S. Pile, Latrobe (Baltimore Med. Coll. '05), April 11, aged 78.

ARE YOU USING THE PACKAGE LIBRARY SERVICE?

Are you taking advantage of the facilities offered by the package library service of The Medical Society of the State of Pennsylvania? There are, at the present time, over 100,000 re-

prints and tear sheets from current periodicals filed in the library for your use.

Prior to 1944 the average yearly number of requests was approximately 350. However, from 1944 to 1948 inclusive, there has been a continuous increase in borrowers. A total of 1192 requests were received during 1948—an increase of 293 requests over the total for 1947.

A package of reprints will be sent immediately for a loan period of two weeks to any member of the State Society. There is a charge of 25 cents for each subject requested to cover postage and part of the expense of collecting the material. Send requests to the Librarian, 230 State St., Harrisburg, Pa.

Subjects requested during the months of April and May were:

- | | |
|------------------------|------------------------|
| Bronchoscopy | Workmen's compensation |
| Sludged blood (2) | Sex education for boys |
| Coarctation of aorta | Tumors of the lungs |
| Ductus arteriosus | Cancer study |
| Cholera | Psychotherapy |
| Cardiac edema | Kidney pathology |
| Leukemia (2) | Erythroblastosis |
| Hypoparathyroidism | Spinal anesthesia |
| Gaucher's disease | Encephalitis |
| Parkinsonism | Aureomycin |
| Pentothal sodium | Lichen planus |
| Perirenal insufflation | Infections of the hand |
| Laboratory technicians | Narcolepsy |
| Drugs | Thymol turbidity test |
| Rh factor (2) | Folic acid |
| Decubitus ulcers | Blood substitutes |
| Abdominal hysterectomy | Nurses and nursing |
| Rice diet | Medicine |
| Blood plasma | Health in rural areas |
| Pneumococci | Marriage |
| Lipid pneumonia | Blood transfusions |
| Public relations (2) | Mental hygiene |
| Sinusitis | Muscle cramps |
| Euthanasia | Bee stings |
| Practice of medicine | Tuberculosis mortality |
| Industrial medicine | Scoliosis |
| Health of the Negro | Posture examinations |
| Causes of death | Infectious hepatitis |
| Pollen count | Expectorants |
| Hospital care | Fetal hydriops |
| Diabetes and diet | Torticollis |
| Physical medicine | Epistaxis |
| Fragility tests | Siderosis |
| Tropical medicine | Effects of thiamine |
| Hay fever (3) | Blindness |
| Arrhenoblastoma | Hypertension |
| Status epilepticus (2) | Tropical medicine |
| Sturge-Weber disease | Vagotomy |
| Diphtheria immunity | Treatment of psoriasis |

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|--|------------------------|
| Mediterranean anemia | Abdominal hysterectomy |
| Atrophic rhinitis | Shock |
| Third stage of labor | Silicosis |
| Eye exercises | Multiple sclerosis |
| Nerve impulses | Hospitals |
| Acetylcholine | Blue Shield |
| Obesity | Asthma |
| Cesarean section | Diabetes mellitus |
| Diabetes insipidus | Psychosomatic medicine |
| Louis Pasteur | Angina pectoris |
| Use and toxicity of penicillin | |
| Socialized medicine (5) | |
| Early ambulation in surgery | |
| Approved schools of nursing in Pennsylvania | |
| Tattooing in plastic surgery | |
| Potassium bromate poisoning | |
| Bacteriology of the vagina | |
| Surgery of the gallbladder | |
| Unipolar electrocardiography | |
| Treatment of acute rheumatic fever | |
| Pharmacology of benadryl | |
| Delaware County Medical Society | |
| Effects of radiation on normal and malignant cells | |
| Socialized medicine in Australia and New Zealand | |
| Treatment of exfoliative dermatitis | |
| Chemistry of streptomycin | |
| V leads in electrocardiography | |
| Diagnosis and treatment of myasthenia gravis | |
| Enterobius vermicularis infestation | |
| Children's reactions to radio and movie horrors | |
| Use of quinidine in heart conditions | |
| Aminophylline in cardiovascular diseases | |
| Radium therapy for nasopharynx | |
| County medical societies | |
| Inflammation of the brain | |
| Subacute bacterial endocarditis | |
| Emotional problems of living | |
| Essentials of a registered hospital | |
| Postoperative complications | |
| Electrocardiography (2) | |
| Poikiloderma atrophicans vasculare | |
| Acne vulgaris treated with vitamin A | |
| Sickle cell anemia in the white race | |
| Pharmacology of strychnine | |
| Emergency care in the hospital | |
| Toxic effects of streptomycin | |
| Hemorrhage from tooth extraction | |
| Treatment of undescended testicles in children | |
| Treatment of chronic brucellosis (2) | |
| Arthritis and undulant fever (2) | |
| Histamine in treatment of headache, mental disorders, and hypertension | |
| Uses of para-aminobenzoic acid | |
| Kolmer modification of Wassermann test | |
| Abnormalities of menstruation | |
| Methods of obliterating skin blemishes | |
| Phenobarbital poisoning | |
| Internship in pediatrics | |

TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the co-operation of the Pennsylvania Tuberculosis Society
and The Medical Society of the State of Pennsylvania

THE screening of large numbers of people for tuberculosis by the use of chest x-rays has resulted in an appreciable number of cases of primary carcinoma of the lung being found at a stage in which surgical intervention may be effective. As with tuberculosis prompt detection and treatment before symptoms appear give the greatest hope for complete recovery.

CANCER OF THE LUNG

Cancer of the lung, its detection and treatment, is so closely linked to the modern attack upon tuberculosis that every physician and surgeon, every social worker and educator, interested in the latter disease should likewise be well informed about primary cancer of the lung. Many skilled observers believe that this disease actually is increasing in incidence; others argue that it is merely being identified more accurately in recent decades. All agree that it is one of the most frequently encountered and one of the most important types of malignant disease encountered in the male sex, probably second only to cancer of the stomach.

There is no explanation for the remarkable fact that primary cancer of the lung is six to eight times as common in men as it is in women. Its amazing frequency among miners working with radioactive materials in certain German mines may be significant to the coming age of atomic warfare and atomic power. Its possible relationship to potentially carcinogenic agents in road building materials and exhaust products of internal combustion motors has been questioned and denied. The actual causes of cancer of the lung are as obscure as are the causes of other types of malignant growth.

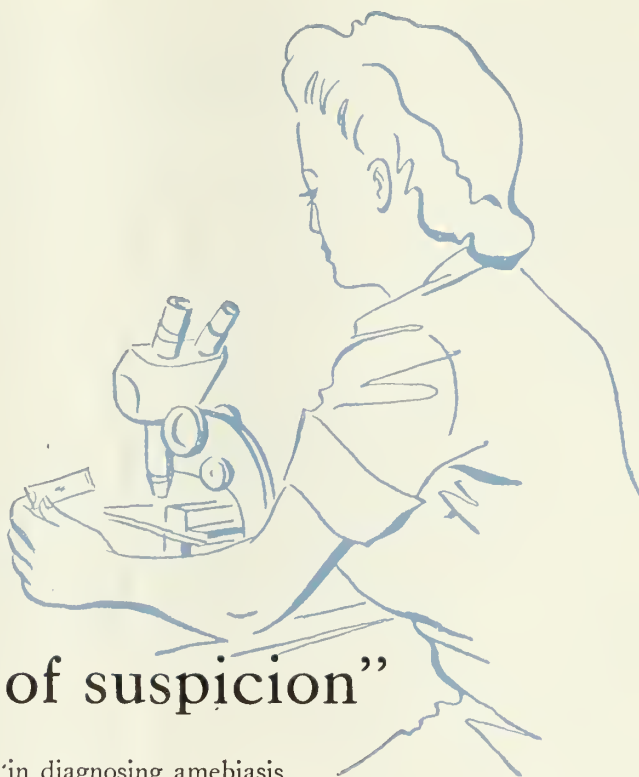
The effective surgical treatment of primary cancer of the lung has developed largely within the past ten years, aided by new techniques and by the protective value of modern antibiotics. Many surgeons received their special training and experience in thoracic surgery during the recent war, hence the availability of such treatment has been greatly increased within the past five years. Surgical mortality rates are still de-

clining steadily, so that exploration of the chest can be performed almost as freely and almost as safely as surgical exploration of the abdomen.

Chemotherapy of cancer has not yet come of age, but steady progress has been recorded in recent years and never before have so many diligent and skilled scientists devoted so much energy to a medical problem. Indeed no previous medical problem could be more significant to the human race.

As with other cancers, early diagnosis is of paramount importance; and, as with other pulmonary diseases, x-ray examination of healthy persons and of those with early respiratory symptoms is the most useful screening procedure. However, early cancers of the lung often cast indefinite or confusing shadows upon x-ray films, simulating tuberculosis, pneumonia, lung abscess, or almost any other type of localized pulmonary infiltration. Bronchoscopy will reveal the early cancers which originate in larger bronchi, especially those of the lower lobes of the lungs. Recently the microscopic examination of sputum for cancer cells has gained in accuracy and in popularity, but few trained diagnosticians in this difficult technique of examination are available today.

Every large chest x-ray survey project brings to light cases of primary cancer of the lung, and these may prove to be the most readily curable if detected and treated before symptoms have developed and before the disease has proceeded to an inoperable stage. Some of these cases have been referred to tuberculosis sanatoriums under erroneous diagnosis or for observational pur-



“A high index of suspicion”

The difficulties and pitfalls in diagnosing amebiasis are stressed frequently in medical literature.

“... despite the absence of a history of dysentery, amebiasis must be considered in the differential diagnosis of many bizarre clinical syndromes. . . . A high index of suspicion is the keynote of early diagnosis.”¹

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1. Warshawsky, H.; Nolan, D. E., and Abramson, W.: Hepatic Complications of Amebiasis, New England J. Med. 235:678 (Nov. 7) 1946.

2. Manson-Bahr, P.: Some Tropical Diseases in General Practice: “A Post-War Legacy,” Glasgow M. J. 27:123 (May) 1946.

poses. Sanatorium physicians are learning to view with suspicion any localized pulmonary lesion, especially if somewhat circumscribed and progressive and if tubercle bacilli cannot be demonstrated.

Modern cultural techniques for isolating tubercle bacilli are sufficiently accurate that negative examinations of secretions have real value in excluding tuberculosis and in increasing the suspicion of cancer. But occasionally the shadow cast by x-ray is sufficiently suggestive of cancer, even when the lesion is small, to justify exploratory surgery without awaiting the prolonged incubation of cultures. As with all other medical decisions which affect the life of the patient, the physician must have the skill and experience to balance the risk of early radical action against the sometimes greater risk of delay and observation. Whether or not a curative operation can be performed may depend upon whether it is done within the first few weeks after detection of a lesion.

Physicians in general practice and specialists in internal medicine are learning that repeated attacks of pneumonia may actually be obstructive pneumonitis caused by the blocking effect of a

bronchial cancer, and that symptoms may be relieved promptly but only temporarily by penicillin treatment. They have learned that every case of pneumonia should be studied by x-ray and followed by repeated films until the possibility of an obstructing cancer is excluded. The expectoration of blood is more typical of cancer than it is of tuberculosis. Wheezing respiration caused by an obstructing bronchial cancer may simulate asthma for a few weeks or months. Pleurisy caused by cancer extending to the pleural surface of the lung may at first simulate the pleurisy of tuberculosis or of pneumonia.

The campaign against cancer, like the campaign against tuberculosis, must depend upon an enlightened public, a skillful and alert medical profession, and an inspired corps of scientific investigators. The universal use of x-ray, almost to the point of apparent extravagance, would seem to be required if any large proportion of cases of cancer of the lung are to be detected in time to permit curative treatment by present-day methods.

Cancer of the Lung, H. Corwin Hinshaw, M.D., The NTA Bulletin, February, 1949.

CANCER IN CHILDREN

Claiming the lives of well over 2000 children each year, cancer, including leukemia and Hodgkin's disease, has now become an increasingly significant cause of death from disease among youngsters, according to data on children insured by the Industrial Department of the Metropolitan Life Insurance Company. While it is the second ranking cause among ages 1 to 14 combined, it leads all other diseases in the 5 to 9 age group.

Although in 1930 cancer was not even among the first ten causes of death among children, taking the life of one in every 50 deaths from disease (ages 1-14), in 1946-47 it accounted for one in every nine such deaths. In all, the mortality rate rose about 40 per cent in the seventeen years after 1930.

Leukemia, the most common type of fatal cancer in children, accounts for nearly one-half of the cancer deaths at ages 1-4, slightly more than two-fifths at ages 5-9, and somewhat over one-third at ages 10-14. Cancer of the bladder and kidney now ranks second at ages 1-4, but declines rapidly in relative importance with advance in age. The brain is third in the list at the preschool ages, but is second at age periods 5-9 and 10-14. Cancer of the bone features prominently in later childhood. Hodgkin's disease is a relatively minor factor.

Other trends shown are: (1) mortality from cancer in childhood is highest in the 1-4 age group; (2) while

the increase in death rate from cancer has been substantial at every period of childhood, the 60 per cent rise in the 5-9 year group was by far the highest; (3) a large percentage increase has been recorded in mortality from malignant brain tumors in all age groups; and (4) leukemia has also shown a sharp over-all increase.

This considerable growth in mortality from cancer does not necessarily reflect more frequent incidence of the disease. Rather, more accurate diagnosis of cancer has resulted in increased reports on death certificates. Today more children cancer victims are being treated in the early stages, and medical literature reports that an increasing number of children are surviving five and ten years after treatment.

The prominence of cancer as a cause of death in children clearly points to the need for increased attention to this problem in the cancer control program. Co-ordinated study of cancer among children as promoted by the American Academy of Pediatrics, education of parents to extend health supervision of their children well beyond the period of infancy, and a greater readiness on the part of the physician to investigate apparent and harmless growths and swellings in children, coupled with constant work in basic research on the fundamental causes of the disease, provide the main hope for the future.—*Statistical Bulletin*, Metropolitan Life Insurance Company, January, 1949.



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minerals compare favorably with those of human milk . . .

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THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

547 Water Street

Indiana, Pa.

THE PRESIDENT'S MAILBAG



It is hard to realize that the twenty-fifth year of the Auxiliary is almost over. As you all know, it has been busy, hectic, and discouraging at times, but rewarding to all who have given time, interest, and energy to develop our program, under the direction

of the Medical Society, to fit the needs of the day.

"Our yesterdays follow us, they constitute our life, and they give character and meaning to our present deeds." So I trust that the deeds of this year almost past will serve as a foundation for greater deeds in the year to come.

The panorama of our activities spreads across the months—the good, the careless, the successful, the triumphs of fine work, the failures caused by indifference. But everywhere is the evidence of friendliness.

Perhaps nothing tells the story of this twenty-fifth year so well as letters to me, those personal comments, told so pointedly, often with humor. The following quotations* from my mail have given me a year to remember. My thanks to all of you who have made it so memorable.

Membership

"We must remember that, to the doctor's wife, the Auxiliary is the most important of all organizations, excepting the church. Civic and social clubs are necessary and desirable, but let us put first things first. No other group backs up our husbands as ours was meant to do. We cannot let them down."

Program

"Experience has shown us that we have a much more active auxiliary by having a project that has community value as well as value to our husbands and also that, if our programs are integrated to the project and health needs and work of the parent organization, the greater ma-

jority of the organization participates both in meetings and in work."

"I have definitely stressed a pleasant mingling of social affairs with educational material. I can't quite agree that doctors' wives are well informed, although I'll admit they're supposed to be. However, we have young members coming in and I think it is our duty to impart knowledge in small doses along the lines upon which we feel they should be informed."

"We had an excellent meeting last night, spirited and enthusiastic, about animal experimentation and medical insurance. Articles reported on were Mr. Ewing's in the *January American* and the *New York Times* for January 9. We shall continue to do what we can from this end. It is encouraging to note that, despite the fact that we have long business sessions and little time for bridge, we have had greater attendance than in other years. Speaks well for the interest of the group!"

Medical Benevolence

"The latest reference to committee action is characteristic of response to many situations requiring supplementary financial assistance:

- "1. To maintain an aged member and his wife in their home.
- "2. To assist a younger doctor and his wife, he being physically unable to carry on more than a very limited office practice.
- "3. An increased grant in a previously approved application for an aged member and wife living in their own home."

—W. F. D.

PLAN NOW TO ATTEND

The *Silver Anniversary* Convention

of the

Woman's Auxiliary to the MSSP

Roosevelt Hotel, Pittsburgh

September 25-29, 1949

Make your reservations early!

* The majority of these letters were received as personal communications and not meant for publication, hence their source is not revealed.

Legislation

"As usual, we have not been contacted by our county society members as per Dr. Palmer's instructions to them for contacting senators; so I took it upon myself to call ours for an appointment. I could not reach him, so got off the enclosed letter." (There followed an excellent argument for S. 278, which did win the senator to the medical viewpoint.) "At long last I got the senator; he had read my letter, and it had been the only contact he had had in favor of the bill. He wants to talk to me about it."

"Every person says 'What shall I write?' but just so they *do* write how they feel to their Congressmen is the important thing now."

Hygeia

"My face is very red to discover that your letter concerning *Hygeia* was still on my desk. I shall get it to Dr. Fishbein at once with my reactions, and meantime you know whom to shoot." —M. D.

From Dr. Fishbein: "I am much interested in your proposal that we follow the technique used by most lay magazines and number each issue separately. The disadvantage of this lies in the preparation of a satisfactory index. Several thousand *Hygeia* readers want an index each year, and many persons use *Hygeia* in libraries and need a comprehensive index in order to refer to it. This is much easier when the pages are numbered consecutively for the volume."

Federation of Women's Clubs

"It is my opinion, based upon many years as a professional social worker (and so only too familiar with governmental interference and incompetence) as well as a taxpayer, that better health based on more adequate medical care for more people at less cost cannot be legislated. Such a condition will exist only when science is free to advance unfettered, when standards of practice and training are kept high, and when individuals themselves and as part of their communities plan for and pay for their own facilities. This is the American way and tradition. I sincerely hope that the members of our Federation will have the wisdom and foresight to vote down any resolution that would favor government participation or control of medicine."

Radio

"In haste—because if I don't write this at once I'll procrastinate. While putting the children to bed a few minutes ago, I happened to catch the beginning of a program taking some excellent swings at socialized medicine. Sample: "The

doctors will be so busy filling out papers that an office visit will go like this, "Doctor, I am 107799805. My boy just swallowed a peach stone." And by the time the doctor finishes filling out the papers the kid will have a tree growing out of his head.' There was more of the same, with excellent audience reaction both in the studio and from my small fry. I suggest we write and praise the program, hoping more will do the same. You may have heard other programs with jokes for government medicine. . . . I feel humor is badly needed in our work. I hope you will approve if we watch for this sort of thing and write our approval to the programs."

Health Meetings

"I seem to get tied up with more jobs by opening my mouth. A number of auxiliary members wanted to give up the health meeting. I just had a fit, which of course landed me in the middle of the work. I don't mind this, but I can't understand why more doctors' wives don't want to work. Maybe I won't make good, but at least I think it can be done. You must make personal contacts to stimulate interest; people will not come out just by receiving a card."

Libraries

"I am giving material against political medicine to all libraries in the county—material which I have obtained from the AMA and from the state office. It seems there is a demand for such knowledge, for librarians in public and school offices were overjoyed to see me. I would like to give each library a copy of the bibliography if it is possible; they would welcome it I am sure."

From a librarian: "Thank you so much for the book. It has been read by and used for a paper on socialized medicine by a college student here, and since it is so up-to-date and objective, it has been greatly appreciated."

Progress

"We have had a very slow year, with little to indicate that things will speed up remarkably during the remainder of the year. But we will make a few tries. When the steam from the president's teakettle meets with clouds of passiveness from our small membership, it is a bit dampening. But then we all are caught in the rain occasionally. I do not give up hope, for there is always next year, or better yet, next month."

Cooperation

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GYNECOLOGY—Intensive Course, two weeks, starting September 26, October 24. Vaginal Approach to Pelvic Surgery, one week, starting September 19, November 7.

OBSTETRICS—Intensive Course, two weeks, starting September 12, November 7.

MEDICINE—Intensive General Course, two weeks, starting October 3. Gastroenterology, two weeks, starting October 24. Gastroscopy, two weeks, starting July 18, September 26. Electrocardiography and Heart Disease, two weeks, starting July 18. Electrocardiography and Heart Disease, four weeks, starting September 7.

PEDIATRICS—Personal Course in Cerebral Palsy, two weeks, starting August 1.

DERMATOLOGY—Formal Course, two weeks, starting October 24. Informal Clinical Course every two weeks.

UROLOGY—Intensive Course, two weeks, starting September 26. Ten Day Practical Course in Cystoscopy every two weeks.

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"The meetings for 1948-49 have been most successful. Much of the credit goes to the members of the Woman's Auxiliary who have given so unselfishly of their time and effort to provide refreshments. Many physicians attending sessions held elsewhere have commented on how nice this personal courtesy was and how it helped to sponsor a feeling of good fellowship among those attending. This personal attention and interest on your part could not be duplicated in a coffee shop or elsewhere. I would like to express my personal appreciation on behalf of the members of the Society. Would it be possible for you to continue this fine help for the 1949-50 seasons?"—THA and GRT—Graduate Education Institutes.

"Our society's Speakers' Bureau met last Friday. Four of us have been asked to join the group."

Husbands

"We physicians are just like all the rest of the male group. We secretly admit that our wives do dominate, but successful wives run us by never punching until they put on about eight-ounce gloves."

Your Mailbag

"I doubt if the letter was ever opened. . . . When I called the president, she replied, 'I know nothing about it.' 'But did you not receive a request?' . . . 'Perhaps, but I am so weary receiving mail from the state officers that I do not always open it.' How can people be so indifferent? You know they can be most gracious when in your presence."

Indifference vs. Personal Public Relations

"Our women seem to be happier to go along their own way. When I try to talk to them about our group, they just say that our county society does not need us, and will not show interest in any way.

"I for one am talking up voluntary health plans every chance I get. Both Blue Cross and Blue Shield are very popular here in town."

Personal Socialized Medicine

From a patient in a tuberculosis sanatorium: "But as to my opinion of the Wagner bill . . . remember, in a small way I am living under socialized medicine—one doctor for over 100 patients; aspirin for headache; oil of peppermint for tummy ache; if your cough is thick, elixir of terpin hydrate, if dry and rasping, one-fourth codeine. A toothache gets painted with oil of cloves. No one bothers to find out why you have

these pains; they just dose you. When a critical illness arises, they seem helpless. I thank my lucky stars that so far I've been hale and hearty except for the tuberculosis. All of which adds up to let me pick my own M.D. and a man I have confidence in. Also, working for a doctor as I have, I have a pretty shrewd idea of government forms and red tape, which would be too horrible to contemplate if the government ever ran medicine. Finally, as a member of the middle class, I heartily endorse medical insurance for the whole family. It's worth doing without other things because the specter of medical bills isn't pleasant, but Blue Cross or any of the others keep the fear and dread of illness away. Fortunately, practically everyone I've talked to feels the same way. The question is—is your lobby more powerful than the pro-Wagner lobby? I'm afraid that's the only thing that counts."

Conference

"Just a small note to tell you I enjoyed your mid-year conference very much. It was the best auxiliary meeting I ever attended—well planned, stimulating, thought-provoking."

"May I congratulate you on the excellent meeting in Harrisburg. I was surprised at the large attendance and at the intense interest everyone present showed. I want to thank you for the privilege of appearing on the program."
—G. C. E.

Pamphlet

"I have read the Pennsylvania pamphlet 'Your Family's Future Health' and I like it very much. I am sure a broad distribution of this will help. May I express my appreciation for the yeoman work you and the women are doing this year in Pennsylvania."—F. F. B.

President's Guide

"So far the only redeeming feature of my administration is being told that my questions were in some way responsible for the 'President's Guide.' At least I have that to pass on to my successor."

Auxiliary News

"The *Auxiliary News* is excellent as usual. I did not expect credit, but you know how we love seeing our names in print."

Scrapbook

"Am sending the picture from the paper and hope it finds a place in your scrapbook, with memories of the county whose little bridges look like dead-end roads." . . . Actually they had a wonderful year.

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"If any kindness I have done pleases you, pass it on to someone else. That is far better than to try to repay me in kind. To know that my deed has spread beyond the recipient is the best thanks. 'Pass it on' is the best motto."

(MRS. PAUL C.) CATHARINE PALMER CRAIG,
President.

COUNTY NEWS

During April and May your editor received news from fifteen counties. Four activities occurred in many auxiliaries: a report of the Mid-winter Conference held in Harrisburg in March was given; officers were elected and installed; a resolution opposing compulsory medical legislation and recommending voluntary prepayment health insurance was passed and copies sent to Congressmen and the state office; the personal contact committees are getting organized.

At this time of year, budgets are "balanced" and many contributions are made. The medical benevolence fund shared in these as follows: CLINTON, \$75; DELAWARE, \$150; FAYETTE, \$500, which was made on the Medical Ball held in October, and \$25 in memory of Mrs. Paul Staman; INDIANA, \$110 and \$15 in memory of Dr. Joseph C. Lee; LEHIGH, \$518.30; NORTHAMPTON, \$350; and SCHUYLKILL, \$100.55. Other contributions included: CLINTON, \$10 to the Cancer Society drive; DELAWARE, \$25 to Camp Sunshine, the county camp for underprivileged children; and PHILADELPHIA, \$500 to the Philadelphia Aid Association, bringing their total contribution for the year to \$1,500, and a \$300 nursing scholarship. MIFFLIN purchased new draperies for the doctors' lounge at the Lewistown Hospital. ERIE is taking over a section of the city in the house-to-house canvas for the Cancer Society drive.

DELAWARE admitted eleven new members in March. MIFFLIN welcomed Mrs. Harry A. Cramer and Mrs. Andrew B. Steele. Mrs. Harry Bowman, Bethlehem, joined NORTHAMPTON.

Programs at auxiliary meetings varied throughout the State:

BUTLER—Animal experimentation was discussed; Mrs. Frederic B. Davies' questionnaire on Blue Cross and Blue Shield was read and discussed; Miss Doris Breth, R.N., state health nurse, gave a report on the various health clinics in Butler County.

CLINTON—George S. Klump, M.D., Williamsport, talked on Blue Cross, Blue Shield, and socialized medicine at a joint meeting with the medical society; present legislation was discussed and pamphlets distributed at a later meeting.



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DAUPHIN—A résumé of current legislation was given by Mrs. W. Paul Dailey; Miss Anna VanKirk, directress of nurses, Harrisburg Hospital, and Mrs. Dorothy Bollinger, directress of nurses, Polyclinic Hospital, spoke on "Present-Day Trends in Nursing." The newly formed CUMBERLAND group were guests.

DELAWARE—A talk entitled "Between the Lines in Germany" was given by Mrs. Herbert F. Fraser; Mr. James L. Verity, director of Fronefield Hall and chief probation officer of the county, spoke on the work of the Delaware County Juvenile Court with respect to juvenile delinquency; Mrs. William J. Heydrick gave an interesting talk on "Women Are People, Too!"

ERIE—A style show highlighted the April meeting, with members of the auxiliary as models.

FAYETTE—Mrs. Jacobs talked on "Brotherhood"; Miss Mabel Bowmaster, executive secretary of the Tuberculosis League, was a speaker; Mrs. Paul C. Craig, state president, visited in May.

LEHIGH—Past presidents were introduced and Mrs. Donald W. Haff gave a reading in memory of past presidents who have died; Mrs. Harry H. Reichard delved into the history of old quilts, at which time auxiliary members displayed many quilts which had been in their families; Howard K. Petry, M.D., Harrisburg, discussed the problem of the mentally ill at a joint meeting with the Allentown branch, American Association of University Women; a one-act play, "Joint Owners in Spain," was presented by a group from the Allentown Woman's Club.

MERCER—Mrs. Norman K. Beals, state program chairman, addressed the group on "The Free Man vs. the Puppet Man" and on the auxiliary program.

MIFFLIN—Mrs. Paul C. Craig, state president, and Mrs. Ralston O. Gettemy, Sixth District councilor, visited the auxiliary.

NORTHAMPTON — Francis J. Conahan, M.D., chairman of the advisory committee, spoke on public relations, and Paul E. Schwarz, M.D., president of the medical society, spoke briefly, at which time Mrs. Edgar S. Buyers, Norristown, was a guest; Mrs. Wood Moore, Easton, reviewed "The Big Fisherman."

PHILADELPHIA—Mrs. William Mabon, president of the Philadelphia Federation of Women's Clubs, and Mrs. Wellington D. Griesemer, Reading, past state president, were speakers.

SCHUYLKILL—Mr. James C. Kirk, superintendent of Pottsville Hospital, took the group on a tour of the hospital.

WARREN—Mrs. Alfred A. Grant gave an illustrated talk on "Sex Education in the Schools," which was followed by dinner and a movie on "Sex Education."



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Three counties reported public health programs. INDIANA had Elmer Hess, M.D., Erie, speak on "Government Medicine," April 21, in the afternoon to the high school students and faculty, and in the evening at a public meeting in the college auditorium. These meetings were sponsored jointly with the medical society. In addition to newspaper and radio publicity, letters of invitation were sent to county groups, posters were displayed, and pamphlets of invitation distributed by the doctors and drug stores.

The speakers for MERCER'S health day program, April 26, in the Sharon High School auditorium, were Elmer Hess, M.D., on "Socialized Medicine," and Mary Baker Davis, M.D., on "Cancer." James W. Emory, M.D., president of the medical society, presided at the meeting.

PHILADELPHIA'S annual health institute, April 12, included the following: "The Family and Public Health," Rufus S. Reeves, M.D.; "The Fife-Hamil Memorial Health Center," Wm. Harvey Perkins, M.D.; "Experiences with the Rooming-in Project of Baby with Mother," Thaddeus L. Montgomery, M.D.; a panel discussion on the "Problem Child"; and the motion pictures, "Human Growth" and "Human Reproduction."

FAYETTE was hostess to the wives of former interns who were present for Uniontown Hospital Day. PHILADELPHIA entertained the wives accompanying physicians to the thirteenth annual Postgraduate Institute.

LEHIGH sent 4200 petitions to their Congressmen against socialized medicine and approximately 500 signatures favoring the animal experimentation bill.

Mrs. Charles E. Peach, SCHUYLKILL, visited three of the county legislators in behalf of the animal experimentation bill. She also ordered 100 copies of the socialized medicine pamphlets put out by Representatives Frederick C. Smith and Roy O. Woodruff and followed their plan of sending copies to ten friends and asking them to do likewise.

SCHUYLKILL BRANCH displayed the school health posters from the contest at the tri-county luncheon of NORTHUMBERLAND, COLUMBIA-MONTGOMERY, and SCHUYLKILL.

The public health project for the coming year for FAYETTE will be the sale of plastic piggy banks, called "Pete the Pig," for the benefit of the American Mission to Lepers. Thirty-eight banks were sold at the May luncheon.

LEHIGH received two silver tea services from the past presidents in memory of departed members. These were used for the first time at the May meeting.

A SIGNIFICANT STUDY

The Brookings Institution has made available recently a study on compulsory health insurance that should be read and studied by personnel of health professions and consumers alike.

The Brookings Institution was incorporated in 1927 and according to its own statement has two primary purposes: (1) To aid in the development of sound national policies; and (2) to offer training to students in the social sciences. The function of the trustees is to

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make possible scientific research under favorable conditions and safeguard the research staff in the pursuit and publication of the studies. It approves the field of investigation and satisfies itself as to the competence and integrity of the staff.

The study on compulsory health insurance was undertaken at the invitation of Senator H. Alexander Smith, chairman of the subcommittee on health of the Senate Committee on Labor and Public Welfare. Dr. Lewis Meriam, one of the investigators, has worked in the Census and Children's Bureaus; he was director of the Institution's survey of Indian Administration, including health, and is author of a treatise on relief and social security. Dr. George W. Bachman was formerly on the faculties of Chicago, Johns Hopkins, and Columbia Universities. While at Columbia he organized and directed the School of Tropical Medicine in Puerto Rico. He was representative of the American Bureau of Medical Aid to China during the recent war.

The study of compulsory health insurance is divided into two parts. Part one deals with (1) the issues, (2) the analysis of evidence, including international, interstate, age, and racial comparisons, selective service statistics, etc., and (3) draws up conclusions and recommendations. Part two is a detailed study of the evidence.

It is impossible to review this book satisfactorily, as every page has vitally interesting data. The table on consumer expenditures, for instance, indicates that expenditures for recreation and tobacco combined exceed expenditures for medical care for practically all income classes except the one under \$500. One conclusion reached in regard to costs is that most consumer units have the capacity to pay if medical care were given a high priority or a preference over other expenditures such as automobiles, alcoholic beverages, tobacco, recreation, and savings.

Extensive analysis is made of costs of compulsory health insurance, lack of personnel, type of services given, etc. The conclusions reached in part are as follows:

Probably no great nation in the world has among its white population better health than prevails in the United States.

Under a voluntary system of medical care the United States has made greater progress in the application of medical and sanitary science than any other country.

Non-whites have poorer health than whites, but this is not due to inadequacy of medical care.

Advances in health, white or non-white, do not suggest basic defects in the American system.

Selective service statistics are unreliable as a measure of the health of a nation.

Medical care in the United States compares favorably with that which existed in other leading nations prior to the second world war.

Poor rural areas need several approaches to improve general conditions. Care of incompetent people in various categories cannot be effectively covered by compulsory insurance because they lack the means to maintain an insured status.

Compulsory health insurance would necessitate high degrees of government regulation. Politics would be eliminated with extreme difficulty. Government would be injected into relationship between patient and physician and hence quality of care. The costs of medical care would increase. At present there are not enough facilities to administer it.

The recommendations include:

1. National government should leave compulsory health insurance to the experimentation of states.

2. For the time being the national government and many state governments may well devote their revenues and energies to:

- a. Research and developments in the fields of public health.
- b. Health education at the school level.
- c. Teaching of preventive medicine.
- d. Assisting in the acquisition of physical facilities and training of personnel.
- e. Providing systematic care for the indigent and medically indigent.

The study may be obtained from the National Publishing Co., Washington, D. C., under the title "The Issue of Compulsory Health Insurance" by George W. Bachman and Lewis Meriam.—*Journal of the American Medical Women's Association.*



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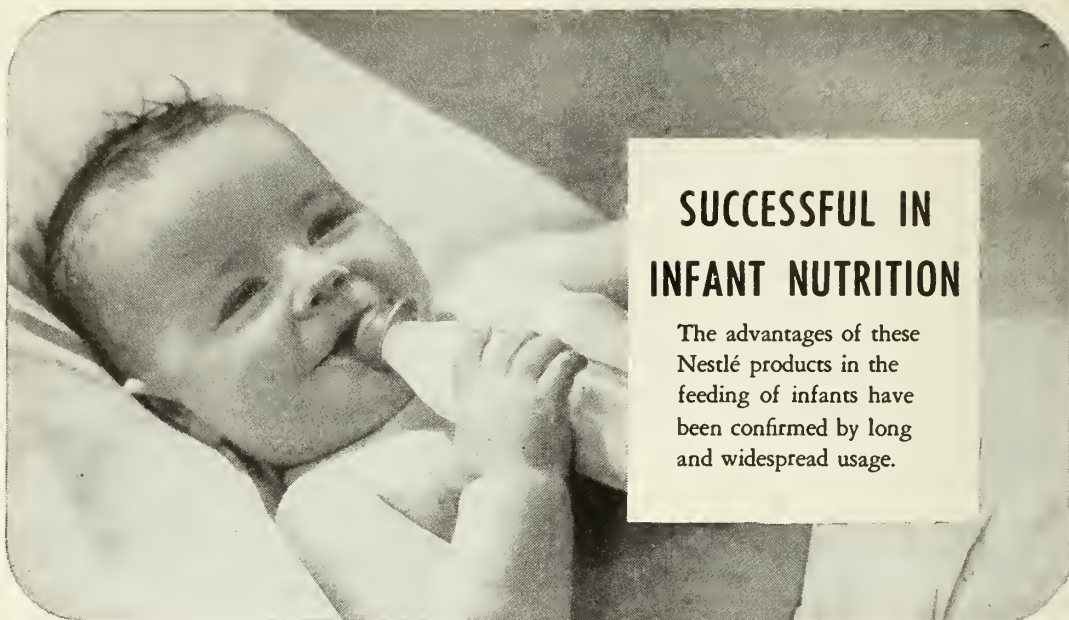
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MEDICAL NEWS

Engagements

MISS ANNA ELISABETH WHITACRE to Mr. Harold Sender, son of Dr. and Mrs. Arthur C. Sender, all of Lanerch.

MISS DOROTHY DRAKE LANGDON, daughter of Dr. and Mrs. Roy L. Langdon, to Mr. Ralph L. Sitley, all of Philadelphia.

MISS GRACE EVA FRIEDMAN, daughter of Dr. and Mrs. Reuben Friedman, of Philadelphia, to Mr. Harold G. Ross, of Brookline, Mass.

Marriages

MISS MARY KALISH, of Bridgeton, N. J., to Jacob L. Gluchoff, M.D., of Bloomsburg, June 26.

MRS. CHARLES WARREN KLUBER, of Gladwyne, to Francis R. Manlove, M.D., of Alden Park, June 14.

MISS CARLYN ANN LAGERMAN, of Bryn Mawr, to Mr. Chevalier J. Tucker, son of Dr. and Mrs. Gabriel F. Tucker, of Cynwyd, June 11.

MISS SHEILA HOPKINS, of Wynnewood, to Thomas M. McMillan, 3d, M.D., son of Dr. and Mrs. Thomas M. McMillan, of Philadelphia, June 18.

MISS ALICE MARGARET PHAIR, of Allendale, N. J., to Mr. Richard Ware Walkling, son of Dr. and Mrs. Adolph A. Walkling, of Cynwyd, June 11.

MISS HENRIETTA STARR MALLOY, of Philadelphia, to Mr. Eugene Adam Jaeger, son of Dr. and Mrs. J. Rudolph Jaeger, of Wynnewood, June 4.

MISS JANE WALKER WILLIAMS, of Wyncote, to William Kerst Runyeon, M.D., son of Dr. and Mrs. Frank G. Runyeon, of Reading, June 30.

MISS NANCY HILLES DEWEES, daughter of Dr. and Mrs. Lovett Dewees, of Glen Mills, to Mr. William Shoemaker Flash, of Chatham, Mass., June 11.

MISS PENNY ELAINE RECHTMAN, daughter of Dr. and Mrs. Abraham M. Rechtmann, of Elkins Park, to Dr. M. William Yarrow, of Wilmington, Del., June 8.

MISS SARAH BEAMAN, of Plymouth, Mass., to Mr. William James Walker, 3d, son of Dr. and Mrs. William J. Walker, of Philadelphia, June 18.

MISS ROSEANNE ELEANOR KLAPPER, of Narberth, to Mr. Thomas Mitchell Campbell, son of Dr. and Mrs. Edward H. Campbell, of Wynnewood, June 9.

MISS PAMELA COTTIER, of Greenwich, Conn., to Mr. Charles Budd Forcey, Jr., son of Dr. and Mrs. Charles B. Forcey, of Sewickley, June 19.

MISS NINA BLUMENTHAL, of New York City, to William N. Winkelman, Jr., M.D., son of Dr. and Mrs. Nathaniel W. Winkelman, of Philadelphia, June 5.

MISS NANCY THOMAS DUNNING, of Baltimore, Md., to Mr. John Harold Harris, Jr., son of Dr. and Mrs. John H. Harris, of Harrisburg, June 18.

MISS HENRIETTA UNDERWOOD LIZARS, of Bryn Mawr, to Mr. Jacob Hursh Vastine, 3d, son of Dr. and Mrs. Jacob H. Vastine, 2d, of Wynnewood, June 15.

MISS MARY KATHERINE MILLER, daughter of Dr. and Mrs. Richard J. Miller, to Mr. Charles Buffington Fager, IV, son of Dr. and Mrs. Charles B. Fager, III, all of Harrisburg, June 11.

MISS PATRICIA FINN LEWIS, daughter of Rubin M. Lewis, M.D., and the late Mrs. Lewis, to Robert Jaffe,

M.D., son of Dr. and Mrs. Samuel Jaffe, all of Philadelphia, May 25, in Paris.

MISS PATRICIA ANNE TAGGART, daughter of Mrs. Isabelle Rettew Taggart, of Lansdowne, and Harold A. Taggart, M.D., of Drexel Hill, to Mr. Roger Alan Burt, of Hinsdale, Ill., June 25.

MISS BIANCA DEITZ, daughter of Dr. and Mrs. George W. Deitz, Jr., of Philadelphia, to Dr. William Whitlock Mattson, Jr., son of Dr. and Mrs. William W. Mattson, of Tacoma, Wash., May 28.

Deaths

○ *Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.*

○ **Ralph Pemberton**, Philadelphia; University of Pennsylvania School of Medicine, 1903; aged 72; died June 17, 1949, at his home. In 1931 he became a full professor of medicine in the Graduate School of Medicine of the University of Pennsylvania, and was consultant to Abington Memorial, Chester County, and Bryn Mawr Hospitals. He was a national consultant in rheumatism and arthritis under the program of War-time Graduate Medicine meetings. He was an honorary Fellow of the Royal Society of Medicine in London. In 1939 the Commonwealth of Pennsylvania presented him with a meritorious service medal. In 1946 the American Congress of Physical Medicine presented him with its gold key award. During World War I, he served as a major in the U. S. Army Medical Corps. His widow survives.

○ **Elizabeth F. C. Clark**, Atlantic City, N. J., formerly of Philadelphia; Woman's Medical College of Pennsylvania, 1909; aged 70; died June 28, 1949. Dr. Clark was a direct descendant of Thomas Holme, the architect who laid out the plans for the City of Philadelphia. She traced her ancestry to Count Falaise, who accompanied William the Conqueror in the invasion of England in 1066. Retiring in 1938 because of illness, Dr. Clark was formerly chief gynecologist at the Woman's Hospital. She was chief of the gynecologic clinic at Notre Dame de Malades in Philadelphia and a founder of the National Society of The Little House of St. Pantaleon for Foreign Relief in France and Great Britain.

○ **Lloyd W. Johnson**, Pittsburgh; University of Pennsylvania School of Medicine, 1913; aged 62; died June 6, 1949, of a heart attack at Allegheny General Hospital where he had been a member of the staff since 1913. An orthopedic surgeon, Dr. Johnson was chairman of the Regional Fracture Committee of the American College of Surgeons for the past five years. During World War I, he was in the American Expeditionary Forces. He is survived by his widow, two sisters, and two brothers.

○ **Homer J. Rhode**, Reading; University of Pennsylvania School of Medicine, 1901; aged 71; died June 3, 1949, at his winter home in Coral Gables, Fla. A widely known ophthalmologist, Dr. Rhode was chief at Reading Hospital from 1913 to 1927 and consultant there as well as at St. Joseph's Hospital, Reading. He was a member of the American Academy of Ophthalmology and Otolaryngology and a Fellow of the American College of Surgeons. He is survived by two sons and two daughters.

○ **Charles J. Cole**, Elkins Park; University of Pennsylvania School of Medicine, 1914; aged 62; died

June 22, 1949. Dr. Cole was a member of the staff of Abington Hospital, and was a Fellow of the American Academy of Pediatrics. During World War I, he commanded a field hospital in France and was discharged from the service with the rank of major. His widow survives.

○ **Herman H. Levin**, Lancaster; aged 36; died May 4, 1949, of coronary thrombosis a few hours after he became ill. A native of New Castle, Dr. Levin was consultant on anesthetics at the Lancaster General Hospital and to the Veterans Administration hospitals at Coatesville and Lebanon. His widow and six brothers and sisters survive.

○ **Granville H. Walker**, Bellevue; Jefferson Medical College of Philadelphia, 1902; aged 73; died June 27, 1949. Dr. Walker was on the staff of the Suburban General Hospital, Bellevue, and was president of the Bellevue Board of Health. He was a veteran of World War I. Surviving are his widow, a daughter, a stepson, and a sister.

Blanche Harpst Jackson, Duquesne; aged 74; died June 27, 1949. One of the first women physicians in the Pittsburgh area, Dr. Jackson specialized in gynecology in later years. She retired twelve years ago. Two sisters survive.

Percy H. Corson, Plymouth Meeting; University of Pennsylvania School of Medicine, 1894; aged 88; died June 27, 1949. He had practiced for forty-seven years before his retirement. A son and two daughters survive.

○ **Anne H. Thomas**, Colorado Springs, Colo., formerly of Philadelphia; Woman's Medical College of Pennsylvania, 1905; aged 77; died May 21, 1949. She was a Fellow of the American College of Physicians.

○ **Charles F. Smith**, Topton; University of Pennsylvania School of Medicine, 1911; aged 61; died June 4, 1949, following a long illness. He is survived by his widow, three children, and a sister.

○ **Robert B. Greer**, Butler; University of Pennsylvania School of Medicine, 1899; aged 74; died June 17, 1949, after a prolonged illness. He was a Fellow of the American College of Surgeons.

○ **Percival M. Kerr**, Wilkes-Barre; Temple University School of Medicine, 1906; aged 64; died April 11, 1949. Dr. Kerr specialized in eye, ear, nose and throat diseases.

○ **Alfred S. Sigmann**, Pittsburgh; Medizinische Fakultät der Universität, Austria, 1897; aged 81; died May 7, 1949. He was a specialist in eye, ear, nose and throat diseases.

○ **George W. Sharshon**, Phoenixville; Hahnemann Medical College and Hospital of Philadelphia, 1925; aged 50; died April 9, 1949.

○ **Frederick E. Abbott**, Erie; Hahnemann Medical College and Hospital of Philadelphia, 1921; aged 55; died May 8, 1949.

○ **Warren W. Preston**, Montrose; Hahnemann Medical College and Hospital of Philadelphia, 1907; aged 70; died May 8, 1949.

○ **Isaac N. Lear**, Vandergrift; University of Pittsburgh School of Medicine, 1896; aged 82; died March 18, 1949.

○ **Robert J. Heffley**, Berlin; Medico-Chirurgical College of Philadelphia, 1898; aged 78; died May 9, 1949.

○ **Caroline J. Gilliland**, Sharon; Woman's Medical College of Pennsylvania, 1906; aged 83; died recently.

Miscellaneous

DEAN CHARLES L. BROWN, of Hahnemann Medical College, Philadelphia, has announced the retirement of Drs. William A. Pearson, G. Harlan Wells, and Thomas W. Phillips from the faculty.

ON JUNE 7 WILLIAM N. PARKINSON, M.D., dean of Temple University School of Medicine, was awarded the honorary degree of Doctor of Science by the Pennsylvania Military College.

ON MAY 10 THE WOMAN'S AUXILIARY TO THE LEHIGH COUNTY MEDICAL SOCIETY adopted resolutions "against compulsory health insurance—endorsing and urging the expansion of Blue Cross and Blue Shield plans in Pennsylvania."

THE HONORABLE LEROY E. CHAPMAN, M.D., of Warren, who is an active member of the State Society's Commission on Cancer, was the recipient on June 24 of the honorary degree of Doctor of Laws bestowed by Hahnemann Medical College, Philadelphia.

TEMPLE UNIVERSITY, Philadelphia, has announced three postgraduate courses in laryngology and bronchoesophagology to be given by Drs. Chevalier Jackson and Chevalier L. Jackson September 12 to 23, October 24 to November 4, and December 5 to 16.

DR. THEODORE L. CHASE, of Reno, Nevada, who contributed one million dollars to establish the Agnes Barr Chase Surgical Research Foundation in memory of his wife, has made an additional gift of \$400,000 toward the new building to be erected at the Temple University Medical Center.

LANKENAU HOSPITAL, Philadelphia, will receive a million dollars from the estate of Joshua R. Morgan, banker and attorney of Philadelphia who died March 20, according to an inventory of his estate. It is to be put in trust for free beds and free medical care in memory of himself, his parents, brothers, and sister.

COMMENCEMENT OF THE WOMAN'S MEDICAL COLLEGE OF PENNSYLVANIA was held on June 16. Thirty women received the degree of Doctor of Medicine. Helen B. Taussig, M.D., associate professor of pediatrics at the Johns Hopkins University School of Medicine, gave the address on "Problems of Today and Tomorrow Confronting Young Doctors."

KATHARINE R. BOUCOT, M.D., president of the Alumnae Association of Woman's Medical College, awarded citation medals to eight fifty-year graduates. Those present to receive the medals in person were Drs. Ella Williams Grim and Jeanette H. Sherman of Philadelphia, Dr. Caroline S. Marshall of Pittsburgh, and Dr. Lillie Rosa Minoka-Hill, Oneida, Wis.

THE NINETY-THIRD MEETING OF THE READING EYE, EAR, NOSE AND THROAT SOCIETY was held jointly with the Reading Dental Society on May 18. S. Gordon Castigliano, M.D., of Philadelphia, spoke on "The Oral Cavity—the Physician and the Dentist," and Benjamin F. Souders, M.D., of Reading, discussed "Ocular Manifestations of Tropical Diseases and Their Treatment."

THE VETERANS ADMINISTRATION has announced plans to have available some time in August at every post office, veterans' service organization, and VA office a special application form for the two billion eight hundred million dollar special National Service Life Insurance dividend. Veterans who took out NSLI and kept it in force for three months or more are eligible for the dividend.



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THE HOBBY OF C. IRVIN STITELER, M.D., of Chester, long-time editor of the *Bulletin* of the Delaware County Medical Society, has taken him far afield. With his daughter and son-in-law he spent some time in New Mexico this summer photographing many wild flowers new to him to add to his collection of more than 3000 colored slides. Dr. Stiteler has shown his wild flower photographs to many botanical societies and other groups.

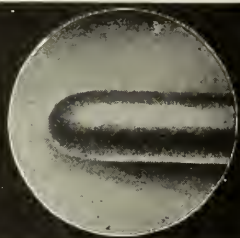
COMMENCEMENT EXERCISES FOR TEMPLE UNIVERSITY SCHOOL OF MEDICINE were held at Convention Hall, Philadelphia, June 16. In the medical class there were 84 men and 14 women. Miss Lyndall Molthan received the Faculty and the Alumni Gold Medals, as her grades placed her first for the entire four years. Twenty-six physicians completed three-year postgraduate courses and received the degree of Master of Science in the specialty studied.

RECENT FACULTY PROMOTIONS AT WOMAN'S MEDICAL COLLEGE, Philadelphia, include Dr. Marjory K. Hardy, clinical associate professor in dermatology and syphilology; Dr. Mildred Pfeiffer, director of the Department of Oncology; Dr. Jean Crump, professor of pediatrics in charge of allergy; Dr. William H. Erb, associate professor of surgery; Dr. Lloyd W. Stevens, assistant professor of surgery; Dr. William A. Weiss, associate professor of anesthesiology.

AT THE ANNUAL MEETING OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS held in Atlantic City, June 2 to 5, Dr. Chevalier L. Jackson, Philadelphia, was elected second vice-president, and Dr. Burgess Gordon, Philadelphia, was elected governor of the College for Pennsylvania. Drs. Reuben J. Cohen and Katharine R. Boucot of Philadelphia, Kenneth I. Fetterhoff and

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James W. Macdonald of Pittsburgh, Matthew R. Hadley of McKeesport, and J. Ivan Hersey of Bryn Mawr, received fellowship certificates at the session.

CLARENCE E. NORTHCUTT, M.D., past president of the Oklahoma State Medical Association, and one time mayor of Ponca City in that state, was elected president of the Conference of Presidents and Other Officers of State Medical Associations at the fifth annual session of that group held during the AMA meeting in Atlantic City. Dr. Julian Price, of Florence, S. C., secretary of the medical society in that state, was named president-elect, and John E. Farrell, of Providence, R. I., executive secretary of the Rhode Island Medical Society, was re-elected secretary-treasurer.

MARY RIGGS NOBLE, M.D., of Bowmansdale, was presented with the Dr. Elizabeth Blackwell centennial award by the American Medical Women's Association at a dinner meeting of the organization in Atlantic City, N. J., June 4. Dr. Noble, former chairman and still a member of the Citizens Advisory Committee of the Tri-County Child Guidance Center in Harrisburg, was cited by the association for "contributing most in terms of service, aiding growth and progress of AMWA over a period of years." She was chief of the Child Health Division of the Pennsylvania Department of Health from 1920 to 1936.

THE CHICAGO MEDICAL SOCIETY is offering two post-graduate courses in October, 1949, each of one-week duration, which will be open to all physicians who are members of their local medical societies. A course in cardiorenal and peripheral vascular diseases will be given October 17 to 22, and a course in obstetrics, endocrine-gynecology, and sterility will be offered the following week, October 24 to 29. Those interested in attending may secure additional information by writing Willard O. Thompson, M.D., Chairman, Committee on Postgraduate Medical Education, Chicago Medical Society, 30 N. Michigan Ave., Chicago 2, Ill.

GROSVENOR B. PEARSON, M.D., director of the Western State Psychiatric Institute and Clinic, Pittsburgh, announces that the Sarah Mellon Scaife Foundation of Pittsburgh has made a substantial grant to the Institute and specifically to Lewis E. Etter, M.D., roentgenologist, for the completion and publication of Dr. Etter's research on the roentgen-anatomic studies of the skull and individual skull bones. It is expected that Dr. Etter's findings will be of great advantage to roentgenologists, anatomists, neurologists, neurosurgeons, and psychiatrists in teaching and clinical practice. Dr. Etter's exhibit has recently been shown at roentgenologic and anatomic meetings in Erie and Philadelphia, Buffalo, N. Y., Chicago, Ill., and San Francisco, Calif., and at the recent meeting of the American Psychiatric Association in Montreal, Canada. The Institute has been carrying on this work over recent months, and the Sarah Mellon Scaife Foundation's grant-in-aid will materially increase the progress of the work.

MEDICAL AND DENTAL OFFICERS WILL BE GIVEN PRIORITY of consideration in assignment of quarters, and their families will be allowed to accompany them on overseas tours of foreign duty.

This policy takes cognizance of the fact that Army medical and dental officers, as a result of the present shortage of service medical and dental personnel, are required to be on duty more hours per day, in many cases, than is normal, as well as to perform more than normally arduous duties.

It was also announced that the Surgeon General will be placed directly under the Chief of Staff. This re-emphasizes and facilitates his direct access to the Secretary of the Army and to the Chief of Staff in order that these officials may be kept constantly informed on

the critical medical situation. General Omar N. Bradley, Chief of Staff, said this same organizational pattern is being implemented throughout the Army so that all medical officers will have direct access to their respective commanders.

Orders allowing families of medical and dental personnel to travel with them have been issued to the field.

The policy is the latest step in a continuing campaign designed to relieve the critical shortage of medical and dental officers in the Army by making their careers and living conditions more attractive. Previous action in this direction includes: provision for an extra \$100 per month in pay for medical and dental officers, giving them every opportunity to pursue their specialties, assigning ranks on the basis of civilian accomplishment, and emphasizing stability of their assignments by making only an essential minimum number of transfers of these officers.

These policies were announced by General Bradley with the concurrence of Gordon Gray, Acting Secretary of the Army.

"The dead hand of bureaucracy can destroy the wholesome flexibility of the voluntary hospitals which usually are controlled by a lay board familiar with local conditions and directed by a medical board of competent physicians and surgeons. The proof of the adequacy of our hospitals is that we have the largest plant in relationship to population and the best hospitals in all the world."—GEORGE E. SOKOLSKY in *The Columbus Dispatch*.



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LOOKY, OSCAR!

Oscar (it-won't-cost-you-a-dime) Ewing took it right on the button in Hollywood, Fla., April 28, when the annual convention of the General Federation of Women's Clubs, by a vote of 2000 to 3, adopted a resolution opposed to socialized medicine.

This is especially significant when it is realized that the Federation represents 5,000,000 women members of 16,500 clubs. The resolution was passed despite the fact that government-paid representatives of Oscar's Federal Security Agency swarmed all over the convention doing their best to swing the tide their way. But it was no go. The convention realized, as the adopted resolution stated, that the Greensburgian's fable would "jeopardize free enterprise, establish heavy new tax burdens and unprecedented national deficits, and infringe upon the powers of the individual states."—*Indianapolis Medical Society Bulletin*.

CLASSIFIED ADVERTISEMENTS

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For Rent.—Offices of retiring general practitioner. Location established for 35 years. Write CHARLES A. FITZGERALD, M.D., Clarion, Pa.

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For Sale.—Home, office, drugs and equipment in growing town of 1500 with ten surrounding towns within eight miles. Hospital within seven miles. Write Dept. 163, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Physician to work month of August while doctor is away. Small town in western Pennsylvania. Good salary. Write Dept. 167, PENNSYLVANIA MEDICAL JOURNAL.

Wanted.—Opportunity open in large Philadelphia hospital for resident in approved department of anesthesiology. Address MEDICAL DIRECTOR, Jewish Hospital, York and Tabor Roads, Philadelphia 41, Pa.

For Rent.—Equipped office of general practitioner in town six miles from Pottsville. Owner died two years ago after practicing in community for forty years. Excellent opportunity for young man. Write Dept. 164, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—Doctor's office. Dwelling, garage, best-equipped corner in northeast. Suitable for conversion into apartments. Seen by appointment only. Practiced 40 years. Telephone, Philadelphia, Nebraska 4-2226. Write to 3050 Frankford Ave., Philadelphia, Pa.

Wanted.—House physician with Pennsylvania license for 185-bed general hospital 18 miles from Pittsburgh. Adequate salary. New Hospital addition planned. Good location for later private practice. Apply to DIRECTOR, Citizens General Hospital, New Kensington, Pa.

For Rent.—Office rooms in desirable location. Office furniture for sale at reasonable price. Growing population of 23,000 in vicinity. Great need for general practitioner. Hospital facilities near. Vacancy left by death of doctor who had been established for 30 years. Write P. O. Box 387, Carmichaels, Greene County, Pa.

Wanted.—General practitioner to locate in Marion Center, Indiana County. Good farming and coal mining section on Buffalo to Pittsburgh highway. Fine schools and churches. Two hospitals within 15 miles. For further details write Mr. CHARLES P. NIGHTINGALE, Marion Center Lions Club, Marion Center, Pa.

For Sale.—Home and office combination, located at Tower City, Schuylkill County. Immediate possession. Ten-room brick home, tile bath, modern kitchen, one-car garage, Stoker heat, two-room office suite, including drugs and equipment. Terms open, 4½ per cent mortgage on the balance. Price \$17,000. For further information write P. R. EVANS, M.D., Masonic Homes, Elizabethtown, Pa. Telephone 78.

Physicians' Printed Supplies.—Medico* sanitary dispensing envelopes (*Reg. U. S. Pat. Office); gummed flap dispensing envelopes; gummed bottle labels; prescription blanks; time-saver statements and window envelopes; professional cards; record cards; plateless engraved letterheads and envelopes on Hammermill Cockletone bond paper. A complete service for physicians. Established 1938. Prices and samples sent on request. Write: THE MEDICO PRESS, Millerstown, Pa.

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BLUE SHIELD MEMBERSHIP IN STATE PASSES 400,000

As of April 30 the number of Blue Shield subscribers in MSAP was 416,838, an increase of 126.1 per cent over the corresponding date last year. One year ago on April 30 MSAP's enrollment was 184,380.

The number of physicians' services paid during the first four months of this year showed an increase of 183.2 per cent over the same period in 1948. This year from January 1 to April 30 the number was 12,703 as compared to 4486 during the same four months in 1948.

The cost of physicians' services incurred by MSAP for the first four months of this year totaled \$768,852, an increase of 148.6 per cent over the January 1 to April 30 period a year ago.

Annual subscription fees in force, as of April 30, amounted to \$3,947,094 as compared to \$1,612,531 on the same date in 1948—an increase of \$2,334,562, or 144.8 per cent.

REPORTS OF MEDICAL EXAMINATIONS FOR VETERANS ADMINISTRATION RATING AGENCIES

The National Rehabilitation Commission of the American Legion wishes to call to the attention of the medical profession that many veterans who are attempting to get disability claims adjudicated before Veterans Administration rating agencies are experiencing delays and handicaps in accomplishment of final rating because of physicians' reports and statements which are unsatisfactory or not acceptable to the Veterans Administration for one reason or another. The purpose of this statement is to clarify what the Veterans Administration desires of physicians' reports to adjudicate claims properly. The Veterans Administration regulations require that the physician's statement be notarized only in initial establishment of service connection for a specific disease or condition. While this requirement is considered a waste of time by most physicians, it is a Veterans Administration requirement in establishing initial service connection. However, most doctors will be examining and working on reports for veterans who have already had service connection established, and are conducting the examination to determine whether the condition has improved, regressed, or remained stationary. In such cases the statement on the physician's letterhead is sufficient. Notarization is not required in these cases.

Since claims may be made months, or, in some cases, years after the physician has examined or treated the veteran for a given condition, the doctor should state in the body of his report whether the information is from his office or clinic records, or from memory. Since Veterans Administration adjudication personnel have physicians among their number, or they can obtain the advice of Veterans Administration doctors, the reports should be in professional language with no attempt to simplify the terminology for lay interpretation. Interpretation of the validity of the doctor's data in relation to the veteran's claim will be made by medical per-

sonnel. Therefore, the reports should be as complete and detailed as possible.

In the report, the date of first treatment and the length of time the veteran has been observed by the doctor should be included. Details of the pertinent history and physical examination are essential. The detailed medical findings, both physical and laboratory, should be included. For instance, degree of extension or flexion of an ankle may be very important in determining adjudication results. Such detailed medical findings should be listed by the reporting physician. When this is done, the final diagnosis made by the doctor can be interpreted in the light of the data that led to the making of the diagnosis. It is not sufficient merely to state that the veteran was treated for a given condition, without giving some of the pertinent facts relative to the condition in the particular veteran. If laboratory tests or roentgenologic or other special examinations are done, reports of these should be included, if such reports are available. Some of these data may be valuable to aid the Veterans Administration in establishing the merit of a veteran's claim.

In summary, the medical report for the veteran for adjudication purposes should be complete and as detailed as possible. History, physical examination, laboratory and special examinations, with dates of period of observation and performance of examinations, are desired. Only with such complete reports can justice to the claim of the veteran be done by the Veterans Administration adjudication agencies.

WHAT IS A PREMATURE BABY?

The new international code of deaths has been enlarged to include morbidity as well as mortality items. In this code the premature (immature) infant is any baby with a birth weight of 5 pounds 8 ounces (5½ pounds, i.e., 2500 Gm.) or less.



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The above studies should be supplemented, when possible, with courses in mathematics, qualitative analysis, physical chemistry, foreign languages (Spanish, French, or German), and sociology.

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BOOK REVIEWS

PEDIATRIC NURSING. By GLADYS S. BENZ, R.N., B.S., M.A., Associate Director, Union University School of Nursing, Albany, N. Y.; formerly, Head Nurse, University Hospital, Minneapolis; Head Nurse, Sarah Morris Hospital (Children's Division of Michael Reese Hospital), Supervisor and Assistant Superintendent of Nurses, St. Louis Children's Hospital; Nurse, Institute of Child Welfare, University of Minnesota; Instructor in Nursing Education, Summer School, University of North Carolina. With 119 illustrations. St. Louis: The C. V. Mosby Company, 1948. Price, \$4.00.

This book is well written and easily read. The subjects discussed are well covered, and all phases of pediatric nursing are included. If used as a textbook for student nurses, the reviewer makes the following comments:

1. More details on nursing procedures should be given.
2. This book alone cannot be used for a general pediatric course, as medical pediatrics is not thoroughly discussed. Most training schools prefer a textbook covering medical, surgical, and pediatric nursing for use by students. This type of book may be used as a reference book for pediatric nursing.

The illustrations for general child care are good and would be helpful for students who come in contact with patients' mothers on discharge.

The different types of restraints illustrated and their uses are well explained.

This book can be easily understood by young mothers and it is recommended for them and practical nurses.

THE CHILD IN HEALTH AND DISEASE. A Textbook for Students and Practitioners of Medicine. By CLIFFORD G. GRULEE, M.D., Rush Professor of Pediatrics, University of Illinois; Attending Pediatrician, Presbyterian Hospital, Chicago; Chief Editor, *American Journal of Diseases of Children*; Secretary of the American Academy of Pediatrics; and R. CANNON ELEY, M.D., Associate in Pediatrics and Communicable Diseases, Harvard University Medical School; Chief of Isolation Service and Visiting Physician, Infants and Children's Hospital, Boston; Member of the Committee on Awards of the American Academy of Pediatrics. Baltimore: The Williams & Wilkins Company, 1948. Price, \$12.00.

More than fifty outstanding physicians in the country have contributed to the making of this very fine textbook on pediatrics. It is an expensive book, printed on good paper and in fairly small type. It covers the field amply and lacks nothing to commend it as a complete text.

The only issue the reviewer takes with the publisher is the need for this book. Actually such a need does not exist. There are other complete works on pediatrics, both in single volumes and in sets, which do an equally good job in providing the student and the practitioner with a text on this field of medicine. Without constant revision and new editions, large parts of this book will be antiquated in relatively a few years. In the long run, the conscientious physician who wishes to keep up to date on the changing panorama of pediatric progress will do better with a revised set of Brenne-man's books than by acquiring the competitive publications being released every year or two by rival book houses.

The authors have chosen wisely in their selection of

contributors. Each chapter or section is written by a leading light in his field. The sections on growth and nutrition are well done, as is the section on the newborn and prematurity. Charts dealing with the composition of most commercial products are wisely included under infant feeding.

The illustrations in the chapters on communicable disease are poorly chosen. The unusual rather than the commonplace conditions are pictured. Colored photos of the various rashes are more useful than skull x-rays of rare cerebral complications following pertussis.

The acute and chronic infections follow next, and this is where revisions must soon be considered. The rapid succession of new antibiotics is changing the therapeutics of so many of the acute infections that many paragraphs in this new book are already wholly outdated.

Two brief chapters comprise the section on circulatory diseases. The blood and lymphatic diseases are well covered by Sanford, Poncher, and Farber. In the chapters on the respiratory system there is some wasteful repetition of material covered earlier in the text. This is one of the necessary evils of "symposium style" texts.

Chapter 58 dealing with the tonsils and adenoids is especially deserving of commendation. Diseases and deformities of the intestinal tract including the parasitic infestations are embodied in the next section. There are many typographical errors in these chapters and incidentally several are noted throughout most of the book.

The Bakwins capably contribute the chapter on psychologic disorders of childhood in the section on the nervous system. The chapters on allergy, eczema, and skin diseases are unusually good and an adequate formulary is included. There are sections on endocrinology and the eye, also a chapter on adolescence which contains width-weight tables for boys and girls up to age sixteen. Finally, there are chapters relative to pediatric surgical principles, various types of poisonings and their treatment, pediatrics techniques (well illustrated), and even a chapter on children's teeth, which incidentally is most worthy of inclusion in a pediatric text.

This book in future editions, with more careful proof-reading, elimination of some redundancies, and inclusion of some fine color illustrations, will make an excellent textbook on pediatrics.

CLINICAL RADIATION THERAPY. By IRA I. KAPLAN, M.D., F.A.C.R., Clinical Professor of Radiology, New York University Medical College; Attending Radiation Therapist, Beth-David Hospital, New York; Director, Radiation Therapy Department, Bellevue Hospital, New York. With 614 illustrations. Second edition. New York: Paul B. Hoeber, Inc., 1949. Price, \$15.00.

This book is the second edition of a volume which was first published in 1937. It is a marked improvement over the original work, and has completely kept abreast of the advances in radiation physics and therapeutics since the advent of the first volume.

The chapters on the general considerations of radiation therapy and on physics have been completely rewritten. The present chapter on the physics of irradiation is written in a clear and concise manner. It is profusely illustrated with charts and diagrams, many of which have been borrowed from standard texts. This chapter brings together the essential physics governing application of radium and x-rays. It serves as a ready reference for the therapist.

The greater portion of this book is devoted to the

treatment of both benign and malignant tumors which are amenable to treatment by either radium or x-ray. The discussion of each clinical entity is given according to its anatomical location. The specific lesions are clearly described, well illustrated, and the presentation includes the basic pathology necessary for the understanding of the radiation reaction. The actual treatment of each condition is described in detail. The treatment of choice is given whether it be radium or x-ray. The method of treatment is clearly described and in many cases illustrated either by drawings or photographs. Dr. Kaplan has drawn upon his vast experience as director of the Radiation Therapy Department of Bellevue Hospital, New York City, to give many ingenious methods of applying radium as well as many helpful suggestions as to the practical aspects of x-ray therapy. He has also comprehensively covered the literature and added the suggestions of other prominent therapists to the methods described.

In this edition greater emphasis has been given to the treatment of inflammatory conditions and arthritis than in the first volume. Also, radiation of eye conditions has been fully described. This includes beta radium therapy and the new Bellevue-Kaplan applicator which utilizes beta therapy in radon tubules.

This volume offers to the radiotherapist a comprehensive and authoritative reference book. It is an extremely valuable addition to the literature on this subject.

AN ATLAS OF ELECTROCARDIOGRAPHY. By WILLIAM DRESSLER, M.D., Cardiologist, Maimonides Hospital of Brooklyn; Consultant in Cardiology, The Brooklyn Hospital; Lecturer in Medicine, Long Island College of Medicine, Brooklyn; and HUGO ROESLER, M.D., F.A.C.P., Cardiologist, Department of Medicine; Associate Professor of Radiology, Temple University Medical School and Hospital, Philadelphia. Springfield, Illinois: Charles C. Thomas, 1949. Price, \$14.00.

This publication is essentially the best atlas of electrocardiography that the reviewer has seen. He believes, however, that such a book is not suitable for beginners in the field of electrocardiography, but as an atlas it furnishes an excellent medium for those experienced in the field of electrocardiography to review the various patterns and tracings.

The book is so arranged that the reader can easily form his own opinion before checking with the opinion of the authors; and the authors are to be commended upon the inclusion of brief clinical résumés of the patients from whom the tracings were taken.

There seems to be little justification for the inclusion of certain chest lead tracings which were taken in the old manner, i.e., with the electrodes reversed, since this leads only to confusion. However, this occurs only two or three times throughout the book and is not a serious objection.

This reviewer highly recommends the "Atlas" to those in the field of electrocardiography who wish to refresh their memory from time to time on the rare electrocardiographic patterns.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

THE 1948 YEAR BOOK OF ENDOCRINOLOGY, METABOLISM AND NUTRITION. Endocrinology edited by WILLARD O. THOMPSON, M.D., Clinical Professor of Medicine, University of Illinois College of Medicine; Attending Physician (Senior



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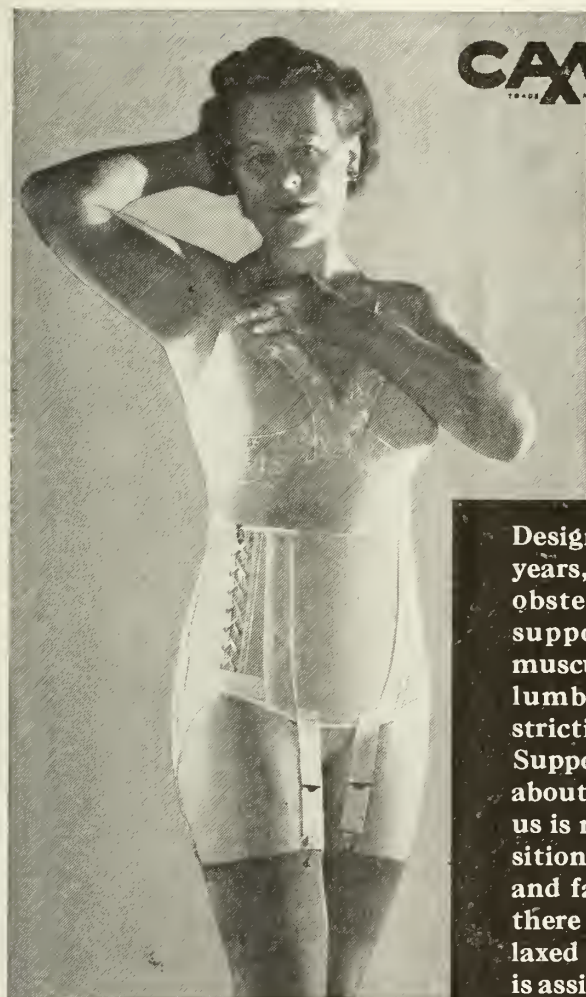
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Staff), Henrotin Hospital; Attending Physician, Grant Hospital of Chicago. Metabolism and Nutrition edited by TOM D. SPIES, M.D., Chairman, Department of Nutrition and Metabolism, Northwestern University School of Medicine; Director, Nutrition Clinic, Hillman Hospital, Birmingham, Ala. Chicago: The Year Book Publishers, 1949. Price, \$4.50.

THE AMERICAN NURSES DICTIONARY. The Definition and Pronunciation of Terms in the Nursing Vocabulary. By ALICE L. PRICE, B.S., R.N., Instructor of Nursing Arts at Columbia Hospital, Milwaukee. Philadelphia: W. B. Saunders Company, 1949. Price, \$3.75.

MEDICINE THROUGHOUT ANTIQUITY. By BENJAMIN LEE GORDON, M.D., member of American Association of the History of Medicine and American Academy of Ophthalmology and Otolaryngology; certified by American Board of Ophthalmology; Attending Ophthalmologist to Shore Memorial Hospital, Somers Point, N. J., and to Atlantic County Hospital for Tuberculous Diseases and Atlantic County Hospital for Mental Diseases, Northfield, N. J.; Authorized Medical Examiner for Civil Aeronautics Administration, Department of Commerce, Washington, D. C.; author of *The Romance of Medicine*. Foreword by Dr. Max Neuburger. 157 illustrations. Philadelphia: F. A. Davis Company, 1949. Price, \$6.00.

THE COMPLEAT PEDIATRICIAN. Practical, Diagnostic, Therapeutic and Preventive Pediatrics. Sixth edition. For the use of medical students, interns, general practitioners, and pediatricians. By WILBURT C. DAVISON, M.A., D.Sc., LL.D., M.D., Professor of Pediatrics, Duke University School of Medicine, and Pediatrician, Duke Hospital; formerly Acting Head of Department of Pediatrics, Johns Hopkins University School of Medicine, and Acting Pediatrician in Charge, Johns Hopkins Hospital. Durham, N. C.: Printed by Seeman Printery for Duke University Press, 1949. Price, \$4.75 postpaid.

HOW TO BECOME A DOCTOR. A complete guide to the study of medicine, dentistry, pharmacy, veterinarian medicine, occupational therapy, chiropody and foot surgery, optometry, hospital administration, medical illustration, and the sciences. By GEORGE R. MOON, A.B., M.A., Examiner and Recorder, University of Illinois Colleges of Medicine, Dentistry and Pharmacy. Philadelphia: The Blakiston Company, 1949. Price, \$2.00.

CLINICAL CYSTOSCOPY. Technique, Procedures, Diagnosis, and Treatment. By LOWRAIN E. MCCREA, M.D., F.A.C.S., F.I.C.S., Clinical Professor of Urology, Temple University Medical School; Attending Urologist, Philadelphia General Hospital; Civilian Consultant in Urology, Valley Forge General Hospital. Drawings by B. Engle Shaffer. Volumes I and II. With 742 illustrations, 201 in color. Second edition. Philadelphia: F. A. Davis Company, 1949. Price, \$28.00.

PSYCHOSOMATIC MEDICINE. The Clinical Application of Psychopathology to General Medical Problems. By EDWARD WEISS, M.D., Professor of Clinical Medicine, Temple University Medical School, Philadelphia, and O. SPURGEON ENGLISH, M.D., Professor of Psychiatry, Temple University Medical School, Philadelphia. Second edition. Philadelphia: W. B. Saunders Company, 1949. Price, \$9.50.

GERIATRIC MEDICINE. The Care of the Aging and the Aged. By EDWARD J. STIEGLITZ, M.S., M.D., F.A.C.P., Attending Internist, Suburban Hospital, Bethesda, Md. (Chairman of Staff, 1945-47); Doc-

tor's Hospital, Washington, D. C.; Attending Internist (Geriatrics), Chestnut Lodge, Rockville, Md.; Consulting Internist, Washington Home for Incurables; Associate, Washington School of Psychiatry; Special Lecturer, Institute of Industrial Medicine, New York University, and Bellevue Postgraduate Medical School, New York City. Second edition, illustrated. Philadelphia: W. B. Saunders Company, 1949. Price, \$12.00.

ORAL AND DENTAL DIAGNOSIS. With Suggestions for Treatment. By KURT H. THOMA, D.M.D., F.D.S.R.C.S. Eng., Professor of Oral Surgery, Emeritus, and Brackett Professor of Oral Pathology, Harvard University; Lecturer on Oral Surgery, Graduate School of Medicine, University of Pennsylvania. With contributions by Henry Goldman, D.M.D., head of the Dental Department, Beth Israel Hospital, Boston, and Fred Trevor, D.M.D., formerly Instructor in Oral Pathology, Harvard Dental School. Third edition with 776 illustrations, 60 in color. Philadelphia: W. B. Saunders Company, 1949. Price, \$9.50.

ZINC IONS IN EAR, NOSE, AND THROAT WORK. By A. R. FRIEL, M.D. (Univ. Dub.), F.R.C.S.I. Illustrated. Bristol: John Wright and Sons, Ltd., 1948. Price, \$2.00.

LIP CANCER MAY BE INFLUENCED BY COMPLEXION TYPE

The possibility that lip cancer may have a genetic background and may not be primarily due to the influence of sunlight, as some authors have suggested, was revealed recently by the Army Institute of Pathology.

After grouping lip carcinoma records according to the patient's complexion type and place of birth, scientists in the Dental and Oral Pathology Section of the Institute discovered that, of 528 lip cancers among white soldiers of World War II, the majority of patients were of fair or ruddy complexion.

Only 9 per cent of World War II soldiers with proved lip cancer had medium or dark complexions. This minority group reported nativity in every geographic quarter of the United States. Army dental pathologists point out that the significance of complexion type as a genetic factor in cancer cannot be established conclusively until it is determined how long each patient lived in the area of his birth, the degree of exposure to sunshine, and other possible causative agents. They also point out that the Army is not able to make comparable studies of lip cancer in women.

With regard to possible elimination of this type of cancer, responses to 637 follow-up inquiries sent out by the Army Institute of Pathology showed that 92.5 per cent had no recurrences. Of these, 139 had been treated more than five years before, 40 had been treated more than ten years before, and one had been treated thirty-two years before. Surgical removal of the lesion in an early stage has been found the most effective form of treatment.

Continued study of cancer at the Army Institute of Pathology will take into consideration the patient's change of residence from one geographic section to another, altitude and other climatic conditions, occupation, as well as exhaustive clinical and histologic examinations.

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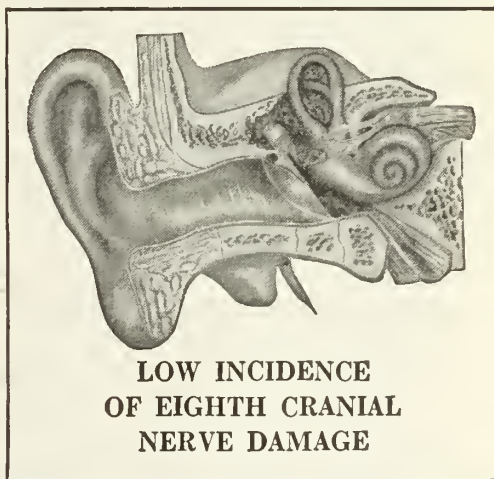
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Consent by word of mouth to an operation or an autopsy is probably the most common form of consent. . . . Oral consent is, however, open to misunderstanding and may be difficult of proof. Whenever it is to be relied on, consent should be given in unequivocal terms, in the presence of one or more disinterested witnesses. Written consent to an operation or to an autopsy is by far the safest, for it permits a clear record of the nature and extent of the operation or autopsy that is authorized. If the patient is a minor, authority for an operation must come from his parent or guardian.—*Board of Trustees, The Medical Society of the State of Pennsylvania.*

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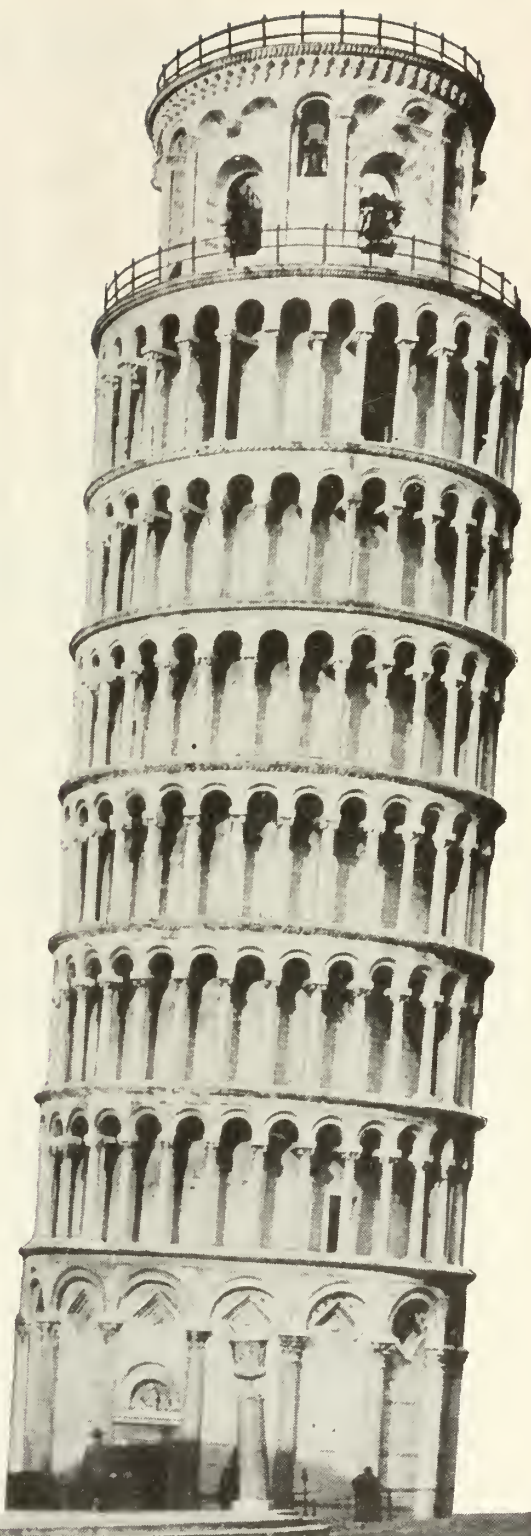
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THE PENNSYLVANIA MEDICAL JOURNAL

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ANNUAL SESSION ISSUE

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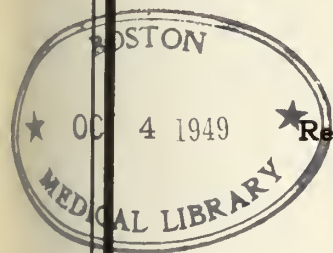
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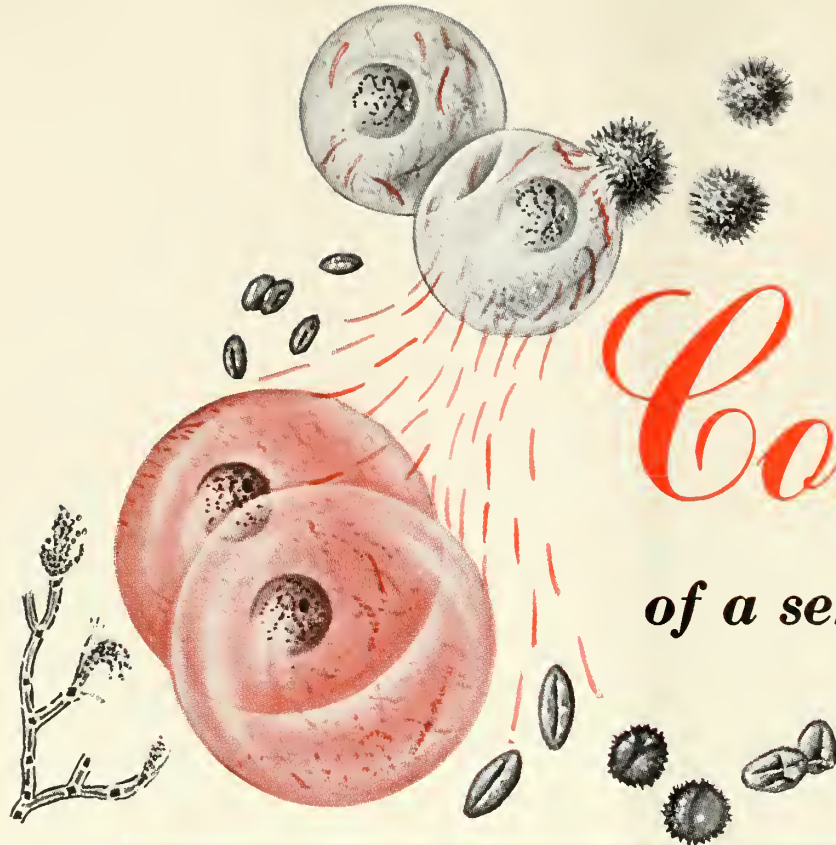
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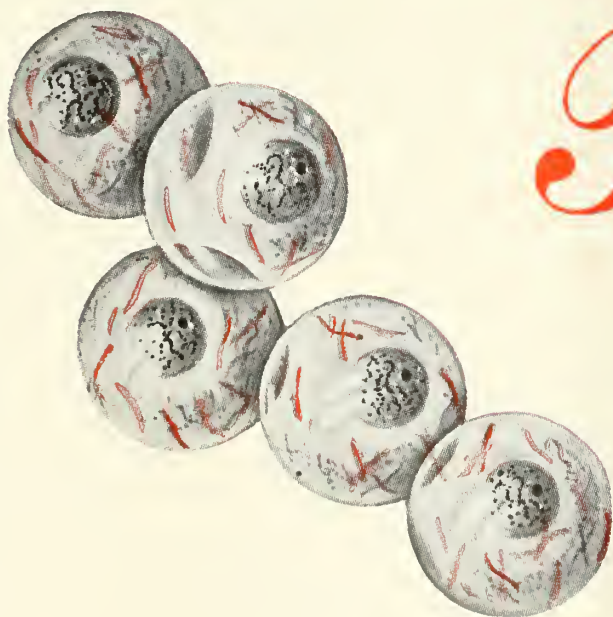
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ANALYSIS	
Moisture, ...	23.20
Solids by drying (Vacuum 70°C.)	87.84
by Refraction	86.80
Ash	0.72
Chlorides as Sodium Chloride	0.18
Sugars, Before Inversion	33.21
As Invert.	32.13
As Dextrose	
Sugars, After Inversion	39.13
As Invert.	37.66
As Dextrose	4.50
Sucrose	66.3
Glucose	
(211°V)	
Total Sugars after Prolonged Acid Inversion (Includes Dextrins)	68.3
As Invert Sugar	65.9
As Dextrose	25.4
Dextrins (calc.)	144
Calories, per fluid ounce (calc.)	



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LETTERS

A.M.A. Progress Brings Conversion

GENTLEMEN:

I am enclosing my check for \$25, which is the assessment for the members of the A.M.A. I postponed sending this check for certain reasons. Up to the present time I believe that the A.M.A. had not been handling this matter wisely. The tactics employed by the Association had only served to bring the A.M.A. into disrepute with a great many people. I believe our Association was not getting anywhere in confining its efforts to manifesting its opposition to various bills which were presented to Congress. Its efforts were being used to oppose any change whatsoever in medical practice and were not presenting constructive means to secure better medical care for the people as a whole.

Fortunately, the policy of the A.M.A. has now been altered. Too much money was formerly spent in educating doctors, who as a whole need no education in the matter of socialized medicine, and too little money was spent on educating the laity. The recent pamphlets which I have received labeled "Fifty Questions You Want Answered" are the first evidence I have had of any useful method employed by the A.M.A. I have been distributing these pamphlets to my patients and have talked with them on the subject of socialized medicine.

I am, therefore, happy to contribute my \$25 towards assisting the work of educating the public and furthering the principles of voluntary health insurance.

_____, M.D.
Pennsylvania.

Replies "Favorable or Unfavorable" Solicited

GENTLEMEN:

This is in response to your circular letter of June 24 soliciting additional participating physicians for MSAP, which I have read with considerable displeasure, calling my attention to the fact that I am "one of an ever-dwindling number of members" of my State Society who continue to receive letters appealing for support of the Medical Service Association, "our Blue Shield Plan in Pennsylvania."

Your appeal is apparently based on the supposition that anything less than one hundred per cent support is undemocratic. This type of reasoning, frequently employed in certain nations of eastern Europe, is rarely encountered here. I should think that the State Society would be well satisfied with its thumping majority in favor of the plan, and permit us, the underprivileged minority, to sulk in our tents.

The statements "every member . . . should be a participating physician" and "members of a few spe-

cialty groups . . . do not participate directly in the plan," when placed side by side, constitute an absurdity, since the groups in question do not participate in any fashion whatsoever. Furthermore, and of greater importance, the reason they do not participate in any may be found in the State Society's lack of sufficient gumption to insist that anesthesiology, pathology, and radiology be eliminated from the Blue Cross and transferred to Blue Shield, where they belong!

This failure on the part of the State Society to support its members who practice these specialties has resulted in irreparable harm, since it has served to encourage the erroneous impression held by lay persons that anesthesiology, pathology, and radiology do not constitute the practice of medicine, but are properly classified as *hospital* services.*

Is there any doubt that countless subscribers to Blue Cross are receiving cut-rate services in these medical specialties, to the detriment of private practitioners? One wonders how many surgeons or obstetricians would continue to participate if their services were transferred to Blue Cross and their fees diverted to the hospital treasury.

The assumption that my support of Blue Shield will help to show the people that I am in favor of the voluntary democratic way is entirely without foundation, since a plan which not only discriminates against some of its supporters but also lends comfort and assistance to a hospital plan which sponsors unethical competition with these same supporters certainly is not democratic, even though it may be quite voluntary.

The implications of the statement "the time has arrived to stand up and be counted" are unpleasant, to put it mildly, when contemplated by an individual who not only has been left out in the cold but also has been asked to contribute to his own strangulation.

I am aware that there are some radiologists who have agreed to "participate," but I am quite certain that none of them seriously considered what they were doing. I, for one, am unalterably opposed to both Blue Cross and Blue Shield as presently constituted in this state. When the obvious prohibitive defects, indicated in the foregoing, have been corrected, I shall become an enthusiastic participant.

Our state medical society, being a truly democratic organization, should encourage free and open discussion of vital questions. I shall be highly gratified if I find the sentiments expressed in this letter published in the JOURNAL, together with any favorable or unfavorable comments.

EDWIN J. EUPHRAT, M.D.,
Pittsburgh, Pa.

* EDITOR'S NOTE: See pages 1243 and 1279, this issue.

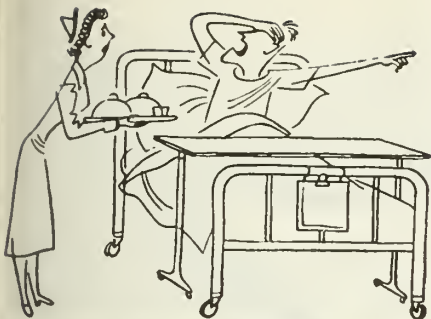


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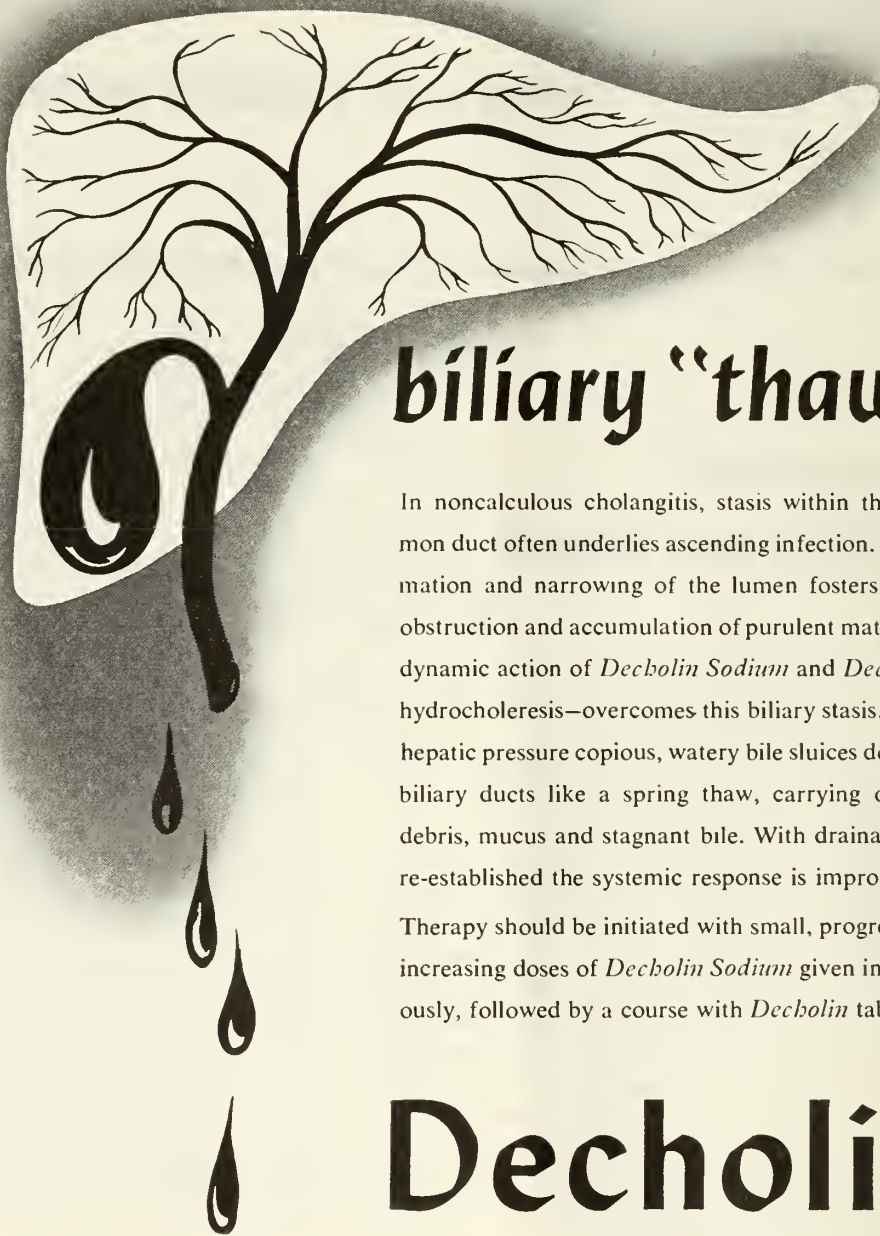
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By the end of July of this year we will have lost almost one-third of the physicians and dentists now serving with our Armed Forces. Without an increased inflow of such personnel, the shortage will assume even more dangerous proportions by December of this year.

These losses are due to normal expiration of terms of service. The professional men who are leaving the Armed Forces during this critical period are doing so because they have fulfilled their duty-obligations and have earned the right to return to civilian practice.

Without sufficient replacements for these losses, we cannot continue to provide adequate medical and dental care for the almost 1,700,000 service men and women who are the backbone of our nation's defense.

Normal procurement channels will not provide sufficient replacements!

To alleviate this critical, impending shortage of professional manpower in the three services, I am urging all physicians and dentists who were trained under wartime A. S. T. P. and V-12 programs under government auspices or who were deferred in order to complete their training at personal expense, and who saw no active service, to volunteer for a two-year tour of active duty, at once!

We have written personally to more than 10,000 of you in the past weeks urging such action. The response to this appeal has not been encouraging, and our Armed Forces move rapidly toward a professional manpower crisis!

Many responses have been negative, but worse—a great number of doctors have not replied. It is urgent that we hear from you immediately!

We feel certain that you recognize an obligation to your fellow men as well as to your profession in this matter. We are confident that you will fulfill that obligation in the spirit of public service that is a tradition with the physician and dentist.

There is much to be said for a tour of duty with any of the Armed Forces. You will work and train with leading men of your professions. You will have access to abundant clinical material; have the best medical and dental facilities in which to practice. You will expand your whole concept of life through travel and practice in foreign lands. In many ways, a tour of service will be invaluable to you in later professional life!

Volunteer now for active duty. You are urged to contact the Office of Secretary of Defense by collect wire immediately, signifying your acceptance and date of availability. Your services are badly needed. Will you offer them?

Louis Johnson

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THE DILEMMA OF OTOLARYNGOLOGY

LYMAN G. RICHARDS, M.D.

Boston, Mass.



BAKED beans are a Boston tradition. Served customarily on Saturday night they become, to most connoisseurs, even more delectable when warmed over on Sunday morning. My remarks today are in a sense warmed over. Several months

ago at the annual meeting of the American Laryngological, Rhinological and Otological Society I ventured some comments on the present status of the specialty of otolaryngology, the changes it has undergone since its inception, and the problems which clearly beset it in the future. I did this with grave misgivings since the picture I painted was not a very happy, nay even a rather pessimistic one, and I felt it quite likely that many if not all of my audience might rise up in condemnation and charge me with a degree of misrepresentation and general dolefulness such as to make even Jeremiah regretful.

Surprisingly my address was greeted with acclaim and many who quite probably in past years had swiftly consigned my most cherished reprints to the wastebasket gathered around to wring my hand and congratulate me on a truly great pronouncement. Shortly the mails brought four invitations to me to appear as a guest speaker at meetings in such far-flung areas as Texas, Ten-

nessee, Illinois, and Pennsylvania, the latter the obvious reason for my being here today.

All this I wisely took with several grains of salt. For the apparently enthusiastic reception I take absolutely no credit, either forensically or literarily, but see in it only an indication that the subject was nearer to the hearts of many of my audience than I had realized, the more so since it was composed of otolaryngologists of well-established and secure position.

With great trepidation, lest it be thought that I had lost my mind, I had couched my thesis in an allegorical picturization of the old-time laryngologist as the solitary dweller on a desert island, the sole possession of which left him unmolested and free to enjoy all the branches of our specialty without let or hindrance from any rivals from the mainland.

Fantastic orchards of tonsil-bearing trees, flocks and herds of otitic infections, telescopic views of heavenly foreign bodies and rich ore-containing mines of deafness—all may have presented, I fear, a picture strongly suggesting the bizarre scribbblings of a victim of dementia praecox.

All went well on this hypothetical island until strangers appeared on the horizon and landing parties of general practitioners, pediatricians, chest surgeons and roentgenologists, fenestrators, and allergists captured beach heads and sought to enjoy a portion of the rich crops and harvests for themselves. Despite distorted figures of speech and mixed metaphors my mean-

Read before the Section on Eye, Ear, Nose, and Throat Diseases at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 6, 1948.

Dr. Richards is chief of the Bronchoscopic Clinic at the Massachusetts Eye and Ear Infirmary.

ing, I think, was clear—that the former immunity from encroachment by competitive branches of medicine is no longer enjoyed by the otolaryngologist. Thus has been produced the confused and changing picture which has led to the complaint heard on all sides that the good old days of otolaryngology are gone, that a sort of *Götterdämmerung* has set in and that the future looks dim.

But, it will be argued, outstanding leaders in the field have stated that, judged by the brilliant research projects and investigations now going on, the prospects for our specialty were never brighter. We must, however, at the outset recognize two major subdivisions in what is commonly designated as the specialty of otolaryngology—one the science, the other the practice. Granted that ideally the two should be combined as an integrated unit, practically they are widely separated. Considering the purely scientific side of the shield, we must all agree that the future of otolaryngologic investigation and experimentation and hence of new discoveries is limitless. Aided by such modern devices as high-speed photography and the newer knowledge in allied branches of science, otolaryngologic research is on the march. It must, however, be conceded that most or all of such work can be done only in acknowledged teaching institutions and hospital laboratories with adequate specialized equipment and by men with exceptional skill, interest, and aptitude and supported by endowments, grants, or other financial backing available to only a limited extent. Given all these the future of otolaryngology need not concern us further.

But how stands the matter for the man who enters the practice of otolaryngology as a principal if not sole means of livelihood, relying only upon his own skill and training and with the expectation that adequate opportunities will be available for the exercise of these?

If, on opening his office, he finds general practitioners freely performing tonsillectomies, pediatricians treating otitis media, and chest surgeons accomplishing their own bronchoscopies, may he not wonder how he is to make economic headway against this unexpected and perhaps in his opinion unwarranted competition?

That such perplexities are no figment of my imagination and that they are causing serious concern to the rank and file of the members of our specialty is attested by answers to 500 questionnaires sent to junior members of the American Academy of Ophthalmology and Otolaryngology. Almost universally these men are of the opinion that a new concept of the practice of oto-

laryngology, of its limitations, weaknesses, problems, and future potentialities, is in the making and must be dealt with if this specialty is to continue to hold an interest and appeal as well as economic security for newcomers to it.

Chemotherapy and its almost universal employment by general practitioners and pediatricians, bronchoscopic competition from the thoracic surgeon, radiation therapy by the roentgenologists, nay even, with the upsurge of psychosomatic medicine, the broadening scope of psychiatry—all are of vital concern to the present-day otolaryngologist.

I would like first, for a few minutes, to discuss some of the outstanding factors which have in a relatively short time brought about these changes to a greater degree than in any other major specialty.

A discussion of chemotherapy and its influence on otolaryngology could consume my entire allotted time. Briefly, I think it is now generally recognized that the advent of chemotherapy has curtailed and in many instances well nigh eliminated formerly commonplace surgical procedures which constituted a high percentage of operative otolaryngology. There are still those who feel that the reduction in incidence of surgical mastoiditis rests primarily on a temporarily lessened virulence of the infecting bacteria, but each succeeding year tends to refute this theory. That the loss of operative work is utterly insignificant in comparison to the benefits to humanity is too obvious to mention.

An equally vital effect on the otolaryngologist is the availability of chemotherapy not only to himself but to the general practitioner and pediatrician, in whose hands numberless patients recover from incipient infections of the ear, nose, and throat without ever developing the complications which formerly required specialized therapy and surgery. The lessened incidence of myringotomy in present-day otologic practice is an obvious example of this trend.

The greater infrequency of otitic and, to a lesser extent, rhinologic complications poses yet another problem to the prospective practitioner of otolaryngology. With the diminution of formerly commonplace surgical procedures goes hand in hand a lessened competence in dealing with them when they do arise. Time was when an intern could look back on a service experience of a hundred personally performed mastoidectomies. Today he has been well regarded by his seniors if he can boast of twenty. Who of us today can claim the taxing and soul-trying experience with brain abscess or sinus thrombosis of the men of fifteen years ago? Where is adequate

training for these occasional but always serious emergencies to come from? The modern otologist has come so to rely on chemotherapy that without the classical signs of hidden danger he stands on slippery ground. Moreover, reliance on chemotherapy to care for possible residual infection tends toward incomplete and timid surgery with occasionally disastrous results.

Bronchoscopy

That there is today a nationwide increase in the performance of diagnostic bronchoscopy by or under the direction of thoracic surgeons is an established fact. The desire for personal visualization of a pathologic lesion is a quite natural one and analogous to that of the urologist to perform his own cystoscopies. For this point of view I can see much justification. Its greatest threat to the laryngologist lies in the deprivation of endoscopic experience so necessary if he is to continue to deal with the occasional foreign body which the thoracic surgeons still seem disposed to relegate to him. To meet this dilemma in some measure it has been proposed that those laryngologists interested in this field follow the example of a small number of endoscopists who undertake to cover all diseases pertaining to the air and food passages from the larynx to the duodenum. These men leave to their confreres all conditions relating to tonsils, sinuses, and mastoids, if any, hoping for and, in certain large cities, receiving such reciprocal cooperation that their economic needs are adequately met while restricting themselves to the field of endoscopy. Chest surgery, however, does not as yet fall within their province and only in the largest cities and medical centers could a man restrict himself to this radical limitation of activity.

Among the many comments repeatedly supplementing the answers to the questionnaire the opinion was expressed again and again that the otolaryngologist must greatly amplify his basic knowledge of allergy. The relatively recent formation of the American Society of Ophthalmological and Laryngological Allergy is ample evidence that a strong movement is underway to expand and fortify the allergical knowledge and interests of the otolaryngologist. It is high time that we recognized that much ill-advised and inappropriate surgery has far too often littered nasal beaches with mucosal wreckage and that a clearer understanding of nasal physiology will save our patients much discomfort and ourselves much disappointment.

The frequent suggestion that rhinoplasty be added to the field of otolaryngology is not surprising in view of the nationwide upsurge of this

offshoot of conventional rhinology. As a surgical field, it would still seem a territory of dispute between the rhinologist who considers the nose his by right of eminent domain and the plastic surgeon who considers it merely one more anatomic opportunity for the exercise of his specialized techniques. Given daily repetition in the execution of plastic procedures, whether in the nose or any other locality, it would seem that the plastic surgeon, despite his limited knowledge of conventional rhinology, has the better of the argument.

It has been proposed that the future otolaryngologist expand his present field to include the entire head and neck. Consider for a moment the present recognized special fields with which this would bring him in conflict. Already brain surgery is one of the most rapidly expanding and technically exacting of the specialties, demanding the full attention of an increasing number of highly trained workers. Plastic surgeons are as much at home in nasal and aural reconstruction as in plastic work elsewhere in the body. Maxillofacial surgery is constantly gaining ground as a separate surgical specialty and any work in the neck is part and parcel of a general surgeon's routine. Adequately to prepare himself for such surgical expansion would, under the exact standards of today, entail such extensive preliminary general surgical training that I seriously doubt that thereafter any man would be attracted to a field a large segment of which is so taken up by non-surgical activities as to preclude time and opportunity for the maintenance of adequate surgical dexterity. A man with interest and talent for fitting hearing aids and detailed allergic studies is not likely to have either skill or opportunity for surgery of the neck, and much as he may miss the loss of formerly interesting and spectacular work, present medical trends and developments are likely to compel him, except in the case of a few favorably situated individuals, to accept the situation as gracefully as possible.

Such a novel and revised anatomic specialization would necessitate a completely new concept of the place of the otolaryngologist in the field of medicine by all referring groups, particularly the family physician, and I doubt if at the present time it can offer a feasible solution to the problem.

One frequently encounters the optimistic opinion that the loss of aural surgery incident to chemotherapy need cause no concern since it has been supplanted by fenestration. When I survey the work of certain otologists—equipped with the highest degree of surgical skill and enthusiasm, able to carry on experimental investiga-

tion under ideal conditions, and aided by foundations and special grants—who are still dissatisfied with their results and who are still seeking the answers to ever recurring problems, I cannot believe that this operation has as yet reached the point where it can be added to the stock in trade of the average practicing otologist. I am doubtful if, either by observation of the work of other operators or by self-tutelage, he can safely undertake such work except after training under conditions available to only a small minority.

Like marriage, fenestration should not be entered into lightly or unadvisedly but soberly and with full realization that brilliant as have been the results these have been largely in the hands of a few talented operators whose endless hours of patient effort have brought this operation to its present state of development. Until such time as this procedure becomes practical in the hands of the average otologist, patients suitable for operation should, I think, be referred to those men best qualified to perform it, and to this extent it constitutes another limitation in the field of conventional otolaryngology.

It must, I think, be admitted that in many respects otolaryngology is today somewhat on the defensive and can no longer complacently consider itself immune to certain criticisms. For years specialists have been chided by their colleagues for the sharp limitations of their anatomic boundaries. The otolaryngologist in particular, more than the pediatrician or dermatologist, has felt constrained to adhere to a sort of Mason and Dixon line somewhere above the neck, beyond which he dare not trespass. I have seen interns look in blank amazement when requested for the loan of a stethoscope. Yet to omit a blood count, a urine examination, or a metabolic determination may lead to a wholly erroneous diagnosis. There are those who estimate that fully one-third of their office patients suffer only from some emotional disturbance which can never be reached through a submucous resection or local nasal applications, persistence in which only brings disrepute to our specialty.

Many men returned from service in the armed forces with the often justifiable feeling that otolaryngology lacked the prestige of other specialties. There was absolutely no representation in Washington. Otolaryngologists were time and again assigned to work with complete disregard for their special capabilities. The designation E. N. T. stressed far too strongly a rigid anatomic restriction, to which the armed forces gratuitously prefixed an extra E on the naive assumption that every otolaryngologist must perforce be also an ophthalmologist.

For some reason the designation otolaryngology has never succeeded in gaining the accepted usage of urology, gynecology, or even gastroenterology, despite the fact that the latter contains one more letter. Stationery and private letterheads continue to designate the specialty as Ear, Nose and Throat and thus to carry a connotation of restricted anatomic interest which I believe contributes to a lowered prestige among allied medical specialties. Otolaryngologists are everywhere known as “nose and throat men.”

In many state medical societies there is no sectional representation of otolaryngology. General medical digests, handbooks, and periodicals usually give short shrift to otolaryngologic abstracts. Symbolic of a too limited and restricted clinical point of view is the hole in the forehead mirror through which may be seen a brilliantly illuminated tip of a turbinate but not the anxious look on the patient's face, behind which may lie the basic clue to the nasal complaint.

Rightly or wrongly, there is being leveled at the head of present-day otolaryngology the charge of needless and repetitive nasal applications and throat paintings which are a strain on the physician's conscience as well as the patient's pocketbook. An attitude which tends to minimize the importance of a knowledge of general medicine and of the patient as a whole and which puts too much emphasis on surgical techniques, operations, and local examinations lies basically at the heart of the dilemma. It constitutes the clearly discernible handwriting on the wall which warns that the Kingdom of Otolaryngology, like that of Belshazzar, is being weighed in the balance and if it continues to be found wanting, it must risk further partition amongst the Medes and Persians of other fields of medicine.

A word now as to our relationship to the general practitioner. Once the very backbone of American medicine, in close contact not only with his patient's illness but with his economic, social, and familial status, the general practitioner has tended to fall a victim to the wave of specialization and to become a referral station and, as the L. M. D., to be looked upon by hospital interns with tolerance if not with a touch of disdain. The paucity of medical students who express the intention of entering general practice is causing great concern among all those who see the standards of rural medicine declining. Factors favoring this urge to specialize are higher fees, prestige of board examinations, encouragement from medical school teachers, themselves mostly specialists, and exclusion from hospital staffs of non-specialists. The latter policy is considered by the Council on Medical Educa-

tion and the Advisory Board for Medical Specialties as highly detrimental to the health of the people and to American medicine.

Movements are on foot in certain medical centers to remedy this situation by providing residencies, not only in the conventional specialties but also in general practice, with a view to enhancing the prestige of this branch of medicine and of inducing more men to enter it. If a man so trained is to be truly competent, it must be conceded that he should have some basic knowledge of otolaryngology, ability to care for many of the simpler conditions in this field, and an appreciation of situations demanding specialized attention. Many patients would frequently be better off in the hands of a good general practitioner with a sound knowledge of the simpler and admittedly more common infections of the ear, nose, and throat than in those of a specialist who by force of limitation of time or facilities gives no heed to the more general aspects of the patient's complaints.

For the specialist to bemoan competition from the general practitioner is analogous to the drug-gist's complaint of the sale of vitamins by department stores. I am by no means resentful of this competition; I am merely concerned with its effect on the future otolaryngologist. On the contrary, I once so far lost my sense of perspective as to write a book in which I endeavored to set forth as plainly and as simply as possible an account of those otolaryngologic procedures which might quite properly be undertaken by a general practitioner so situated as to preclude all but the most essential reference to a specialist. An inkling as to the success of this book can best be gained by the publisher's statement that never was a book so favorably reviewed so difficult to sell.

Patients themselves prefer first to consult their family physician and expect him to be competent to care for the majority of their ailments (85 per cent of them according to many estimates). Their present tendency to rush to the specialist with a self-made diagnosis of sinus trouble for a headache more likely to be due to high blood pressure is to be decried. Some of the outstanding pioneers in our specialty who came into it through the then customary background of some experience in general practice had many advantages in dealing with a huge group of patients whose symptomatology is to be sought in vain in the latest textbooks of otolaryngology. I think I might safely challenge any of you at the end of a busy week in the office to list your patients' essential complaints and see how many would conform to academic textbook classification.

That increased recruitment to general practice and increased competence in that field must of necessity provide competition for the otolaryngologist is inevitable. So long as the general practitioner stays within acknowledged limitations and is prompt to seek specialized help when indicated, I can see few objections and many advantages from the point of view of the patient.

The future vulnerability of otolaryngology is curiously associated with yet another factor, that commonest of all surgical operations, tonsillectomy. Of it can be said, to paraphrase Mr. Churchill's famous remark, that never in the history of medicine have so many physicians owed so much economic security to a single operation as to tonsillectomy. The increased efficacy of penicillin, the increased understanding of the effect of radiation on lymphoid tissue, and the already receding wave of pediatric enthusiasm are all horizontal clouds no bigger than a man's hand but still apparent. Changing medical precedent and public sentiment so evident in the questionable relationship between tonsillectomy and poliomyelitis provide only one example of the potent effect which such changes in attitude can exert on medical practice.

House Officers

To no one are these problems of more vital importance than the intern and hospital resident of today, and there is disturbing evidence to indicate that the formerly ample training is failing to meet their changing needs. Their time in the hospital is fully occupied with the care and observation of patients with frank organic disease demanding hospitalization and affording something interesting to treat or operate upon. The timid lady waiting patiently on the clinic bench for relief of a lump in her throat has scant opportunity to be questioned as to what is worrying her. Only when he hangs out his shingle and adjusts his shiny head mirror does the budding otolaryngologist discover that sinus malignancies, bronchial safety pins, and today even cases of acute mastoiditis are few and far between the host of such bizarre and illogical complaints as, "I feel as if water were running in my head," "there is a burning in my tongue," or "I smell violets all the time." Tardily it becomes apparent that office practice needs a degree of psychologic training at present available to a far too meager degree.

With the lessened incidence of otolaryngologic surgery, many hospital graduates are hesitant to open an office in a metropolitan center unless with an assured assistantship to an older man, and those contemplating starting in a smaller

city are becoming more and more interested in supplementary ophthalmologic training, presumably with the idea that refractions pay the rent.

Unless adequately subsidized, expansion of the period of internship to include a more adequate foundation in allergy, psychosomatic medicine, rhinoplasty, or possibly in neck surgery so prolongs the training period that physicians desirous of becoming established before they are 35 years of age are often diverted from undertaking such a program. Certainly the disproportion between applications for the otolaryngologic service and the ophthalmologic service in some of our special hospitals is a striking one.

To shorten somewhat the duration of the training period without impairment of its quality, it may be possible to steal time, a month here, a month there, from conventional otolaryngologic activities. Better training in fundamental allergy might well come at the expense of fewer tonsillectomies; time spent on the radiologic service might be bought at the price of fewer submucous resections. Perhaps we should curtail it further back—in college, in medical school, in the general internship. Each segment of the curriculum is loath to see its own portion yield ground to any other.

We are rapidly approaching the point where it is felt that the well rounded and adequately prepared otolaryngologist must be a composite paragon, trained as an anatomist, a physiologist, a biochemist, an audiophysicist, an allergist, internist, radiologist, surgeon, and even psychiatrist, all with some measure of justification. Were we able to produce such a superman, I fear that on emerging from his training chrysalis, he might appear little more than a gray-haired and stoop-shouldered figure leaning heavily on his cane.

Having tried to present what I think constitutes a vital problem to the present-day and fu-

ture otolaryngologist, I feel chagrined that I can offer no assured solution. Perhaps I view this picture with a far too jaundiced eye. Perhaps my impression that the specialty is undergoing a reverse metamorphosis from the colorful butterfly of pre-chemotherapeutic brilliance to a more sober caterpillar stage of less dramatic clinical experience is quite erroneous. Let us by all means hope that this is the case. A prophet, particularly of unpopular eventualities, is quite likely to find himself in danger of being stoned from the market place, but this is how I, and incidentally many others, see the picture.

Nevertheless, I believe that some solution for this situation will be evolved, possibly on a quite different pattern from that to which we have been accustomed. There is in the history of otolaryngology too much achievement and scientific accomplishment for us to feel any serious concern as to the future. Too many unsolved problems still lie before us and the lure of their solution is too strong to anticipate anything but progress, whatever redistributions and revisions of organization may eventuate in this specialty. Our point of view should be that of Tennyson's Ulysses in urging on his valiant mariners:

"There lies the port; the vessel puffs her sail
There gloom the dark broad seas. My Mariners,
That ever with a frolic welcome took
The thunder and the sunshine and opposed
Free hearts, free foreheads—you and I are old
Old age hath yet his honor and his toil
Death closes all but something ere the end
Some work of noble note, may yet be done
Not unbecoming men who strove with Gods."

Such a challenge is just as pertinent and stimulating to the otolaryngologist of the future as to those who "go down to the sea in ships." The methods, the objectives, and results may differ from those of the past, but the goal is always ahead and attainable to any who combine enthusiasm and hard work.

CLINICAL PATHOLOGISTS TO MEET

The Pennsylvania Association of Clinical Pathologists, the College of American Pathologists, Middle Eastern District, the Clinical Pathological Society of Pittsburgh, and the Allegheny County Division of the American Cancer Society, Inc., will hold a joint meeting in Pittsburgh on Friday, Sept. 23, 1949, at the Roosevelt Hotel.

The following day, September 24, the regular semi-annual scientific meeting of the Pennsylvania Association of Clinical Pathologists will take place.

A feature of the joint meeting will be a slide seminar

on "Cytologic Diagnosis of Cancer of the Lung" with Dr. Peter A. Herbut of Philadelphia as referee. There will be 75 sets of slides available for the seminar. The registration fee for the seminar is \$3.00. The slides will be mailed to registrants two weeks before the meeting. Because of the limited number of slide sets available, it is expected that those applying for these sets intend to be present at the meeting.

Registration for the slide seminar may be accomplished by applying to: Dr. Elwyn L. Heller, Secretary of Seminar, Department of Pathology, University of Pittsburgh, Pittsburgh, Pa. A check covering the registration fee should be enclosed with the letter.

Pelvic Infection—Present Status of Treatment

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THIS discussion will be divided to include four general groups of cases—two acute, one subacute or chronic, and one which might be called recurrent. This classification is designed to clarify the problems of therapy which vary markedly with the type of case involved.

The two acute groups now offer us very satisfactory results when diagnosis is made early and when treatment is both early and adequate. The first group is that of acute Neisserian infection. Public Health Service statistics for the population (male and female) of the continental United States list 392,498 new cases for the year ending September, 1947 (excluding known military cases). As surgeons operating on women, we frequently see the sequelae of this infection and yet it is comparatively rare that the acute phase is diagnosed in average office practice. How frequently should the acute phase be suspected?

Peters¹ studied the results of routine cultures taken on all new gynecologic patients in a large California clinic over the period of a year. Positive cultures for the Neisserian organism were obtained in 13.8 per cent of these cases which presented every variety of chief complaint. Of these positive cases, 317 histories were reviewed to discover the chief complaint which brought the patient to the doctor; 36 per cent complained of abdominal pain and 25 per cent of menstrual irregularity, usually excessive flow. This is particularly interesting, as that symptom might not make one think of gonorrhea. Sixteen per cent came in for suspicion of venereal disease, 13 per cent for vaginal discharge, 7 per cent for urinary complaints, and 5 per cent were in a miscellaneous group. These are very important observations because statistics show that the efficiency of all types of treatment steadily declines when the duration of the patient's infection exceeds fourteen days.²

We all know that if Neisserian infection can be confined to Skene's and other peri-urethral glands, to Bartholin's glands, or to the cervix uteri, no permanent destruction of the function

of the pelvic organs will result. General treatment must be promptly instituted, but avoidance of repeated examinations or local treatment is very important. The Neisserian organism is sensitive both to penicillin and to the sulfonamides, so that in theory good results should be close to 100 per cent. Unfortunately, as far as the average patient is concerned, this is not so. The onset of a menstrual period removes the defensive mucus plug in the cervix uteri and also provides a good culture medium for the organisms. The infection ascends along the columnar epithelial surfaces of the uterus into the fallopian tubes, and the best time for therapy has passed. Even so, prompt and persistent medication may still prevent permanent distortion of the tubes and sterility.

The most helpful method in establishing the diagnosis of Neisserian infection, especially in the female, has been the increased use of cultures as well as of smears from suspected secretions. In acute cases, both will be positive in over 90 per cent of cases; in the more chronic stage 35 to 70 per cent positives may be obtained by culture, but only 10 to 20 per cent of smears are positive.³ Care must be taken to cleanse the surface of the meatus, introitus, or external os before expressing material for culture from the deep-seated glands. If this is done, fewer contaminations and overgrowths of cultures by ordinary organisms will occur.

There are now a number of successful laboratory media for culture in vitro of the Neisserian organism. One of the major difficulties has been drying of specimens on swabs in transit to the laboratory. The exact method will of necessity vary with your local facilities. The method which we have been using with considerable success at the Woman's Medical College has been to plant the swab directly into a sterile tube containing 1 per cent peptone water. This may be taken to the laboratory for transference to the tryptose with dextrose blood agar plates within two hours. Where the diagnosis is in doubt, repeated cultures taken at the end of a menstrual period will give best results. Blood is the best culture medium there is for these organisms and

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the menstrual blood will wash out organisms from deep in the endo-cervix. Haphazard treatment prior to adequate diagnosis, either with penicillin or sulfonamides, will often mask a deep-seated infection by rendering the first laboratory examinations negative. In these cases especially it is important to follow the patient with cultures and smears for at least three months. The risk of masking early syphilis is also a definite one. Serologic examinations should be made at intervals of six weeks and three months after treatment.

Penicillin is used at present in the Philadelphia city clinics with the dosage of 300,000 units in peanut oil and beeswax, single injection. Another satisfactory method is to give three injections of 100,000, 50,000, and 50,000 units of aqueous penicillin every two hours; 300,000 units of procaine penicillin may be substituted, as a single injection. This last product is so new that insufficient data have accumulated as yet to evaluate it properly. A high blood level over a short period has proved to be more effective than a lower blood level over a longer time interval.² Any of these methods will control the infection in its early lower genital tract stage in over 90 per cent of cases.

Penicillin acts quickly from the point of view of preventing dissemination of the infection. In cases of reinfection or in resistant cases, either the penicillin dosage must be considerably increased or a combination of penicillin and sulfonamide given. Five weekly negative cultures, at least one after a menstrual period, should be taken as a safe criterion of cure.² Streptomycin is effective as a weapon in this disease, but is still very expensive and produces serious reactions in some individuals. Since penicillin and sulfonamides are so easily available, there should seldom be a need for streptomycin in this situation. A single injection of 300 to 500 mg. intramuscularly may be given.

The second group of acute ascending infections, the so-called cellulitis group, are seen usually following pregnancy, either in the puerperal or postabortal period. Streptococci, aerobic or anaerobic, and many other organisms may be responsible for these fulminating infections. The organisms travel by way of veins and lymphatics involving the tubal walls and structures in the broad ligaments rather than mucosal surfaces. Brawny induration is the palpable result with a frozen pelvis. Postradiation infection may also give the same picture. We will all agree that, with modern obstetric and gynecologic care, many of these infections should not occur. Many of them can be blamed on careless technique on

the part of the attendant. No amount of penicillin can be a satisfactory substitute for proper aseptic technique in the handling of deliveries and spontaneous abortions. However, there remains a group of endogenous infections and of self-induced infections following criminal attempts by the patient and others to terminate pregnancy. Gynecologic wards, especially in large city hospitals, are apt to see many of this type of case. In the acute hemolytic streptococcal infections with endometritis, parametritis, and even septicemia, penicillin administration has been life-saving in many instances; 50,000 units every three hours around the clock of the aqueous product, or 300,000 units of the newer procaine penicillin every twelve hours, often produces a miraculous result. These patients are apt to be very anemic from hemorrhage, so that large doses of sulfonamides would be dangerous.

Replacement of sufficient blood and body fluids, continuous suction drainage to reduce bowel distention, sedation, and complete local and general rest must be started promptly. If there is thrombophlebitis, with embolic phenomena, or if there is loculated pus from a diffuse peritonitis, any antibiotic or chemotherapeutic agent is of much less help. For an effective therapeutic result, the antibiotic must reach all parts of the affected tissue and it does not reach the center of an abscess cavity.

In many of these acute infections there is also a mixed infection of colon organisms. These are sensitive only to very large doses of penicillin, 1,000,000 units daily. If the patient can tolerate sulfonamides, a combination of penicillin in ordinary dosage with sulfonamide may be more successful. One gram four times daily of sulfadiazine or sulfathiazole for four to five days may be very helpful. Fluid intake must be kept up to 2500-3000 cc. daily and an output record kept. Alkali should be furnished to render the urine alkaline (10 grains of bicarbonate of soda with each dose of sulfonamide). Urine examinations for crystals and frequent blood counts should be done. A blood level of 12 to 14 mg. of sulfonamide per 100 cc. of blood is considered optimum. Streptomycin may be very helpful in some of these stubborn mixed infections as it will control the intestinal organisms; 125 mg. may be given intramuscularly every three hours for five to seven days (one gram daily). Alkalinization of the urine is recommended except where renal calculi are suspected.

We have not mentioned surgery so far in the treatment of either of these acute conditions. Abscesses of Bartholin's glands must be incised and drained. An acute tubo-ovarian abscess

which points through the vagina must be drained by colpotomy. Aside from these conditions, with the possible exception of certain cases of spreading peritonitis which are not yielding to conservative treatment, it must be stated definitely that surgery has no place in the treatment of acute pelvic inflammatory disease. In these days of early ambulation following surgery, the treatment of infection stands out as being an indication for bed rest. Avoidance of pelvic examinations, douches, coitus, enemas, etc., plays an important part in allowing infection to localize and subside. Occasionally hemorrhage will force the removal of partially extruded placental fragments with blunt forceps, but dilatation of the cervix and curettage should be avoided until all evidence of infection has gone. Observation of temperature, red and white count, and especially blood sedimentation rate may be very helpful in determining the safe time if surgical interference is necessary.

The third type of pelvic inflammation to be mentioned is the subacute or chronic type due to tuberculosis. This infection in pelvic organs is felt to be secondary to a portal of entry elsewhere in the body, that is, via pulmonary, gastro-intestinal, or urinary tract. This is of two types—secondary to generalized tuberculous peritonitis, or due to a hematogenous spread to the walls of the fallopian tubes. Pelvic tuberculosis is then primarily tubal tuberculosis (70 per cent +), later endometrial tuberculosis (30 per cent of the 70 per cent), and rarely cervical tuberculosis (5 per cent of the 30 per cent). It is a descending infection and is often rather silent considering the extent of the pathology when the tissues are examined. The occasional patient who is curetted for irregular bleeding may prove to have tuberculous endometritis. If this is the case, further study will reveal tubal disease.

Pelvic inflammatory disease which fails to yield to ordinary treatment should cause one to suspect tuberculosis. Salpingitis in a vaginal individual should be considered tuberculous until proven otherwise. Pelvic endometriosis may be difficult to differentiate, as both conditions are accompanied by sterility and dysmenorrhea.⁷ Greenhill states that if all fallopian tubes which are removed surgically were examined microscopically, the incidence of tuberculosis would be found to be about 5 per cent.⁸ The treatment of this condition will depend on the presence or absence of tuberculous infection elsewhere in the body.

The advent of streptomycin to our list of therapeutic substances has produced some hopeful results in tuberculous infections in general. Gen-

eralized peritonitis due to tuberculosis would seem a logical indication for the use of this expensive and not entirely harmless drug. Prolonged or excessive dosage may produce any of the following reactions:⁴ (a) histamine type, flushing, headache, abrupt fall in arterial blood pressure; (b) anaphylaxis; (c) neurologic disturbances, as vestibular dysfunction and deafness; and (d) renal irritation. If the use of streptomycin is contemplated in a case of tuberculosis, plans must be made for prolonged daily administration for three to four months, in divided doses of 125 mg. every three hours, or a total of one gram daily.

At present we are observing a negro girl, 16 years of age, who was admitted with a tense swollen abdomen containing demonstrable fluid. After studies had failed to reveal tuberculosis elsewhere, a small abdominal incision was made and a biopsy of the thickened nodular peritoneum was taken, which revealed tuberculosis. We wished definitely to eliminate ovarian malignancy with metastasis. On streptomycin therapy, the whole process responded very satisfactorily and the enlarged adherent pelvic structures returned to normal mobility. This result has now continued to be satisfactory for a year. She has had bed rest and general care at home during this time, as must all cases of this sort.

In discussing the second type of pelvic tuberculosis where salpingitis is present rather than peritonitis, radical surgery must still be performed for permanent cure. Streptomycin in dosage as above may well be given postoperatively to minimize the danger of miliary spread. It must be emphasized again that no antibiotic will penetrate to the interior of an abscess. Surgery in these cases must always be supplemented by the type of routine used in tuberculosis elsewhere. Streptomycin to date has been of most help in the acute types of spreading tuberculosis rather than the chronic walled-off type of infection. In young women it is often possible to save one or both ovaries when panhysterectomy and bilateral salpingectomy must be performed.

The fourth type of inflammatory disease which I mentioned as the recurrent group may be due to all sorts of bacteria. Reinfection in Neisserian cases is a very common cause of chronic cervicitis and salpingitis. One attack certainly produces no immunity against the next one. Once the tissue resistance is lowered by infection of any kind, secondary invaders from the vagina and colon take hold and cause permanent destruction of tubal mucosa and muscular layers. The blood vessels and lymphatics supplying these damaged tissues become congested and infected.

The infection ceases to be confined to the uterus and tubes and extends to supportive structures and adjacent organs. The patient becomes incapacitated by recurrent acute attacks of her chronic pelvic inflammation and congestion. Adhesions cause distortion and interference with function of the urinary tract, bowel, and genital tract. The ovaries become adherent to the inflammatory masses due to invasion by bacteria at the site of ovulation. As more tissue is destroyed, function is interfered with and irregular, often profuse, bleeding results. The presence of myomata or true ovarian neoplasms may complicate the picture.

In the patient with recurrent symptoms transient relief may be afforded by rest, sedation, sulfonamides, and diathermy. However, she is prone to flare-ups under conditions of strain of any type. In this condition, where permanent destruction of tissue has occurred with formation of pyosalpinx or hydrosalpinx, surgery offers the only permanent relief. The degree of involvement, the age and condition of the patient will determine the extent and type of operation used.

One must remember that reinfection usually comes up from the cervix. While there is continuity between the tubes and uterus and cervix there is the possibility of recurrence of symptoms. Dr. Falk at Harlem Hospital designed an operation to interrupt this continuity by excising the uterine cornua in cases with severe inflammatory disease and adhesions.⁵ This appears to benefit a number of patients who are poor operative risks. However, several cases seen at Philadelphia General Hospital have had recurrent symptoms in spite of this operation. In selected cases it may be a very useful procedure.

In general, one should prepare the patient properly for operation with the aid of adequate blood transfusions, vitamins, diathermy, rest, penicillin, and sulfonamides. Occasionally, even in the chronic cases, operation may be avoided.⁶ Hysterectomy, salpingectomy, and oophorectomy as individualized by age and local condition will offer the best permanent results. Surgery in pelvic inflammatory disease is really an admission of defeat, but is our only final help in these recurrent cases where actual destruction of tissue and distorting adhesions are present. If prompt, thorough, and persistent treatment could be given to each acute case, the chronic situation could be largely prevented.

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ABSTRACT OF DISCUSSION

ROBERT A. KIMBROUGH (Philadelphia): Dr. Pettit is to be commended on her excellent presentation of the present status of therapy of pelvic infections. It is concise, clear, and, to my way of thinking, absolutely sound. With her division into types based on etiology there can be no disagreement. In her discussion of gonorrheal infection, the high incidence (13.8 per cent) of positive cultures among consecutive admissions to a gynecologic clinic was impressive. When one bears in mind that rarely more than 50 per cent of chronically infected patients yield positive cultures, one must conclude that approximately 25 per cent of clinic patients are probably so infected. Dr. Pettit's plea for early diagnosis and treatment of this large group is properly well emphasized. We are in complete agreement with the efficacy of penicillin therapy in the early acute cases, particularly in those in which the infection is limited to the lower genital tract. Too much cannot possibly be said concerning the absolute necessity of avoiding local manipulation and local treatment.

Even in acute gonococcal infection of the upper genital tract, particularly in first attacks, complete anatomic and functional recovery can be reasonably expected following the treatment which Dr. Pettit has detailed. Indeed, even before the advent of penicillin, normal pregnancy has been observed following the subsidence of large bilateral adnexal masses. This fact re-emphasizes that ablative surgery has no place in the treatment of acute gonococcal infection.

The pyogenic infections, most commonly due to some form of streptococci, have been well discussed from the standpoint of etiology, prophylaxis, and treatment. In these days of specific antibiotic therapy, most of these infections are aborted early, so that one rarely finds it necessary to drain collections of pelvic pus.

The speaker has had no occasion to observe the effect of streptomycin in tuberculous pelvic infection. The case which Dr. Pettit cited is, however, most encouraging for the relief of these previously pitiful cases.

Again, I agree with Dr. Pettit that surgery in the treatment of pelvic inflammatory disease has its only place in the so-called chronic or recurrent type of infection. In cases in which the damage to the adnexa is extensive, including the formation of large tubo-ovarian abscesses or cysts, nothing short of radical surgery will effect rehabilitation of the patient. The same is true also in cases complicated by benign or malignant neoplasm. In the younger patients, however, I feel very strongly that ovarian conservation should be practiced whenever reasonably possible, giving due thought of course to the preservation of blood supply to the remaining ovarian tissue.

During the past two years I have become guardedly enthusiastic over the Falk procedure which Dr. Pettit has described in her presentation. This procedure is utilized in younger women whose adnexal masses are

not large and whose inflammatory condition is not complicated by neoplastic disease. It is our custom not to perform the operation until the patient has had at least two courses of conservative non-operative therapy. During the past two years on my service at the Graduate Hospital we have performed this operation in 44 cases. In 20 of these the masses have either completely disappeared or are decreasing in size. In 22 there has been no palpable change in the size of the adnexal mass. In 2 cases the masses have enlarged but the symptoms

have not been sufficient to warrant reoperation. The only untoward symptom which we have encountered has been an unexplainable increase in mid-line dysmenorrhea in 8 cases following the operation. All but two of these 44 patients have been either relieved or greatly improved following operation, and psychologically they are definitely better than those patients who have had all of their pelvic organs removed at an early age. My senior resident, Dr. Charles Freed, will report this group of cases in detail within a short time.

THE A.M.A.—A UNION

Mr. Becker, we are glad you came to Kansas to tell our society what your United Automobile Workers want in the way of medical care. Much of what you said is true, and your willingness to discuss your needs will certainly make future negotiations between your group and ours easier.

But there are some words which you and we do not understand alike and those should be clarified in the beginning. For instance, you said the A.M.A. is a union just like the C.I.O. Perhaps we fail to understand your union, but we can tell you about ours. Then you decide if there is a difference—or if you still consider us a union at all.

In its 100-year history the American Medical Association has raised the standards of its members, but along different lines than yours. Our union has shown little if any interest in shortening our hours or in raising our income. Our union has made it increasingly difficult for us to join, requiring high educational standards for admittance. Now, this is not aimed to benefit us; it is done for the benefit of our employers. Our union can now guarantee that we are qualified for our job, which assures the prospective employer that our work is dependable.

Our union also inspects the tools with which we work. We are regularly instructed in the proper use of these tools so they will be safe. Yes, we stress safety as constantly as you do, but there is a difference. Our union demands safety for our employers, not for ourselves. Not only that, but we constantly search for more efficient tools. You might call these labor-saving devices. They reduce the work we need to do, and we regularly replace our tools for others that are better. Again that is done to benefit our employer—it is not directed to aid us.

In fact, the union that is the A.M.A. constantly suggests ways to prevent the need for our services and to shorten the term during which our work is necessary. This is a saving to our employer both on a unit cost basis and in terms of increased production.

The medical trust, as you called it, has never staged a strike nor a slow-down at any time, neither for shorter hours, for better working conditions, nor for higher pay. And when long periods of overtime are required, more often than not without overtime pay, during war, in an epidemic, or at the scene of a disaster, we have continued to work because we believe our services to be necessary.

There is another difference, too. Our union spends much of its time studying ways in which our services

can be obtained more economically. You will call this collective bargaining, but we contract with our employers, the laborer you represent, the farmer, the merchant, on a basis whereby he may obtain more efficient work at less cost. We are earnestly endeavoring to safeguard him against the hazards of unexpected expenses through prepayment plans. That again is a union activity directed toward giving the employer more for his money.

And our opposition to programs of federal compulsory tax-supported plans is not, as you said, selfish. The record in nations where this has been tried proves its inefficiency, and even if we try to profit by the mistakes made elsewhere, the government of the American people has, you will surely agree, not distinguished itself in recent years for economy. We want to give you the best service in the world at a cost that will not disturb your economic welfare. We are perfectly willing to negotiate with you on this point, but we know neither goal can be achieved under government direction. So in that realm our union has again spoken out for us, but once more in your own defense, not ours. The A.M.A. is interested in health legislation, but it is your health rather than ours that has prompted this interest.

So you see, Mr. Becker, our union works toward increasing our efficiency so our employer may realize greater profits of his own. We would rather regard our union as partners with your union and all persons in this nation. We believe that we can help you achieve some of the goals you seek, that when your economic conditions are good, ours will be good too, that this practice will make ours a stronger and a better nation of free men than we have been before. Therefore, our efforts are directed toward those fields.

Now, Mr. Becker, if these are proper ideals for a union, then we are a proper union. It not, then surely one of us is wrong either in our philosophy or at least in our understanding of the word union.—*The Journal of the Kansas Medical Society.*

"We know beyond question that when the American people understand the issues and learn the facts about compulsory health insurance, they will reject it. But our primary job is not so much to prove our case against socialized medicine as to make our voluntary program work so well that all our fellow-citizens will join us in defending it."—J. HOWARD HORNBARGER, M.D., president, The Medical Society of New Jersey.

Recent Trends in Enucleation: Modern Implants and Prostheses

BENJAMIN F. SOUDERS, M.D., Sc.D.(Med.)

Reading, Pa.

ALTHOUGH the history of the surgical removal of eyes dates back to antiquity, the surgical procedure as it is considered today is of fairly recent origin. Thus, the first record of enucleation, or the removal of the globe from Tenon's capsule, had its origin in 1841. The next advancement was the report of evisceration in 1872, following which implantation of a foreign substance into the scleral shell was reported in 1885, and into Tenon's capsule in 1886 by Frost. From this latter date until our present decade, work on enucleation-evisceration procedures consisted principally in the use of implant objects of the widest imaginable variety, including glass, gold, and silver spheres, charred bone, ivory, cartilage, and others too numerous to mention. Of all the implants which were devised, a surprising number were retained in the orbit, if not within the muscle cone, and practically every one had the objection of imparting but a small portion of the movement of the muscle stump to the prosthesis. That they failed to do so and also that few of them prevented depression of the upper lid fold caused many ophthalmologists to hold the proper opinion that enucleation with implantation produced little or no cosmetic improvement over simple enucleation, and certainly none over evisceration. The lack of progress in this field of ophthalmic surgery could not be attributed to limitations of surgical technique, but rather to the limitations in the prostheses which were available.

The history of ocular prostheses, in common with that of surgical eye removal, also dates back to ancient times, but credit for a prosthesis which had some semblance to the device used in the present day is ascribed to Ambroise Paré. Paré reported on the use of shell prostheses of enameled gold to cover disfigured or shrunken eyes in 1575. The modern glass prosthesis received its fullest development in France and Germany during the latter half of the 19th cen-

tury and culminated in the development of the reform eye by Snellen in 1898. This prosthesis was simply a hollow meniscus of glass which, to some extent, lessened the sinking of the upper lid fold and the irritation of the conjunctiva observed with the shell prosthesis, but resulted in little or no improvement in the movement of the artificial eye.

Progress in enucleation was, therefore, at a standstill during the first forty years of the present century, owing to the limitations inherent in glass as the medium for the prosthesis. The disadvantages of the glass prosthesis are not only limited to its restricted form, but its fragility and susceptibility to chemical erosion by lacrimal secretions also make it an appliance which necessitates replacement within a period of several years at the most.

With the advent of the "age of plastics," attention was drawn to these agents as a medium for the artificial eye. Desultory efforts in this direction were made by commercial artificial eyemakers around 1940, but it was not until 1943 that a serious effort was begun to produce plastic prostheses. At this time a critical shortage of glass prostheses for civilian needs existed in this country owing to the wartime loss of certain basic ingredients of the artificial eye which had almost secret and exclusive origin in Germany before World War II. Demands for prostheses by the military services of our country had also begun at this time and were increasing rapidly. The Army, in particular, soon faced the problem of replacing prostheses in limited-service personnel and of obtaining initial prostheses for eye casualties from civilian stocks and facilities which were totally inadequate.

To overcome this problem, study was begun by several dental officers of the Army in the fabrication of artificial eyes from plastic compounds, and resulted in a concerted effort by three of them¹ at Valley Forge General Hospital to train dental officers and technicians in the making of satisfactory ocular prostheses. A tech-

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nique was devised and implemented whereby a dental technician could be trained within a thirty-day period to produce highly acceptable plastic ocular prostheses. Within one year of the outset of this project, more than 7500 custom-made prostheses had been created, and the technique was later adopted by commercial interests to produce the plastic prostheses which are currently available.

The technique of fabricating a plastic ocular prosthesis is beyond the purposes of the present discussion. Suffice it to say that a plastic compound, methyl methacrylate, which includes a suitable pigment to match the scleral color is made into the desired form by pressure-molding. A hand-painted disk is then placed into a recess created in the basic form to imitate the iris, and rayon filaments are placed on the scleral portion to simulate blood vessels. The entire front surface of the prosthesis is then covered with clear plastic and a final pressure-molding completes the process.

The advantages of the plastic prosthesis over its glass counterpart are its permanence with regard to color and surface, its virtual indestructibility, its high tissue tolerance and, of most importance, its adaptability to any contour or cavity. Whereas the glass prosthesis is limited in its shape and, when completed, is unalterable, the plastic prosthesis can be fabricated into any form desired and this form can be altered at any time by simple machining or remolding to compensate for subsequent variations in the socket. It is the adaptability and versatility of the plastic ocular prosthesis which has, I believe, largely contributed to, if indeed has not made possible, the new techniques for enucleation which have gained recent attention among ophthalmologists.

The first and undoubtedly the boldest departure from the accepted methods of enucleation at the present time was introduced by Ruedemann.² At the 1945 meeting of the American Ophthalmological Society, Ruedemann first described a procedure in which a plastic eye implant was inserted into Tenon's capsule. This implant was secured by the use of tantalum paddles which were sutured to the rectus muscles in the case of enucleation, or to strips of Tenon's capsule for delayed implant procedures. The operation was concluded by suturing the conjunctiva to cover the muscles or strips of Tenon's capsule.

Extrusions and deviations of the eye implant were numerous with this procedure, owing to the dubious attachment of the tantalum paddles to the implant, and discoloration of the iris resulted from the erroneous use of vegetable dyes. Ruedemann later revised the implant by adding a

tantalum meshwork to its buried surface to which muscles, Tenon's capsule, and conjunctiva were sutured. Although the improved implant resulted in fewer extrusions and deviations, the technique of implanting a total prosthesis has not received widespread acceptance, but the value of Ruedemann's pioneer work has been considerable in that it has proved that partially imbedded implants are capable of retention in an orbit for a period of several years, at least, and probably indefinitely. This fact has probably been responsible for the exploitation of somewhat kindred procedures which will be referred to later.

The second radical departure from standard enucleation procedures to be reported in recent years concerns a basket type implant which was first employed by Cutler³ at an Army eye center in 1944. This implant was fashioned from methyl methacrylate in the form of a cup, 15 mm. in diameter and 11 mm. deep, having several large fenestrations to allow for the ingrowth of fibrous tissue and two small openings to accommodate a suture. The purpose of this procedure was to produce a cup-like depression in the center of the stump into which a prosthesis with a posterior projection or stud was attached, resulting in a fairly intimate coupling of the muscle stump with the prosthesis. This procedure resulted in considerable improvement in the total range of motion of the prosthesis and, of possibly greater importance, in almost instantaneous response of the prosthesis to the movement of the muscle stump. This latter factor represented a distinct advance over the spherical type of implant, in which the smooth convex face of the muscle stump moves appreciably before such motion is translated to the smooth concave posterior surface of the conventional prosthesis.

In reporting on his first fifty cases in which the new implant was employed, Cutler noted an increase in prosthesis motion from 34 arc degrees with the sphere implant to 50 arc degrees with the basket implant in the horizontal plane; in the vertical plane these figures averaged 40 and 59 arc degrees, respectively. Still another advantage of the basket implant over its spherical counterpart was the fact that once it was secured within the muscle cone it showed no tendency to migrate, owing to the firm anchorage resulting from the invasion of fibrous tissue through the fenestrations in the implant.

The complications arising from the use of the basket type implant were similar to those encountered with other implants, the most disturbing of which was exposure of the implant necessitating its eventual removal. It was felt, however, that successful implantations were guided

by the same considerations which are followed when using the spherical implant, of which the *sine qua non* is the proper closure of Tenon's capsule.

Several disadvantages were observed in a fair percentage of basket implant enucleations which must be mentioned here. The most important of these lies in the inherent lack of volume of the implant to replace the volume lost from the orbit when an eye is enucleated. Because of this fact, depression of the upper lid fold was seen more commonly with this procedure than with the spherical implant. A second disadvantage was found in the occasional obliteration of the desired cup in the muscle stump by granulation tissue formation, thus mitigating to some extent the purpose of the procedure. There was also noted delayed erosion of the basket rim through Tenon's capsule and conjunctiva in apparently well-executed operations, necessitating the removal of the implant. In spite of these disadvantages it is felt by some that the basket type implant for enucleation is worthy of continued investigation. With some modification, especially to provide volume replacement by addition of a posterior spherical projection, the procedure may yet become a standard practice. Interest in it has waned, however, in deference to the consideration of semi-buried implants which were inspired by Ruedemann's work, mentioned previously.

Among the first of the so-called integrated or positive contact, semi-buried implants was a ball and ring type reported by Cutler⁴ in 1947. The basic design of this implant comprised a plastic sphere, 20 mm. in diameter, narrowed anteriorly to permit the incorporation of a metal ring for attachment of the rectus muscles. The anterior face of the implant was flattened and in its center a depression was created to accommodate a metal pin which was attached to the posterior surface of the prosthesis.

The technique of the operation, although somewhat painstaking, requires little more effort than a well-executed Frost-Lang procedure. Enucleation is accomplished in the usual manner, care being taken to expose and secure the rectus muscles with temporary sutures. After proper hemostasis, the implant is inserted and the rectus muscles are looped under and over the metal ring, being secured by a 000 black nylon mattress suture which attaches the muscle to its overlying tendon. Five to eight double-armed 6-0 black silk sutures are then employed to wrap the conjunctiva and Tenon's capsule over and under the ring by entering these tissues from without-inward and after looping the sutures around the

ring directing the needles through Tenon's capsule and conjunctiva from within-outward, several millimeters from the ring. The foregoing procedure results in complete coverage of the ring, leaving the anterior face of the implant exposed. The socket is usually sufficiently healed to allow the fitting of a prosthesis after eighteen to twenty-one days.

The cosmetic results in cases where this procedure has been successfully employed have been startling. Rotations of the prosthesis closely approximate the limits of movement of the normal eye and movement is virtually simultaneous with the normal eye.

In Cutler's original report 22 ball and ring implant operations were performed. Of these, six implants had to be removed—some because of defects in construction of the original implants, and some due to release of muscles from their attachment to the ring, and exposure of the ring. One implant was also removed when orbital cellulitis developed six months after enucleation in a patient who developed mild pneumonia.

It was found impractical to resuture tissue once exposure of the ring had begun. It must also be stated that the procedure was usually doomed to failure if extensive scar tissue or extreme disorganization of the globe was encountered at the time of enucleation.

Later modifications of the ball and ring implant have overcome some of the initial obstacles encountered and, in spite of the apparently precarious attachment of the tissues to a ring, this type of procedure has a number of advocates, notable among whom is Hughes,⁵ who has fashioned implants in vitallium which are applicable to immediate as well as to delayed implantation. But it must be admitted that the ball and ring type of implant has, in general, lost favor lately.

Recent efforts with semi-buried, positive-action implants have inclined toward the use of a tantalum meshwork imbedded in the anterior half or third of the plastic implant to which muscles, Tenon's capsule, and conjunctiva are sutured, or the latter two structures in the case of delayed implantation. At least two such implants are now available commercially and are apparently being used with increasing favor as experience with them widens.

Since some of the procedures which have just been noted have now been successfully used in sufficient numbers to be considered practicable, their advantages should be explored by ophthalmologists in general. Enucleation should no longer be considered a minor, routine operation, and enucleation with spherical implantation fol-

lowed by the fitting of a conventional prosthesis should not be regarded as our best effort, if thought is given to these newer procedures.

Skeptics may justifiably argue against the new techniques which have been mentioned here on the basis of frequent extrusions of implants. In answer to this criticism, the proponents may well rebut by stating that the now occasional loss of an implant leaves a socket which is little, if at all, worse than the best result obtained with a spherical implant, from a cosmetic standpoint. The proposition of a permanent, semi-buried foreign object in the socket might also be considered anathema to sound surgical principles by other critics of these procedures. The answer here is to be found in actual clinical experience. Several hundred semi-buried implants have now been used and, to my knowledge, only one case of orbital cellulitis has been seen, and in this case there was no evidence to suggest that the origin of the infection was in the conjunctival sac.

Conclusion

In closing, it is desired to affirm the basic theme of the present discussion, namely, that the use of modern implants in conjunction with appropriate plastic ocular prostheses has achieved cosmetic results only rarely, if ever, attained by the conventional procedures which have commonly been employed in enucleation. Although the period of observation is too brief to warrant unqualified claims, the results with some of the newer procedures are sufficiently encouraging to merit their earnest consideration by all ophthalmologists.

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ABSTRACT OF DISCUSSION

P. ROBB McDONALD (Philadelphia): Dr. Souders has reviewed the development of the latest types of ocular prostheses. I am only sorry that time did not permit a discussion of some of the operative procedures. Dr. Souders was fortunate enough to be working with Dr. Cutler when the basket and ring implants were first developed and I am sure that there are many points concerning the operative technique that should be clarified. During the past two years I have used a Kennedy modification of the basket implant or a Cutler implant in 9 patients. Early in the series I had two partial extrusions which necessitated removal of the implant. During the same period of time I have seen a fairly large number of modified Cutler implants used at the Valley Forge General Hospital. In the great majority of the cases the results could be classified as excellent.

As in the past, there are two types of operation available—the placing of an implant in the sclera, or the placing of an implant in Tenon's capsule and attaching the muscles to the implant. Both procedures have their indications and are fairly easy to perform. As in any new operative procedure, there are certain little knacks, such as controlling hemorrhage, the freeing of the muscles, the placing of sutures, lubrication of the conformer, etc., that make subsequent operations easier to perform and the results more certain.

The enucleation procedure is now going through the same stage of development as did the use of sutures in cataract surgery about ten years ago, or muscle operations did the decade before that.

No one can deny that the movement obtained when the prosthesis is attached directly to the implant is well nigh perfect. Time only will tell, however, whether we are justified in this more radical procedure. The leaving of an exposed foreign body in an area that is so frequently found to be contaminated is certainly not a sound physiologic procedure. Final judgment must be withheld until we know the extrusion rate, the incidence of infection, and other complications that may arise. Until that time, however, I think we can look forward to as many different types of implant as there are operations for the correction of heterotropia.

President's Reception

The annual President's Reception and Dance honoring the president and president-elect will be held Wednesday evening, September 28, at 9 p. m., in the Pittsburgh Room of the Hotel William Penn. This will be the outstanding social event of the meeting. Formal dress is optional. Music will be furnished by Baron Elliot and his WCAE Orchestra. Tickets may be secured by using the reservation blank on page 1232.

RETROPUBIC PROSTATECTOMY

A Critical Evaluation of the Newest Approach to the Prostate

ANTHONY F. KAMINSKY, M.D.

Erie, Pa.

IN JULY, 1947, Mr. Terence Millin of London visited our clinic in Erie and masterfully demonstrated his technique of prostatectomy by the retropubic method. Since then, we have performed this operation sixty-five times. However, we are reporting on the first 50 cases because they have been done long enough to properly evaluate results.

The earliest references to suprapubic extravesical prostatectomy are the accounts of von Stockum of Rotterdam in 1909. Otto Maier of Innsbruck reported a series of 4 cases by the inguinal route in 1924. In 1934 Jacobs and Casper, in America, reported a case.

In 1945 Mr. Millin cast light into the dark cave of Retzius and began attacking the prostate by this method. Terence Millin deserves the credit for developing this particular technique and popularizing the operation in England, the Continent, and in the United States.

Technique

For the most part, we have attempted to follow the technique of Millin. However, in some instances, we have made variations in the type of incision in the prostatic capsule.

The bladder is emptied by catheter drainage. Bilateral section and ligation of the vas deferens is carried out. Either a transverse or longitudinal mid-line incision is made above the upper border of the symphysis pubis. The aponeurosis is incised and the muscle fibers are separated.

By means of finger dissection, the transversalis fascia is opened and the prevesical fat is drawn upwards, opening the space of Retzius. A self-retaining retractor is introduced. The retropubic space is now open, and inspection should be made for veins lying on the prostatic capsule. These are clamped, cut, and controlled by coagulating current applied to the hemostat.

The anterior aspect of the prostatic capsule

can now be cleansed of adherent fat, and a small gauze pack introduced into the recess on either side of the prostatic capsule. (We seldom employ these packs now.) A sound may be passed through the urethra.

One centimeter below the vesical neck, a transverse incision is made through both prostatic capsules, exposing the adenoma. Small vessels in the edges of the prostatic capsule are clamped and coagulated.

Varying amounts up to 20 cubic centimeters of a solution containing 2 per cent procaine, one cubic centimeter of adrenalin, and one cubic centimeter of pitressin are injected into the lateral prostatic lobes. This combination acts as an operative hemostatic. It is not used on hypertensive or cardiac patients.

The edges of the capsule are freed from the gland by means of curved scissors and the finger. The urethra is cut across at the distal end of the adenoma with curved scissors. The enucleation is continued by digital dissection and the adenoma is freed except for its attachment at the bladder neck. Each lateral lobe can be separately delivered from the capsule. By means of scissor dissection, the curved fibers of the bladder neck are freed from the gland and the adherent mucosa is cut across and the mass removed.

A temporary pack is then inserted into the prostatic fossa. A careful inspection is made for any remaining adenoma (small), loose tags, or bleeding points. The bladder is palpated with the finger and inspected by means of a spreader inserted into the vesical neck.

A V-shaped wedge is removed from the posterior bladder neck for patency and to prevent subsequent constriction at this point. Occasionally, when oozing is annoying and persistent, an oxycel pack is inserted into the prostatic bed.

A Robinson catheter is now inserted into the urethra and guided through the bladder neck. The prostatic capsule is closed with continuous chromic catgut, a boomerang needle being used. At this point, the bladder is inflated with water

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and the suture line is observed for leakage because a watertight closure is desirable.

A soft rubber tissue drain is inserted into the prevesical space. The rectus sheath is closed with interrupted chromic catgut and the skin edges are approximated. The catheter is irrigated to insure patency and free drainage.

Variations in Incision in Prostatic Capsule

In addition to the type of incision in the prostatic capsule advocated by Mr. Millin, we have opened the capsule by various incisions.

The T type of incision has been used. After the original transverse incision has been made in the prostatic capsule, it is followed by a mid-line vertical incision extending upwards from the transverse incision through the bladder neck.

An inverted T incision has also been employed. Here the initial transverse incision is made through the bladder neck; then a vertical incision is carried downwards in the mid-line of the prostatic capsule between the vessels. A suture is placed at the lower end of this incision to prevent tearing during the enucleation. This offers excellent exposure, facilitates enucleation of the adenoma, and prevents some of the bleeding encountered in the incision used by Millin. These incisions have healed well and good functional results followed their use.

In 2 cases where exposure revealed a hard and indurated gland, undoubtedly carcinoma, the entire mass, including the posterior capsule and portions of the seminal vesicles, was removed down to the rectal wall. Virtually a total prostatectomy was achieved. Much to our surprise, these patients made an uneventful recovery with perfect urinary control.

Postoperative care is relatively simple. The catheter is fastened to a drainage bottle and irrigated only if obstructed by clots. The urine is often clear or only tinged with blood on the second day. The catheter is usually removed from three to six days postoperatively, but has been removed as early as twenty-four hours. The average has been five days. If there is any appreciable suprapubic urinary leakage, the catheter may be inserted for a longer period.

CATHETER REMOVED

No. of Cases	Postoperative Day
1	1
3	7
4	3
5	17
6	6
7	7
10	3
14	1
Average—five days	

Early ambulation is desired and the patient is frequently sitting on the edge of the bed in twenty-four hours and out of bed on the third day.

We have not discharged our patients until the wounds are dry and well healed and good urinary control has been established. Some patients have been discharged on the ninth or tenth day. The average postoperative hospital stay of all patients has been 15.1 days.

Review of Results in First 50 Cases

In an endeavor to arrive at a true evaluation of the operation, its applications and results, the patients were not selected and the operations were performed on all types of prostatic enlargement.

The patients varied in age from 55 to 94 years. The average was 71.4 years.

AGE OF PATIENT	
Age	No. of Cases
55-60 years	6
60-69 years	12
70-79 years	26
80-89 years	5
90 years	1
Average age—71.4 years	

A number of patients were decidedly poor surgical risks. Three were admitted in severe to moderately severe cardiac failure. Four were known cases of diabetes mellitus. One patient had carcinoma of the stomach, operated upon previous to prostatectomy; one patient had a tumor of the spinal cord, removed following prostatectomy; one patient had bilateral infected calculous hydronephrosis. Nine patients exhibited bilateral hydronephrotic changes with varying degrees of serious renal impairment.

The glands removed varied in type and size from 17 to 180 grams; the average adenoma weighed 55.7 grams. Pathologic examination revealed malignant changes in three of the glands.

WEIGHT OF PROSTATIC TISSUE REMOVED	
Grams	No. of Cases
19	5
20-39	12
40-79	23
80-180	10
Average—55.7 grams	

Postoperative Hemorrhage: This has not proved to be a troublesome problem. Only 2 cases required evacuation of a moderate amount of blood clots from the bladder within the first twenty-four hours. There were no cases in which bleeding was persistent enough to warrant surgical intervention. To our knowledge, there have been no cases of secondary hemorrhage.

COMPLICATIONS FOLLOWING OPERATION IN 50 CASES

	No. of Cases
Postoperative hemorrhage	2 mild
Incontinence	0
Suprapubic fistula	0
Phlebothrombosis	2
Urosepsis	1 mild
Epididymitis	4*
Urethral stricture—vesical neck obstruction	0
Osteitis of the pubis	0
Postoperative loss of sexual potency	0
Mortality	2

* None since bilateral section and ligation of the vas deferens.

Incontinence: No cases of permanent incontinence were encountered. Practically all patients had full urinary control at the time of hospital discharge. The majority of patients had immediate control following removal of the urethral catheter.

Suprapubic Fistula: There were no permanent suprapubic fistulas following this operation. Two patients were discharged with a slight amount of suprapubic urinary leakage which stopped very shortly and the wounds healed completely.

Urosepsis: We had no serious cases of postoperative sepsis. While 17 cases had urinary tract infection previous to surgery, all were controlled and presented no serious postoperative problem.

There were 2 cases of phlebothrombosis of the lower extremities. Treated with anticoagulants, one of these patients developed pulmonary infarct, but recovered and was discharged in good condition.

Epididymitis: Relatively early in the series, 4 cases of epididymitis occurred. Since then, we have routinely performed bilateral section and ligation of the vas deferens before operation on the prostate and we have not been plagued with this distressing complication.

Stricture: Follow-up studies did not reveal any case of postoperative stricture or vesical neck constriction. The patients demonstrate good forceful streams and remarkably clear urine. The residual urine in follow-up studies has been practically nil and has never exceeded one ounce.

Sexual Potency: There are no known cases of loss of sexual ability following the operation.

Phlebothrombosis: Two cases occurred. One followed an acute epididymitis and was associated with pulmonary infarct. Both patients were treated with anticoagulants and both recovered.

Osteitis of the Pubis: This condition following retropubic surgery has been reported by some operators. Thomas D. Moore, Lawrence Lovalle, and Frank C. Hamm reported cases of this distressing complication following retropubic prostatectomy. It is characterized by pubic tenderness and pain, particularly in the adductor muscles. Its onset may be anywhere from two weeks to five months following surgery. We have not seen this complication in any of our cases to date.

The exact etiology of this condition is obscure and the modus operandi of the process occurring to produce this entity is not clearly understood. But, in an attempt to avoid it, we have been exceedingly careful not to pierce the periosteum with the needle or to traumatize it with retractors. In applying the coagulating current to the hemostat, care must be exercised so that the instrument does not contact the bone. In extending the fascial incision downwards, care should be taken not to open the fascial planes too close to the pubic bones. We have also refrained from packing the prostatic fossa too snugly with gauze to prevent undue trauma to the nerves and vessels in the area. Adequate drainage is considered important; the rubber tissue drain is permitted to remain from four to six days.

Deaths: There were two fatalities in the first 50 cases. The first patient to die was a 67-year-old man, who died on the fourteenth postoperative day as the result of severe lobar pneumonia of the right lung. The skin had healed and he was voiding with complete control. At autopsy, in addition to the pneumonia, a subcutaneous abscess was found at the site of incision, lying between the skin and aponeurosis.

The second patient who died was admittedly a very poor surgical risk, but our previous results with this operation prompted us to attempt retropubic surgery in this instance. He was a 78-year-old patient admitted in cardiac decompensation with marked generalized arteriosclerosis. Urologically, he had poor renal function with a large obstructing gland. He was operated upon after twenty-one days of catheter drainage and general systemic preparation; 130 grams of tissue was removed. His early postoperative condition was encouraging and he was sitting on the edge of the bed on the third postoperative day. However, he began to fail and died on the eighteenth postoperative day of bilateral basilar pneumonia and cardiac decompensation. His wound had not healed and the prostatic capsular incision was open. In considering these two fatalities, it would scarcely be fair to indict the operation.

Summary

In our urologic clinic there has been a somewhat uncrystallized point of view on the best surgical approach to the enlarged adenomatous prostate. One member was for many years a champion of the technique of transurethral resection as being preferable in the overwhelming majority of cases. Another was trained in the perineal prostatectomy "school" of the late Hugh Hampton Young. All of us have been impressed with what can now be done by one-stage suprapubic prostatectomy with primary vesical closure. The present recapitulation of results in our first 50 cases of retropubic prostatectomy represents an earnest effort to evaluate the method in terms of comparison and contrast with the three older and accepted procedures. We now feel sufficiently familiar with the technique to say that it has great value and merits acceptance as a standard procedure. We now feel that the urologist should be proficient in four approaches to the prostate rather than three, and that he will find advantages for each.

Retropubic prostatectomy is not a difficult surgical procedure. It impresses us as technically more demanding than the suprapubic transvesical enucleation, but far less exacting than either the transurethral resection or the perineal exposure. Our resident urologists have mastered it readily and with excellent results.

Clean extirpation of all obstructing tissue is accomplished without difficulty. Here the method is fully as effective as the suprapubic or perineal procedures, and far superior to endoscopic resection. One may predict a very low incidence for "repeat" operations, although it is obviously too soon to quote figures.

Average hospitalization time is short. It is our opinion that only cases of resection make a shorter hospital stay feasible. This is a poor yardstick by which to judge an operation, but as a concession to economics it must be considered.

Postoperative morbidity, on the other hand, is a matter of paramount importance. Prolonged pyuria and urethral strictures are all too common after resection. Incontinence of some degree is an occasional undesirable feature after perineal removal. Fistulas now and then are problems after either the perineal or suprapubic operations. To date, we have seen no trouble on any of these scores after retropubic prostatectomy. Here, it has been our opinion that the retropubic operation offers a prompt and complete return to health, with relative freedom from lengthy follow-ups, treatments, and home medications. We have perhaps been fortunate in having no cases of osteitis of the pubis to deal

with, hence we are not in position to consider this as a drawback.

For the patient who is concerned with sexual potentia, we feel that the retropubic approach has an apparent advantage. It will require a larger series of cases with critical appraisal before we can say that this apparent advantage is real.

As a procedure to be utilized as a "repeat" operation, we have had troubles in exposure. In general, we are not disposed to favor this route in these cases when either endoscopic resection or suprapubic transvesical exposure can be employed. Likewise when diverticula, calculi, or vesical neoplasms are to be considered, the extra-vesical approach is undesirable. When suspicious nodules in the posterior lamella are to be removed for biopsy, the perineal approach is the only practical one.

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ABSTRACT OF DISCUSSION

STANFORD W. MULHOLLAND (Philadelphia): A well-known insurance company advertises that the future belongs to him who prepares for it. We are all students at this meeting. We work in our own clinics, we attend meetings, and we discuss these problems, in order to fit ourselves with better tools with which to solve our own problems. I feel that we are doing this in learning more about the retropubic operation.

There are no two prostates exactly alike. There are no two operators equally capable in every field. Medicine or surgery is not a mechanical trade or specialty where a definite sized bolt fits a definite nut. We have fairly well standardized our opinions regarding the treatment of the smaller sized glands and the contractures of the bladder neck by means of the transurethral operation. There are still very capable operators who are treating the majority of the bladder neck obstructions by the transurethral method. However, there are operators who are still using primarily the suprapubic approach for the treatment of the major bladder neck obstructions due to hypertrophy of the prostate. On the other hand, there are those who favor the perineal route. The advocates of all three types of operation have been equally successful and their accomplishments in their most skilled field are envied by the other operators.

Now, we have still another method that can be added to the so-called "enucleation" method of attacking the hypertrophied prostate. I do not think any definite statement can be made as to just which prostate *must* be treated by which method. I dislike dogmatic statements, because I believe they are made to hide the weakness of the individual who is making them or to impress people who do not know their own or the speaker's abilities. I think all three of these operations

are methods that we all must be able to use with confidence and rely on them when the time presents itself. To me this is another tool that has been added to our armamentarium. It is not a tool that lies on the equipment table at the time of the operation, but it is a mental tool to be used before we approach the operating table—used to the best of our ability and where the particular problem presents itself.

Millin, when he first advocated this operation in 1945, said there were drawbacks to three main approaches and that they could be summarized thus:

Suprapubic transvesical operations:

- High mortality (6 to 10 per cent).
- Uncomfortable and often lengthy postoperative course.
- Considerable loss of blood during and after the operation.
- Relatively high incidence of postoperative infection.
- Considerable incidence of secondary hemorrhage.

And the exponents of the perineal operation will even add that there is a persistence of the suprapubic fistula. It is very difficult for me to agree 100 per cent with all the objections made by Millin, and likewise I must say that in some twenty years, doing a great many, almost exclusive suprapubic operations for the larger hypertrophies of the prostate, I have never seen a suprapubic fistula.

Perineal operations:

- Lengthy apprenticeship necessary before competence is acquired.
- Dread sequelae, in the hands of the foremost exponents, namely:
 - Incontinence (9 per cent by Hinman, 5.8 per cent by Goldstein).
 - Urethrorectal fistula.
 - Persistent perineal fistula.
- Difficult nursing owing to the risk of contamination of the wound from the adjacent rectum.

One needs only to discuss with a person who is skilled in the perineal prostatectomy to immediately have him disagree with these statements.

Transurethral resections:

- Difficult procedure in which to acquire proficiency.
- Considerable blood loss when dealing with large glands.
- Frequent persistent low-grade urinary infection.
- Incidence of postoperative urethral stricture.
- Risk of recurrent obstruction due to incomplete removal.

I have no doubt that the advocates of transurethral operations in some of the large clinics would disagree with these statements almost in their entirety. Nevertheless, it is necessary for us to be able to carry out each one of these operations, and I feel that we must familiarize ourselves with the retropubic operations in order to be able to carry them out when the occasion occurs.

My experience with the retropubic operation has been that it lends itself best to the larger gland. Now, as we discuss the problem with the suprapubic pros-

tatectomist and with the perineal enthusiast, they will tell us that "this gland is a large gland, an excellent gland for perineal prostatectomy or suprapubic prostatectomy," depending on the man speaking. In other words, any large gland that has a fine cleavage plane and is an adenomatous structure is easy to enucleate and would lend itself perhaps to any of these methods.

What is it that makes us decide whether retropubic, or suprapubic, or perineal operation is the one of choice? I think this all has to be decided by the size and position of the gland, whether malignancy is suspected, the condition of the patient, and the status and build of the patient; in other words, factors that will tend to make the operation simpler and with less risk to him, considering also of course, the operator's ability to do each individual procedure well. In my experience, operation upon a patient with a thick abdominal wall, even with a large gland, is often best done by the suprapubic method rather than the retropubic. To me it is more difficult to work behind the symphysis than through the bladder, although we have operated upon a fair number of these large glands in thin patients with excellent results.

Complications have been reported rather recently by men who have tried the retropubic operations, particularly Moore, who states that a surprisingly high percentage of his patients have developed osteitis of the pubis. To date we have not seen this; perhaps as more and more are done we will see it, but as we learn to protect the symphysis better, there will be less likelihood of this complication.

There has been one factor in retropubic operations that has been troublesome to me, and that is the problem of bleeding. In the early cases the patients on the immediate day of operation did not bleed more than would a patient with suprapubic prostatectomy, but they did have only a urethral catheter, which was not able to take care of the bleeding as adequately as does a suprapubic tube, and tended to obstruct, thus needing much attention from the house staff. With a wound that is open, containing a fairly large drainage tube, blood and urine can well out and does not obstruct the drainage apparatus. This was a definite problem in our earlier cases; perhaps it is due to our inability or inexperience as yet to control this bleeding as adequately as Millin does. He speaks rather lightly of "buzzing" the bleeders as he sees them in the prostatic bed. In my hands this has not been such an easy procedure as he implies.

Other advocates of the retropubic operation state that it is a finished surgical procedure. "It is done by clean dissection" and is a much finer technical procedure than the suprapubic operation. To me it does not make a great deal of difference whether one makes the incision in the prostatic capsule behind the bladder neck or in front of it to decide whether or not it is a fine technical surgical procedure. If one is going to do the suprapubic operation blindly, through a hole made in the bladder, and enucleate the gland purely by palpation, it does not impress one as being a fine technical procedure. To my mind that is not the way to carry out a suprapubic prostatectomy. I think it should be carried out under direct vision just the same as the retropubic or perineal operation. Those of us who attended the national meeting in Boston this year remember Millin's criticism of Dr. Orr's "movie," in which he showed the same procedure of enucleating the prostate blindly through an incision made in the prostatic capsule in front of the bladder neck.

The operators who criticize the suprapubic operation as not being a fine technical procedure are the same ones, perhaps, who say that one can do Millin's operation without the use of the instruments that he has found to make the operation easier and to make it a better technical procedure. I think his experience should be recognized. If not, those same individuals will ultimately find the same difficulties in the retropubic operation as they have in the suprapubic.

It is an operation that I intend to learn to do well and have the members of my staff be able to do equally well, and I feel that as time goes on we will do more and more of these operations if they prove that the patients have as short a hospital stay and are as free from morbidity as the enthusiasts of this procedure tell us.

PETER P. MAYOCK (Wilkes-Barre): I would like to ask Dr. Kaminsky if he and his associates are selectionists now that they have had experience with 65 cases and all four methods; in other words, what type of gland do they consider is best suited for removal by the retropubic method.

DR. WEINSTEIN (Philadelphia): Between May and June, 1948, we did 11 retropubic prostatectomies. The thing that impressed us was the fact that we did not need any special instruments. We used one of the Bal-four retractors and the instruments that we use routinely.

The smallest gland that we took out weighed 20 grams. We feel that these small glands should not be attacked by this method, but should be removed transurethraly. The largest gland that we removed weighed 110 grams.

This operation has a definite place in urology, but it is our opinion that it is nothing but a perineal prostatectomy in reverse. We who were trained in the "suprapubic school" learned the operation and thought that we had something good. I feel that with this operation we have a definite approach to the prostate where the larger glands are concerned, but not those weighing 20 or 25 grams.

We have had two troublesome hemorrhage cases. One patient was almost exsanguinated on the table, but we considered that due to the fact that we did not stop the bleeding properly. If one sees several blood vessels running across the capsule and they are picked up and fulgurated, most of the bleeding can be controlled.

Another thing we learned is that if you encounter

bleeding when cutting into the capsule, the minute you start enucleating the prostate gland, forgetting the bleeding, most of it will stop when the prostate is removed.

We also tried packing a piece of oxycel on top of the prostatic pouch. Don't ever do that, because you will have fistulas that will persist for two and three weeks. Fortunately, we have had no permanent urinary fistulas. We have been well blessed with postoperative recoveries, and as far as our resident and intern staffs in some of the smaller hospitals in which we work are concerned, they feel that the operation is ideal.

We did a two-stage retropubic prostatectomy, and in our hurry to see what we would find, we made a high incision into the bladder and two weeks later we enucleated the fistula. That is feasible.

DR. KAMINSKY (in closing): In regard to Dr. Mayock's question as to what type of gland is best suited for removal by the retropubic method, I must admit that the small fibrous gland is not technically easy to remove in this manner and we do not believe that the retropubic operation is indicated in this instance. Any prostatic adenoma can be removed by this method, but the larger adenomatous glands are best suited for removal by the retropubic route. The patient with a thick abdominal wall and deep pelvis may give the operator considerable difficulty due to the deep hole through which he is required to work. In some of these cases we have found the suprapubic approach easier.

We find the instruments designed by Mr. Millin for this operation to be of definite value. The first 25 or 30 cases in this series were operated upon without special instruments. However, we consider his instruments very useful. His retractor and boomerang needle are particularly well designed for this procedure.

In regard to troublesome bleeding from the prostatic capsule, I mentioned several variations in the incision made in the prostatic capsule. The T type incision where the original transverse incision is made at the vesical neck and followed with a vertical incision carried down the mid-line of the prostatic capsule avoids most of the vessels. This incision offers excellent visualization and tends to avoid much of the bleeding encountered in the incision advocated by Millin. The use of the hemostatic solution injected into the adenoma, as mentioned in the paper, retards vascular ooze following enucleation.

Technical Exhibit at Pittsburgh

Sixty-six commercial firms will be on hand to present the newest equipment, pharmaceuticals, appliances, books, and foods. The exhibitors have contributed much towards the success of this meeting and a visit to each booth is the one way in which you can show your appreciation. The exhibit will be open Monday from 1:00 p.m. to 5:00 p.m., Tuesday and Wednesday from 9:00 a.m. to 5:30 p.m., and Thursday from 9:00 a.m. to 3:00 p.m.

Psychosomatic Aspects of Nutritional Therapy

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NUTRITIONAL therapy is predicated upon an understanding of biochemical and physiologic functions and psychologic principles. Many external and internal conditions are capable of altering nutritive balance both in health and in disease (Table I). Those conditions which increase nutritive supply to the body, i.e., higher income with subsequent ability to procure more protective foods, or those which decrease tissue requirement, as in cessation of growth, generally have a favorable effect on body nutrition; those acting in the opposite direction, either decreasing the supply of nutrients or increasing the requirements, tend to bring about nutritive imbalance.¹ For example, in shock and severe diarrhea there is a 10 to 25 per cent loss in the total potassium content of the liver.² A decreased supply to the blood serum results, thereby increasing the requirement for that mineral. Unless adequate potassium therapy is instituted as soon as urine output is assured, nutritive imbalance, manifested by neurologic, muscular, respiratory, and cardiovascular signs and symptoms, will occur.

In chronic nutritional deficiency, the type of nutritive imbalance most frequently encountered by the physician, symptoms, external stigmas, and tissue and blood pathology are not necessarily evident, due to the lengthy period of time required for their appearance. Therefore, reliance on present-day laboratory and physical examination procedures and short-term dietary histories is not altogether feasible. In order to obtain a total picture of the patient's nutritional status, the number, type, and relativity of influence of all the various conditioning factors, both in past and present operation, should be evaluated. Clearly, the psychosomatic phase, under consideration here, constitutes only one spoke in the wheel of nutritive balance. However, it is frequently a significant determinant in the etiology of nutritional deficiency. Furthermore, it has important therapeutic connotations in every medical and surgical case.

Nutritional therapy should be designed to fit the specific psychosocial pattern of the patient along with the needs of his medical problem. In effect, this implies a knowledge of "food habits," the individual's motives for selecting and consuming certain portions of the available food supply. Food habits are determined in part by external environmental pressures, income, education, custom, etc., and in part by basic bodily constitution and nutritional behavior (Table II).

Nutritional behavior, or the primary instinctual process of food intake, gives rise to psychologic representations. Since the intermediate phases of metabolism and utilization are entirely internal, they are not capable of such goal-directed reactions. With the onset of deprivation, the organism develops a synchronized tissue need. Animal experiments have shown that after various gland extirpations, dietary levels can be maintained through behavioral changes in the form of food cravings. In clinical experience this is evident also, as in the case of salt craving after partial or total destruction of the adrenal cortex. In nutritive deprivation, tissue needs may be synchronized only after hours, days, or even weeks, due to the large storage capacity for some nutrients and a long gap between intake and output. Before actual tissue change occurs, however, a warning mechanism comes into operation. Through neuronal pathways this warning mechanism is related to anxiety, and it sets off psychologic patterns of instinctual behavior.³ In body nutrition, hunger is the warning mechanism against tissue depletion and appetite is the resultant psychologic response.

Hunger, an unselective phenomenon, and appetite, its selective psychic counterpart, have postulated centers in the brain through which the individual's eating practices are mediated.⁴ Both may be influenced by various drugs⁵ and through specific autonomic nervous activity.⁶ Physiologically, appetite is expressed by means of the sense organs, through the appearance, temperature, odor, texture, and taste of food. The latter may not be an entity in itself, since recent work indicates that taste is a synthetic sense, a combination of touch and a trophic qual-

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ity related to vibration, in which the tongue reacts to sweet, salt, sour, and bitter qualities.⁷

The psychologic superstructure in relation to food intake is subject to many variations. The initial pattern is formed in infancy when psychophysiologic development is so closely allied with the eating process. The infant's first environmental, interpersonal relationship is between his mouth and the source of food supply, whether it be the breast or the bottle. Pleasure and satisfaction are derived from successful and adequate nursing. Sucking brings contentment, while hunger, eruption of teeth, and other lack of oral gratification produce discomfort and tension. Food and the mother are synonymous. She is the object to whom feelings of love and hate are expressed. Thus patterns of emotional attachment can be set up around food. Adequate mothering or feeding supplies a sense of security and the process of weaning can better be tolerated if consistent oral satisfactions have been experienced. Assured of his ability to obtain such gratification, the physical separateness from the mother does not present fearful prospects of isolation and abandonment, but encourages the child to new achievements and increasing mastery of his environment. In time the mouth takes on a new function, speech. However, in many adults, residues of the oral stage of development are retained, though in modified form. These include satisfaction from excessive eating, drinking, and smoking. A flexible attitude toward food usually results if the child has been encouraged to accept new foods. Rejecting or side-tracking them, due often to misguided parental education, may result in poor food habits and possibly in functional disorders, particularly those of the gastro-intestinal tract.

Distinctive features pertaining to food are present in other age groups. In adolescence, both boys and girls are socially sensitive and physically self-conscious. Compulsive eating is often used as compensation for inferiority feelings and lack of social acceptance. On the other hand, in the case of boys, fatness is particularly unwelcome since social recognition is sought through athletic achievements. With girls, fear of obesity is more closely connected with unattractiveness in terms of current cultural ideals. Eating problems at this period are accentuated by hypersensitive taste buds, in the cheeks and throat as well as in the tongue,⁸ and diplomatic handling by the physician is essential.

Imitation of parental attitudes toward food and other childhood associations with food are frequently carried over into adult eating patterns.⁹ Such expressions as "I dislike eggs" or

"I hate milk" can usually be traced back to parental sources, either identification with or hostility toward one or both parents. The transition from a parasitic, egocentric, impulsive infant to a giving adult is not an easy one. Deep in the unconscious there are remnants of infantile resentment pertaining to early feeding experiences. For example, a husband's underestimation of his wife's household duties is usually concerned with food. The old wounds resulting from the hurts of complete nutritional dependence are still pres-

TABLE I

CONDITIONS INFLUENCING NUTRITIVE BALANCE¹

<i>External Environment</i>	
<i>Socio-economic</i>	<i>Dietary</i>
Living conditions	Form of nutrient
Working conditions	Provitamin: analogue
Available foods	Potential or intrinsic
Ability to seek food	biologic activity
Income	Level
Education	Imbalance—disproportion
<i>Physical and Chemical</i>	Interrelations
	Protein-carbohydrate-fat
	Vitamin-vitamin
	Vitamin-protein
	Vitamin-carbohydrate
	Vitamin-fat
	Inhibitors—antagonists
	Antivitamins
	Enzymatic destruction
	Auto-oxidation-rancidity
	Oxidants-auto-oxidants
	Processing of foods
	Availability of nutrients
	Precipitation
	Phytic acid-iron
	Oxalic acid-calcium
<i>Bodily Environment</i>	
<i>Digestive and Metabolic Channels</i>	<i>Functions and Reactions</i>
Functional form of nutrient	Disease
Ingestion	Degenerative
Digestion	Neoplastic
Absorption	Organic
Transport	Toxic
Formation of enzymes	Infectious
Breakdown of enzymes	Chemotherapy
Metabolism	Endocrine relationship
Elaboration	Nutritional status
Utilization	Morphology and physiology of tissue
Storage	Growth, pregnancy, lactation
Metabolic level	Work
Excretion	Psychobiology
Biosynthesis	Psychosomatic reactions
Intestinal synthesis	Food habits
Biodegradation	(Socio-economic factors)
Intestinal destruction	Body constitution
	Hunger and appetite

ent subconsciously although they must be repressed in the conscious mind. One way to enforce this repression is outwardly to depreciate the person who provides food.¹⁰

Food may be used to cajole, punish, deprive, or to establish a nonverbal means of communication.¹¹ It may be used to relieve anxiety. A person who is unable to accept his sexuality often expresses his anxiety by refusing food. In some instances, anorexia is similar in etiology to the severe clinical syndrome of anorexia nervosa, in which the unattractive appearance resulting from a prolonged "hunger strike" protects the individual against social contact with the opposite sex. Here psychic rehabilitation takes precedence over nutritional and hormonal therapy. The patient should be helped to accept himself, including his sexual drives, and thus renew his appetite for life.

Nausea and vomiting may also be symbolic of rejection, a substitute method of denying one's psychic needs. For example, a 19-year-old college boy was first seen complaining of anorexia and nausea when under nervous tension. These symptoms occurred when eating in a restaurant, traveling in a car or train, or visiting away from home. Subsequent study indicated that there was an infantile association of oral and genital areas. The oral fantasies were related to the mother with whom he identified. Thus there appeared a direct connection between subconscious fear of oral impregnation and inability to retain food when eating in public. The latter experience was filled with anxiety and fear of exposure centering around these oral fantasies, and the car-sickness and nausea in new environmental circumstances were also symbolic of inability to separate from the mother.

Food may stand for love and security. Probably 90 per cent of obesity stems from compulsive alimentation serving as a defense against anxiety or serving as the easiest way to obtain immediate gratification. In most instances, passiveness and dependence have been created by a domineering parent, usually the mother, who, because she herself is unable to give her child affection and security, appeases his needs with the continual offering of food. For the child eating becomes a weapon against anxiety due to insecurity and lack of love. Although many young men and women are outwardly concerned about marriage, they continue to remain fat because they are unconsciously afraid of the opposite sex. Likewise, when business and social contacts are associated with danger and insecurity, avoidance of these relationships is accomplished through acquisition of a large body size. In most cases

the unconcerned, easy-going, jovial attitude of the fat person is but a thin veneer for underlying emotional stress.¹² A 49-year-old salesman, an alcoholic, complained chiefly of obesity. In the history he stated that he was thin as a child, weighed 154 at 19, but for the last twenty years had weighed over 200 pounds. His weight at the time of examination was 255 pounds. Rorschach study indicated that this man had almost completely inhibited aggressive drives. He appeared submissive and unable to be outwardly assertive in emotional relationships with others although he longed for such relationships. This apparently dated back to early childhood domination by the father. There were deep feelings of inadequacy, his own large stomach serving to identify himself with the pregnant female. This man showed great anxiety, emotional immaturity, and compulsiveness, all of which was reflected by his flight through food and alcohol. Special diets and weight-reducing procedures do not by themselves provide the ultimate therapeutic solutions in most instances. Treatment should be accompanied or often preceded by active psychotherapy.

The geriatric group is particularly prone to create dietary problems for the physician. It has been estimated that almost 10 per cent of our population will be over 65 years of age by 1960 and that the greatest challenge for the physician in handling this group will be the host of chronic diseases to which the aged are subject.¹³ This means that more emphasis should be placed on medical guidance and supervision in order to prolong the span of useful endeavor. Adequate diet is of particular significance in the successful management of degenerative diseases. However, in many individuals, food habits are rigidly and tenaciously retained. Suggestions for dietary change are resented and consequently not accepted. Furthermore, there is a decline in structure and function of the taste buds,⁸ which also contributes to the inflexibility of the geriatric eating pattern. Other obstacles pertaining to dietary change are consistent with the personality pattern of the individual.

In addition to certain trends in different age groups, there are significant psychosomatic aspects in the nutritional therapy of medical and surgical conditions. A few of these will be delineated. The deleterious effects of poor food habits on pregnant and lactating women are well-known. Many women do not meet the nutritional requirements for normal needs and do not appreciably change their eating practices during pregnancy, except perhaps for indulging in periodic food cravings. This is especially true in

regard to protein and calcium intake.¹⁴ The obstetrician can, through nutrition education and an understanding of food habits, motivate the patient to fulfill recommended dietary allowances, to drink one quart of milk daily, and to eat liver at least once a week, thereby enhancing the health of both mother and fetus.

Numerous accounts of peptic ulcer in recent literature attest to the significance of psychologic as well as nutritional therapy. In this psychosomatic disorder, the stomach or duodenum, via autonomic nervous system imbalance, vainly attempts to compensate physically for psychic anxieties. The syndrome develops from an unconscious dependent-independent conflict set up in early childhood when parental love has been inadequate or when self-expression has been suppressed in order to conform to overexacting parental standards.¹⁵ Personality studies on three ulcer patients have revealed in each case a basic inferiority causing fear of sexual drives. Restrictions in this area had been present since childhood and aggressiveness had been projected on an intellectual level. The gastro-intestinal

tract had become the target for the negative expression of libidinal drives. In many instances nutritional therapy itself serves a psychotherapeutic purpose. The frequent ingestion of milk and cream does more than neutralize free acid. It satisfies an emotional need for acceptance, milk being symbolic of Mother. Similar to the environs of the hospital, treatment provides security and often results in rapid remission of the ulcer. However, upon discharge and upon contact with previous environmental and personal relationships, symptoms may recur unless adequate help with emotional problems has been given. Surgery, principally vagotomy, although bringing about an apparent cure for the ulcer, does not insure gratification of the above needs, since a food régime becomes unnecessary. In view of the personality profile of the ulcer patient, perhaps the recent advice concerning the postoperative vagotomy patient is worth heeding—"Weaning should not be abrupt."¹⁶

The upper end of the gastro-intestinal tract may express conflicts concerning receptive trends. On the other hand, the lower portion is especially adapted to express holding and withholding tendencies in the individual. Chronic constipation is often a protest against the obligation to give. Similarly, if strong emotional values have remained attached to the intestinal tract in childhood and if the individual in later life is subjected to prolonged trauma, he may revert to the infantile anal phase of development with chronic diarrhea or some form of colitis.¹⁷ Clearly, impaired nutritional status is evident. However, therapeutic procedures should include help with predisposing factors and, if possible, should bring about the elimination of attitudes responsible for the onset of distress.

Psychotherapy along with dietary guidance has considerable prophylactic value for diabetic patients, since they tend to be anxious and indecisive. They may shy away from responsibility and demand attention from others. Some do this by making a member of the family measure out their food. Or they may get sympathy by stressing their deprivations. Often they blame environmental circumstances for their inadequacies and seize upon their disease as an alibi for failure to assume responsibility or achieve success. Adjustment to a prescription diet may be difficult because it signifies further deprivation for an already emotionally deprived individual. Many patients are untruthful about adherence to their diets, although they try to gain favor by insisting that they never break them. Through a sustained physician-patient relationship, diabetic patients can be helped to accept the challenge of

TABLE II

FACTORS DETERMINING FOOD HABITS

External Environmental Influences

Living conditions	Food fashions—advertising
Working conditions	Food fads—a social phenomenon
Income	Custom
Education	a. racial
Social strata	b. national
Available foods	c. religious
a. agriculture	d. traditional
b. technology—food processing	Food etiquette—preparation, service, and manner of eating food
c. food distribution	
Scientific knowledge—nutrition education	

Internal Environmental Influences

Hunger (physiologic) and appetite (psychologic)	Psychologic conditions
a. stimulation of sense organs	a. inertia—fear of change
b. influence of drugs—insulin, hormones, amphetamine sulfate	b. emotional setting
Developmental pattern—infancy	c. memory association
a. inherited emotional and possibly biochemical constitution	d. emotional condition—apathy, depression, elation, anxiety
b. satisfaction of instinctive drives	e. food symbolism—security, power, prestige, friendship
c. pleasure from the act of eating	Physical conditions
Parental attitudes toward eating in childhood	a. work and fatigue
Physical status, age, sex, intelligence	b. sexual excitement
	c. growth, pregnancy, lactation
	d. allergy and intolerance
	e. disease

their illness, thus accommodating themselves to their changed internal functioning and following a recommended dietary regimen.

In many clinical disorders, myocardial insufficiency, hepatic disease, hyperthyroidism, tuberculosis, etc., poor appetite is frequently present. Parenteral supplements may be necessary in order to maintain nutritive balance. However, when possible, the patient should be encouraged to consume an optimal diet, since good food by mouth is the most effective form of therapy. Explanation and reassurance about the particular illness are simple but beneficial aids in alleviating anxiety and restoring desire for food.

Expert nutritional care is of paramount importance in surgery. Surgical procedures precipitate a nutritional assault on the body tissues which in itself, if not remedied, is productive of various mental and emotional symptoms. Apprehension, irritability, headache, and anorexia may be manifestations of vitamin B group deficiency, associated with failure to complete carbohydrate metabolism in the brain and resulting in anoxia. Anxiety relating to subconscious or conscious fears of death is usually present in the surgical patient and appetite is often depressed as a consequence. Furthermore, the patient regresses to earlier behavior patterns of dependence, the doctor and nurse being the symbols of the authoritative parents. He resents his inability to assert himself, and forced fluids, feeding by the nurse, or unappetizing trays may contribute to his indifference to food. Appropriate interest in and cognizance of these factors by the physician would be of value in accelerating the surgical patient's physical and mental readjustment.

Nutritional therapy should not be used as a medical discipline. Supplements or a therapeutic diet are justifiably prescribed only in the event of nutritive imbalance. If used indiscriminately, they may serve to fixate existing symptoms. Adherence to a dietary regimen may fulfill the patient's need for self-punishment or may serve to explain away his shortcomings. Also, the physician may actually retard the patient's progress by keeping him on a diet when in some instances psychotherapy is indicated instead. If help with emotional problems has been given and the patient begins to feel his ability to assert himself, maintenance of a dietary régime may keep him dependent upon the physician at a time when he needs to break away. Frequently dietary instructions are so closely followed in every detail that instead of making a simple substitute for an unavailable food item the patient omits the type of food entirely from the menu. The physician should be aware that the patient does not estab-

lish a prolonged relationship with him, identifying him with authority, thereby obeying the physician indefinitely and prolonging his illness.

Many patients rebel against authority. They do not like to be told what to do. One of the most difficult problems for the physician is this type of person who fails to follow a prescribed regimen. Perhaps the ambulatory ulcer patient will develop a deep resentment due to the non-conformist attitude he feels he is obliged to assume before other people. At the same time, if the diet is violated, guilt feelings may come to the fore and precipitate the return of physical distress. Patients in all clinical groups, the cardiovascular patient in whom salt restriction is necessary, or the patient with cholecystitis who has to abstain from fried dishes and pastries, may also be unwilling to follow their prescribed diets, since such diets aggravate feelings of difference from the group. Everyone assumes that he is an expert when it comes to eating and dietary modifications are not easy to accept.

Diet therapy involves much more than issuing a printed diet list to fit the physical condition of the patient. This practice, however, is evidently subscribed to by many for, in a single year, physicians requested six million reducing diets from one pharmaceutical house alone.¹⁸ Many of these are nutritionally inadequate. For instance, in the obesity diet, coffee is preferred to milk in all three daily meals, when actually it only stimulates the appetite, thereby working at cross-purposes to the objective of therapy. In addition, such diets obviously cannot fit specific socio-economic and psychologic needs. The fat person also believes that the omission of breakfast, the most important (and neglected) meal of the day, or a drug which curbs the appetite, will provide the magic weight-reducing effect he desires. Such measures may give temporary results, but unless the fundamental attitude is changed, lost weight will be regained as soon as he is faced with problems that challenge his low capacity for independent decisions and achievements.

Every illness has a psychic component, whether it be a situation in which neurosis is specifically related to a disorder or one in which anxiety and tension accompany an organic problem. In nutritional therapy, as well as medical and surgical procedures, the physician should be cognizant of this concept. An individualized, dynamic approach recognizes the personal identity of each patient and the fact that his nutritive needs should be correlated with his psychosocial pattern.

An integrated therapeutic program is initiated in the physician's first contact with the patient

through mutual understanding and rapport. It is important to assess the type of help the patient is willing to receive and to grasp the personal forces manifest in the clinical phenomena. In the first interview the physician may profitably utilize simple conversational techniques for ventilation of the patient's difficulties and reactions toward his illness. Vital personal issues should generally be omitted in order to avoid the possibility of protective rigidity and antagonism. A frank explanation of the patient's nutritional and medical problems and prognosis, based on a thorough physical examination and indicated tests, should be forthcoming. This should be done in understandable language and at the same time in such a way that he will not be ashamed of its implications. If temporary or permanent dietary modification is indicated, the patient may be helped to feel his own responsibility in getting well. Psychotherapy in the form of reassurance, suggestion, rational explanation, and education may serve to motivate him to accept the challenge of dietary change. In many instances, however, this type of symptomatic psychotherapy should be accompanied by therapy directed toward re-synthesis of the patient's personality structure. Through weekly conferences and interviews with relatives a more detailed appraisal of his personality, psychic make-up and environmental situation may be obtained and a dynamic physician-patient relationship established. The acquisition of special techniques such as the palmar sweat test,¹⁹ a weekly food questionnaire, and an autobiography including past and present food habits, may be of additional help in securing acceptance of dietary modifications and in realizing rehabilitational goals.

The objective of nutritional therapy is to attain or maintain nutritive balance. In addition to the application of newer nutritional principles, due consideration of individual nutritional behavior, as constitutionally defined and modified in all periods of health and disease, may beneficially supplement preventive and therapeutic recommendations in clinical practice.

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ABSTRACT OF DISCUSSION

J. FRANKLIN ROBINSON (Wilkes-Barre): I have time to touch on only one aspect of this paper.

Dr. Kelly tells us that the individual has a part in directing his own eating. This means that we must become acquainted with the patient as a person if we are going to learn something of the manner in which he behaves at the table. We must know something about his feelings, his emotions, and his attitudes. If we are going to learn these things about an individual, we must invest time in order to draw from him these important personal facts. A close relationship should exist between the patient and his doctor.

When we think about a complex procedure like eating, we must begin to think of what the patient is doing in this respect. Some of you will say I am talking like a psychiatrist, and the psychiatrists will say I am not because I am not using any technical language, but I am thinking about the way we practice medicine. Dr. Kelly tells us about patients who feel anxious and fearful and consequently may be nauseated or have poor appetites. He points out some of the circumstances under which these symptoms may occur. He also describes some case situations in which one must have a considerable acquaintance with the patient and his past in order to understand his eating habits. The doctor who does not know how to become acquainted with his patient is apt to consider him unreasonable or uncooperative.

The aim of many of us is to know so much about a part of medicine that we will not have to spend time in long discussion with the patient. In considering the diet of a patient, Dr. Kelly's paper illustrates that no matter how much we know about the gastro-intestinal tract, we must still invest time to learn about the patient who houses the tract; we must become thoroughly acquainted with him as a person and learn his habits, his aims, his experiences, and his difficulties.

We can be reasonably certain about one thing in human beings—they will behave like themselves. When we undertake a series of procedures for a patient, we must recognize that the way in which he behaves is one of the ingredients which is added to our prescription.

One could talk at length about what is happening to medicine when internists write papers like Dr. Kelly's. Something very profound really is happening. We are rediscovering the patient.

Doctor, don't read this letter but be sure your *Secretary* does!

DEAR JANE:

I'm a medical secretary, just like you, and I'd like to pass on a few tips that I have found helpful to both the doctor and myself.

I know that your mail is as voluminous as ours and that the doctor cannot possibly read it all, but I make a special effort to bring to his attention all mail pertaining to the activities of the state and county medical societies. Now, with the campaign on against socialized medicine, I look forward to receiving the new material available for the promotion of the National Education Campaign.

Here are some of the things I do. Maybe you'll want to do the same. I hope so.

When the mail comes in, I put everything about the National Education Campaign on top of the pile. Then when I place it on the doctor's desk I point out those pieces with which I can help. For instance, when the order card for the poster "Keep Politics Out of This Picture" came, I asked him if he wanted it and then I ordered it right away. The doctor's so busy he probably never would have gotten around to it. That picture attracts a lot of attention in our office. Do you have it in yours?

I make it a point, too, to see that our waiting room table has plenty of pamphlets about government medicine and voluntary health insurance plans. When our supply gets low, I order more from the Committee on Public Relations at 230 State St., Harrisburg, Pa. People pick up these pamphlets as fast as I put them down. I also use the pamphlets as bill enclosures. We ordered a good supply of the stickers about compulsory health insurance, too, and they go out on every bill.

Another thing that I consider a good idea is for every medical secretary to know the facts about Blue Shield and Blue Cross, then she can answer questions that patients may ask her in regard to the service.

When a new patient comes into our office, I always ask him if he has Blue Shield coverage. If he already belongs, I enter his agreement number on his case history card. If he is not a subscriber, I explain the advantages of voluntary prepayment sickness insurance to him and tell him how he may join Blue Shield. I am assuming, of course, that the doctor for whom you work is a participating physician in Blue Shield.

After all, my job will be a lot tougher if we get a system of socialized medicine, so I want to help the doctor fight it.

Well, that's it, Jane. It takes only a couple of minutes for me to do these things, and the doctor seems grateful for my help and interest.

Sincerely,

HELEN

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EDITORIALS

LET'S KEEP THE RECORDS CLEAR

In the earlier developmental days of the Medical Service Association of Pennsylvania (MSAP), its officers and those of its sponsor, The Medical Society of the State of Pennsylvania, depended very heavily upon advice, freely given, from officers of the Michigan voluntary insured medical service plan, who were pioneers in the field. We now gather from recent legislative discussion and action concerning MSAP and from what we read about the experiences of the Michigan plan that the two organizations may again be commonly concerned.

From an Exchange we learn, first, that the income level stipulated by the Michigan plan did not take into account a gradual rise in income for the group for whom the plan was originally designed—from around \$2,500 to nearly \$4,000; second, the premium rates have not risen appreciably and the schedule of payments for professional services has remained generally at the 1942 level except in a few items; third, there has been increasing recognition of the fact that prepayment systems can and do work without government control and are capable of great expansion.

It is said that at present about 40 per cent of the subscribers to the Michigan plan are being billed for professional services over and above the fees paid by the plan, and that 13 of 14 subscribers undergoing a surgical procedure for

which the established fee is \$100 or more will be billed for an additional fee by the doctor. The writer we quote then states that it becomes apparent that a prompt resurvey of income limits and professional fees must be carried out so that what is medicine's effective answer to the threat of governmental medicine may be carried further to the millions who recognize the good in voluntary prepayment plans and want their benefits.

We have no reason to believe that any such marked differentiation exists between guaranteed professional fees and those actually charged individuals or families insured under MSAP, but bring up the subject with the hope that through its pages JOURNAL readers may be reliably informed by MSAP.

NONSCIENTIFIC CONVENTION FEATURES

Much has appeared previously in the JOURNAL, and this issue is replete with information about the scientific program and the exhibits which will draw scores of teachers and essayists and many hundreds of interested practicing physicians, interns and medical students, nurses and technicians to Pittsburgh, Sept. 25 to 29, 1949. Many visiting doctors will be accompanied by their ladies who with those from Allegheny

County may swell their total to seven hundred. They and the doctors, who primarily seek instruction, will need relaxation and entertainment—and they will not be disappointed.

Beginning on Sunday afternoon, the Fifth Avenue and Forbes Street campus of the University of Pittsburgh will be the center sought by those who seek relaxation. From two to four o'clock the eighteen Nationality Rooms in the 42-story Cathedral of Learning of the University of Pittsburgh will be open to visitors, as will also its matchless Commons Room, whose stone arches rise through four stories of this "campus of granite." At four o'clock the Religious Hour will be conducted in the adjoining Heinz Memorial Chapel, a gem of Gothic architecture which, with its color in stained glass, will house the spoken message from God's Word and the music of the organ and a vested choir. This service will be followed at five o'clock by a subscription tea in the beautiful Faculty Club on the seventeenth floor of the Cathedral of Learning.

Entertainment will begin with the State Dinner in the Hotel William Penn, at 6:30 p.m., on Monday, with good food, orchestral and vocal music, and a spine-tingling oration on the preservation of our constitutional rights. Tuesday evening's entertainment will take place in Carnegie Music Hall, which is located across Forbes Street from the University campus. A half hour's organ recital will precede the presidential installation ceremonies, and two twenty-minute addresses will be given, one by the incoming president, the other by an English physician recently voluntarily displaced by England's now socialized form of medical practice. The remaining sixty to ninety minute period will be filled by Pittsburgh's Little Symphony Orchestra (25 pieces, including a golden harp) with Victor Saudek conducting, and two nationally known soloists, Mary Martha Briney, soprano, and Bob Carter, tenor. Light classics with operetta selections and popular encores will abound.

The Wednesday evening entertainment will include the customary early evening alumni affairs, and later the President's reception and dance to the music of a "name" dance orchestra in the Hotel William Penn.

Dress for all of these affairs will be optional, and there will be no charge except for the Sunday afternoon Tea (\$1.00) and the State Dinner (\$5.00).

These Sunday, Monday, Tuesday, and Wednesday events, all of which it is hoped will be graced by the presence of hundreds of members and of the fairer sex, plus those events planned by the Woman's Auxiliary, should as-

sure the success of the relaxing and entertainment features of the coming Pittsburgh convention of our state medical society.

READABLE ANNUAL REPORTS

To the Editor who has read all the annual reports to our 1949 House of Delegates, first as submitted in their original copy and again in the form of printer's galley proof, these reports are rife with surprising information, interesting observations, timely comments, and sound advice.

Every member of the Society should read them, and since they are addressed to this year's delegates from each member's own county medical society, said delegates should, if they are to be truly representative, receive from their constituents expressions of membership opinion. *Dear reader, why not increase your own stature and that of your county society's 1949 delegates by thus recognizing our state medical society as a true republic in which "the sovereignty resides in the membership and the administration is lodged in officers elected by and representing the membership?"*

PURPURA FULMINANS

(Meningococcemia with Adrenal Failure)

Meningococcemia is one of the many serious infectious diseases which carried a high incidence of mortality in former years. With the advent of chemo-antibacterial therapy, control of the disease is now possible; if recognized at an early stage, the infection can almost always be completely cured. This statement is supported by the increasing number of reported cases with cure during the past few years in medical literature. I could find but one recovered case reported previous to 1940; between 1940 and 1943 thirteen cases were reported with recovery; and from 1943 to 1946 I could find some twenty-three cases reported.

Among those who have not had clinical experience in treating patients with purpura fulminans, the so-called Waterhouse-Friderichsen syndrome, there is some question as to whether such a clinical syndrome can exist when the pathologic diagnosis is made upon the existence of adrenal apoplexy. It has been argued that recovery of adrenal function from such hemorrhage is an impossibility. I should like to discuss this question briefly, in addition to emphasizing some of the more important points essen-

tial in making an early diagnosis. This is imperative for successful treatment.

Because prompt recognition of the syndrome is a real medical emergency, certain important features will be re-emphasized. The clinical appearance of the patient is one of acute infectious toxemia. The history usually includes upper respiratory tract infection with subsequent progression to chills, fever, severe malaise, headache, and/or nausea and vomiting. The patients prone to develop adrenal insufficiency usually will show the typical widespread purpura; occasionally, a diffuse petechial eruption will be present. The clinical diagnosis is not difficult and is easily confirmed by the blood count, smears of the lesions or spinal fluid, and cultures of the blood and/or spinal fluid.

The following points deserve special attention: (1) A history of oliguria for a day or two preceding the acute septic episode should arouse suspicion in the mind of the examiner. (2) Frequent blood pressure recordings are essential to the prompt recognition of the syndrome. This is imperative because the usual picture of shock is not present at first, although the patient may exhibit restlessness. The skin is still warm, the patient conscious; there is often no immediate collapse, but the blood pressure will have fallen dramatically. (3) Probably related to the oliguria is the fact that some cases have shown diminution in serum chloride and base. This may be of aid in confirming the diagnosis, but is often discovered too late to be of help in making an early diagnosis.

The often discussed point of whether these patients die of an overwhelming toxemia or whether adrenal failure plays a part in the collapse always arises. This is important in evaluating the treatment program to be used. Certainly an overwhelming toxemia usually exists in these patients. It is known, however, that the meningococcus (or its toxin) seems to have a predilection for the capillary bed and especially for that of the adrenals. Moreover, some cases in which death occurred while clinically exhibiting this syndrome have not shown hemorrhage into the adrenals post mortem. They have, however, shown changes in the structure of the gland, both cortex and medulla, in the form of tubular destruction and degeneration.

It seems logical to suppose that preceding actual hemorrhage certain pathologic processes take place, not only in the adrenals but in other structures as well. It further seems logical that such damage when it occurs in the adrenals will result in dysfunction of those glands. It is our contention that this is exactly what happens in

cases exhibiting the syndrome with recovery. The arrest of the pathologic process depends upon immediate and often heroic antibacterial therapy. Meanwhile, with a typical picture of the meningococcemic shock syndrome present, we believe that substitution therapy is indicated. Few other disease entities produce this particular shock syndrome. Therefore, when it can be recognized, we feel that it should be treated as a deficiency disease. The substitution therapy should include not only the adrenal cortical extract but also replacement for the medulla. The drugs which seem best adapted for this latter purpose are paredrine or ephedrine. This treatment presupposes, therefore, a reversible pathologic process preceding actual hemorrhage into the glands. The oliguria which occurs and the clinical picture of extracellular fluid retention is not specific for this disease. Work has been accumulating to show that the extracellular fluid volume increases in other infectious processes such as malaria and pneumonia. It may be that the same type of mechanism is operating in other infections, but certainly not with the dramatic rapidity seen in the case of fulminating meningococcemia.

The term Waterhouse-Friderichsen syndrome has been accepted in medical literature and is not likely to be discarded. As has been suggested, it would seem best to reserve this term to describe the pathologic entity of adrenal apoplexy as was originally intended. It is highly unlikely that adrenal gland recovery is possible once hemorrhage has occurred. The term fulminating meningococcemia is certainly a better one for the syndrome from which it seems possible to recover. Fulminating toxemia due to a specific septicemia (i.e., meningococcemia, pneumococcemia, etc.) might be best, since other organisms can be responsible and an occasional case has been reported.

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EDWARD W. BIXBY, JR., M.D.

POST-TREATMENT CARE OF SYPHILIS

(EDITOR'S NOTE: This is the sixth and last of a series of guest editorials prepared by members of the Department of Dermatology and Syphilology, University of Pittsburgh School of Medicine, participating in the Pittsburgh Syphilis and Venereal Disease Control Program which is sponsored by the Venereal Disease Division of the Pennsylvania Department of Health. They should refresh the minds of practicing physicians on the procedures necessary to establish a diagnosis of syphilis, the modern therapy, the follow-up of treated cases, and certain public health aspects.)

With the advent of "rapid treatment" in syphilis the most important phase of handling the disease, next to a proper diagnosis, is the period of post-treatment observation. During this period the patient must be fully cooperative in order that the physician can properly evaluate the case.

Many physicians in the past were under the impression that the aim of treatment was to reverse a positive serologic reaction to negative. In the light of present-day knowledge this holds true only in early syphilis. It may be stated that the longer the patient has had an untreated or an inadequately treated case of syphilis the less chance there is to reverse the serologic reaction to negative. Adequate treatment of a patient who has had syphilis for more than four years probably will not result in a reversal of a positive serologic reaction to negative, but adequate treatment of an early case of syphilis should, in the great majority of cases, reverse a positive serologic reaction to a negative within a year.

Early Infectious Syphilis

It is well known that the treatment of syphilis with penicillin results in a small but definite number of treatment failures. It is essential that a patient be followed at monthly intervals following therapy, at which time patients should be examined for signs of cutaneous and mucocutaneous lesions of syphilis, and a quantitative blood serologic test for syphilis done. With a negative physical examination it is not unusual for the titer of the serologic reaction to remain at a constant level for two to four months following treatment. It is reasonable to expect a drop in titer at least after the fourth month. This drop in titer then should quickly, or slowly, progress to negativity. If during the course of observation there is an abrupt rise in the serologic titer, which rise is maintained for three to four weeks, the patient may be labeled as a case of serologic relapse and re-treated. It must be remembered that treatment failure after an initial course of penicillin does not indicate a change in the mode of therapy. Re-treatment should be carried out with penicillin. During the course of observation, if one detects physical signs of relapse such as epidermal lesions, re-treatment with penicillin

is indicated. In a well-followed case, however, serologic relapse usually precedes symptomatic relapse by about a month.

Criteria of Cure—Early Case

The ideal response to penicillin therapy of early syphilis is shown in a patient who has had adequate treatment and who during his period of observation has shown no signs of relapse, whose quantitative titer has reversed to negative within six to nine months, and who has a negative physical examination and normal spinal fluid survey at the end of one and two years.

Late Latent Syphilis

By late syphilis is meant syphilis of more than four years' duration.

It is in these cases that "arrest" of the disease is the aim of treatment. Whereas in early syphilis it is possible to tell the patients they are cured after a sufficient follow-up time, it is very often impossible to talk about cure in a late case. In the first place, it is not reasonable to expect the blood serologic test for syphilis to revert to negative. Presupposing that a thorough examination of the patient prior to treatment shows that the only sign of syphilis is a consistently positive blood serologic test for syphilis, all that is medically possible is to administer *adequate* treatment. Following such treatment the patient should be examined at periodic intervals, for instance, every three months for a year and every six months thereafter, and managed in the same way as one would handle an arrested tuberculosis or rheumatic heart case. Spinal fluid examination should be performed one year following treatment and when indicated thereafter.

Late Manifest Syphilis

By this is meant syphilis (usually late) involving a structure such as the heart, great vessels, bone, etc. Post-treatment observation after adequate therapy is followed purely on clinical grounds according to the structure involved. If clinical examination shows unsatisfactory regression of *inflammatory* lesions, re-treatment is indicated.

Neurosyphilis

Primarily, it must be remembered that central nervous system involvement by the spirochete produces organic damage. Too many times one finds that total relief of symptoms and signs is expected. It is true that pure inflammatory lesions are reversed by therapy in the great majority of cases, but degenerative lesions are unchanged. In the old tabetic and parietic, treatment is indicated to stop the progress of the dis-

ease. In the asymptomatic and meningitic types much better clinical results are seen.

It may be emphasized here that there is only one way by which a neurosyphilis case can be followed, that is, by repeated study of the spinal fluid. Following diagnosis and adequate treatment, blood studies are relatively unimportant in neurosyphilis. Six months after diagnosis and therapy, or sooner if indicated, lumbar or cisternal puncture should be performed and the spinal fluid findings re-evaluated. This should be repeated in six months. More extensive involvement as shown by spinal fluid examination should be handled by re-treatment with penicillin.

One point in reiteration—an old fixed case of tabes or paresis cannot be cleared of symptoms and signs if the lesion has progressed from inflammation to degeneration.

Congenital and Prenatal Syphilis

The proper post-treatment care of an infected infant or child follows exactly the same lines as that of an adult. It is not the age of the patient that counts; it is the age of the disease process.

Quantitative Blood Serology

Quantitative testing of the blood for syphilis is essential in following any treated case. This procedure may be carried out in any laboratory. Qualitative testing once a diagnosis has been established is of very little value. Any standard serologic test for syphilis may be modified, using dilution factors to provide a quantitative reading. It is well to perform quantitative blood tests for syphilis at intervals of from two to three months. The average case will show a gradual diminution

of titer. An abrupt marked and sustained rise in titer may be an indication for re-treatment. If the blood still retains a low degree of positivity at the end of a year, this alone does not indicate re-treatment.

HAROLD R. VOGEL, M.D.

STATE DINNER PROGRAM

The Hon. Clarence J. Brown, Representative in Congress from the Seventh Ohio District, serving his sixth consecutive term, is to be the principal speaker at the State Dinner (subscription \$5.00 for men and women) to be held Monday evening, September 26, in the Hotel William Penn during the Pittsburgh convention (ninety-ninth annual) of the 101-year-old Medical Society of the State of Pennsylvania.

Congressman Brown has been in the newspaper business since 1916 and is the publisher of five small Ohio city newspapers. He is a member of the powerful House Rules Committee in the Congress and was a member of the widely appreciated twelve-man Hoover Commission.

The Congressman is a magnetic speaker and his message on the occasion of the Society's state dinner will be timely, interesting and, above all, inspiring.

Tickets are available for individuals, for couples, for guests of the members, and tables for ten will be reserved for county, for hospital, or for specialty groups.

Music and song will be furnished throughout the dinner meeting by the Homer Ochsenhirt Orchestra and the Westinghouse Quartet.

NOTICE OF AMA MEMBERSHIP ASSESSMENT

(Clip this form and mail with your check today if you have not already done so.)

The American Medical Association has requested your state medical society to collect this year a \$25 assessment. Please make check in favor of *American Medical Association—Assessment* and mail to The Medical Society of the State of Pennsylvania, 8104 Jenkins Arcade, Pittsburgh 22, Pa.

To The American Medical Association, Debtor
Special Assessment \$25.00

....., M.D.
Name

.....
County (Pa.)

TEST YOUR DIAGNOSTIC SKILL

At the request of Dr. William A. Bradshaw, chairman of the 1949 Committee on Scientific Work, we append case abstracts for the Clinicopathologic Conference called for Wednesday afternoon, September 28, in the Urban Room, Hotel William Penn, Pittsburgh.

The ambitious reader will familiarize himself with these case histories—jot down questions as they may occur; also, having completed an analysis of the evidence here presented, record his or her own diagnosis and complete plans to attend the convention and conference prepared to secretly applaud or requite himself as the whole picture is unfolded by the clinicians who conduct the conference.

CLINICOPATHOLOGIC CONFERENCE

1:20 to 3:00 p.m., Wednesday Afternoon,
September 28

PATHOLOGIST: Dr. Allen Graham

CLINICIANS: Drs. Richard E. Haber, James J. Lee,
Clarence B. Penrod, and John W. Shirer

Case 1—White Male—Age 70 Years

First hospital admission, Aug. 28, 1947

The patient, a timekeeper, complained of nausea and pain in his stomach. There was no family history of cancer or tuberculosis. The mother died from an unknown cause. The father died from a stroke. The patient had the usual diseases of childhood including rheumatism at age 15, but no acute rheumatic fever. Eight years previous to admission a suprapubic prostatectomy had been performed elsewhere, but no details are available.

The patient had been under the care of the referring physician since December, 1945, on account of hypertensive cardiovascular disease, with subjective improvement but little change in the physical findings. In May, 1946, the patient complained of nocturia, urgency, and urinary frequency, and rectal examination revealed an enlarged hard prostate. Urologic consultation resulted in a clinical diagnosis of carcinoma of the prostate. In June, 1946, diethylstilbestrol in weekly dosage of 5 mg. was instituted and has been continued. After about one year the dose was reduced to 2.5 mg. due to the development of gynecomastia, which was more pronounced during oral therapy than during periods when the drug was given by injections.

On admission to the hospital (Aug. 28, 1947) the patient complained of nausea and pain in the stomach of three weeks' duration. The pain was severe and localized in the epigastrium, did not radiate, was relieved by food, and was accompanied by nausea but no vomiting. Daily laxatives resulted in two to three thin stools per day, none of which were black or tarry. He also complained of pain in the lower part of the abdomen and in the lower lumbar spine. Nocturia, frequency, urgency, hesitancy, intermittency, and narrowing of the stream were noted, but there was no history of pyuria or hematuria. There had been no loss of weight, chills, or fever.

The admission temperature was 98.6, pulse 96, respir-

ations 26, blood pressure 170 systolic and 100 diastolic. The general nutrition was fair. The pupils were concentric and equal, and arcus senilis was well marked. The mouth was edentulous and the tongue was coated and reddened. The breath sounds were vesicular with a few rales at the bases. The heart sounds were regular, rhythmic, and equal in intensity and there was a soft systolic murmur over the precordium. The liver was barely palpable and questionably nodular. There was a small epigastric hernia and an old surgical suprapubic scar. The prostate was moderately firm but not nodular. There was no edema of the extremities and the reflexes were physiologic.

The urine, which was amber and cloudy with a pH of 7.5, contained a slight amount of albumin but no sugar, occasional hyaline casts, phosphate crystals, a few epithelial cells, and 2 to 3 white blood cells per high power field. The blood count revealed 12.5 grams of hemoglobin, 4,000,000 red blood cells, 8700 white blood cells, neutrophils 63 per cent, lymphocytes 34 per cent, eosinophils 1 per cent, and mononuclears 2 per cent. Chemical analysis revealed nonprotein nitrogen 38 and blood sugar 89 mg./100 cc. Three units of acid phosphatase were reported. The sedimentation rate was 4 mm. in a half hour and 8 mm. in one hour. The electrocardiogram was interpreted as showing minor changes of myocardial origin, probably incidental to hypertension and arteriosclerosis.

A flat plate roentgenogram of the abdomen was reported as showing gas in the intestinal tract, but not sufficient in amount to indicate an obstructive lesion. There were no bony changes to suggest metastasis. Gastro-intestinal series were interpreted as indicating the presence of upper right quadrant adhesions and antral irritability.

The patient was discharged on the eighth hospital day.

Second hospital admission, Sept. 13, 1947

After discharge from the hospital nine days before, the patient continued to complain of the abdominal pains which became worse. Frequency and nocturia had continued, but there was no hematuria.

On examination the temperature was 99, pulse 74, respirations 22, and blood pressure 190/105. The skin was sallow and pale. The lungs were clear and there were no cardiac murmurs. There was active intestinal peristalsis, tenderness in the epigastrium over a small epigastric hernia, and tenderness in the right lower quadrant.

Urinalysis: amber, cloudy, specific gravity 1.022, pH 7.0, faint trace of albumin, no sugar, occasional hyaline casts, and 3 to 4 white blood cells per high power field. Blood count: hemoglobin 10.5 grams, red blood cells 3,300,000, white blood cells 10,000, neutrophils 69 per cent, lymphocytes 28 per cent, eosinophils 1 per cent, monocytes 2 per cent.

On Sept. 18, 1947 an exploratory laparotomy was performed under a general anesthetic. Dense adhesions between the gallbladder and the first portion of the duodenum were found and divided. The appendix was found to be retrocecal and bound down by adhesions. The appendix was removed in the usual manner and the abdomen was closed without drainage. Pathologic examination of the appendix revealed no abnormality other than melanosis of the mucosa.

The patient was given two blood transfusions before operation. The convalescence was uneventful and the patient was discharged on the twelfth hospital day.

Third hospital admission, Jan. 3, 1948

The patient complained of pain in the chest, cough, headache, and mental confusion. The temperature was 102, pulse 96, respirations 32, and blood pressure 198/108. There was moderate cyanosis of the lips and groaning respiration, and slight sagging of the left oral angle was noted. Fine moist rales were present over the lower part of the left lung anteriorly, but no bronchial breathing or rhonchi. There was no visible precordial pulsation and no murmurs. The fingers were not clubbed and there was no edema of the ankles. The abdomen was moderately distended and the liver was palpable just below the costal margin, but there was no ascites.

The condition was interpreted as bronchopneumonia, and sulfadiazine, sulfathiazole, and penicillin were administered. The temperature returned to normal in about seven days.

During this admission the urinalysis, blood counts, and chemical analyses were essentially the same as those noted on previous admissions. The blood culture was negative. After recession of the fever the patient was confused and disoriented at times, and these phenomena were attributed to the hypertensive cardiovascular disorder.

Two weeks after admission a stereoscopic examination of the chest was reported as showing clouding in the right axillary region which seemed to be localized to the pleura, suggestive of pleural metastasis. There was increased density of lung markings, but no masses typical of metastatic lesions were identified. There did not seem to be involvement of the bones. The left side of the heart was enlarged.

Urologic consultation: "In view of roentgenographic chest findings and the absence of osseous metastases, I do not feel that orchietomy, bilateral, will be of value. I suggest the continued use of stilbestrol in therapeutic doses to the point of mastitis." The patient was discharged on the twenty-second hospital day.

Fourth and final hospital admission, Jan. 7, 1949

The patient was admitted on account of urinary retention, mental confusion, weakness, loss of weight, shortness of breath on exertion, severe pain in the chest, occasional non-productive cough, and weakness of the legs. He had been using crutches to get around, had fallen at times, and thought there had been periods of unconsciousness.

On admission the temperature was 97, pulse 68, respirations 12, and blood pressure 188/90. There was ptosis and weakness of the left eyelid. Expansion of the lungs was fair and equal; no impairment to percussion was noted; the breath sounds were bronchovesicular to bronchial; a few moist rales were heard at both bases posteriorly. No enlargement of the heart to percussion was apparent. The rhythm was regular, the rate 68, the sounds of fair quality, and there was a blowing systolic murmur over the apex. The abdomen was soft; the liver, felt two fingerbreadths below the costal margin, was firm and non-tender. Peristalsis was active, no masses were palpable, and no tenderness was elicited. On rectal examination two small firm nodules were palpable in the prostatic region. There was weakness of both legs, but no edema. The reflexes were active and equal.

Urinalysis: amber, cloudy, specific gravity 1.022, pH 6.5, trace of albumin, no sugar, 12 to 15 red blood cells

per high power field, and 20 to 25 white blood cells per high power field. Blood count: hemoglobin 11 grams, red blood cells 3,520,000, white blood cells 10,600, neutrophils 74 per cent, lymphocytes 21 per cent, eosinophils 1 per cent, monocytes 3 per cent. Chemical analysis revealed: nonprotein nitrogen 34, blood sugar 107, creatinine 2.1 mg./100 cc.

Roentgenograms of the lumbar spine and chest were not satisfactory because of the general condition of the patient. No areas of destruction or other osseous abnormality were noted. The chest films were also unsatisfactory, but there appeared to be nothing to substantiate the previous impression of pleural metastasis. Roentgenograms of the cervical spine were unsatisfactory.

The patient became increasingly stuporous and died on the eleventh hospital day. Necropsy was performed.

Case 2—White Male—Age 58 Years

The patient was admitted to the hospital Jan. 31, 1949, complaining of weakness, loss of appetite, vomiting at intervals for five weeks, jaundice of a few weeks' duration, and loss of weight.

Two and one-half years before admission a mid-third gastric resection and gastrojejunostomy had been performed at a hospital in a neighboring state. At operation an apparently benign ulcer was situated on the lesser curvature of the mid-portion of the stomach. There was no fixation of the ulcer in any direction and no glands were found in the gastrocolic or gastrohepatic omentum. On examination of the tissues removed, a pathologic diagnosis of "a well differentiated carcinoma with superficial necrosis, and a diffuse gastritis" was made. There were no involved lymph nodes. Recovery was uneventful, and after discharge from the hospital the patient remained symptom-free for about two years.

At the time of the current admission to the hospital (Jan. 31, 1949), in addition to the symptoms previously noted, there were jaundice, an enlarged firm lymph node in the left supra-clavicular region, and a palpable mass in the right epigastrium. Otherwise, the general condition appeared quite good and the remainder of the general examination was essentially negative.

The temperature was 98, pulse 70, and respirations 20. The urine was acid; had a specific gravity of 1.010; contained 2 plus albumin but no sugar; there were a few granular casts and 4 to 5 white blood cells per high power field; and a test for bile was positive. The hemoglobin was 13.5 grams, red blood cells 4,560,000, white blood cells 8300, neutrophils 68 per cent, eosinophils 1 per cent, lymphocytes 29 per cent, and monocytes 2 per cent. Blood chemical examination disclosed: nonprotein nitrogen 27 and blood sugar 77 mg.

RESERVATION FORM

In order to plan accommodations for the social events, it is necessary to have as many advance reservations as possible. For your convenience there has been included with this Journal, see page 1232, a reservation form.

Reservations for the Sunday Tea and State Dinner on Monday night should be received by September 15, accompanied by a check made payable to The Medical Society of the State of Pennsylvania.

Send your reservation form today! Do not delay!

per 100 cc. The Fouchet test was positive. The prothrombin time was 80 per cent of average normal.

In view of the previous history and positive pathologic diagnosis of carcinoma of the stomach, the patient's condition was interpreted as carcinomatous involvement of the liver and cervical lymph nodes, probably metastatic from the stomach, and was considered to be beyond other than palliative treatment.

One week after admission (Feb. 7, 1949) a limited exploratory laparotomy was performed, at which time extensive involvement of the liver, the gastrohepatic ligament, and the lymph nodes around the head of the

pancreas was found. A small piece of tissue was removed from the liver for histologic examination. On the tissue removed a pathologic diagnosis of adenocarcinoma was made and it was assumed to be metastatic from the stomach.

The subsequent course in the hospital was marked by continuation of jaundice, abdominal pain, failing appetite, and recurring vomiting, and it was thought that the gastrojejunal stoma had been occluded by the neoplasm.

The patient died March 2, 1949, on the thirty-first hospital day. A necropsy was performed.

DOCTORS ACCUSED AS TAX CHEATS

From the *Detroit Medical News* of July 25, 1949, we garner the following* of interest to Pennsylvania physicians:

From all indications, a close scrutiny of doctors' income tax returns is being made. This does not necessarily mean that any particular group is being singled out by the Treasury Department, but rather that all groups of businesses and professions can anticipate a closer check in the future. Many of you have read that the Treasury Department will hire five thousand additional employees, and this may be interpreted to mean that a tightening of audit and checking procedures can be expected by all taxpayers.

Recently in one of our local newspapers a large red headline stated that the doctors in this area were being accused as tax cheats. It goes without saying that such a headline is quite unfair, because in any given group the percentage of tax cheaters is the same as in any other group. But, of the doctors who have been called by the Treasury Department, there are some who, because of apparent misinformation, seem to feel that merely because they are called they are being classed as tax cheats, and therefore, rather than have any risk of adverse publicity, are willing to accept a compromise offer of an additional amount of tax. By so doing, the doctor is being very unfair to himself. He, better than anyone else, knows whether or not his tax returns were correct, and if they were, there should not be any additional tax.

The purpose of this article is to advise the doctor, when he receives a letter requesting him to appear at the Treasury Department office with books and records, that his best procedure would be to first contact his tax consultant, and after a thorough and frank discussion with him, the doctor will then be in a far better position to determine just where he stands.

From information and experience gained from previous audits, it would appear that all personal and business deductions are being checked quite thoroughly, but in particular, conventions, meetings, entertainment, and auto expenses. Therefore, as has always been the case, it would be advisable to keep all receipts and canceled checks. In addition, if entertainment is necessary to further your professional interests, it would be wise

to mark in your book, *who, where, when, and how much!* Another item of great importance is the method of keeping an accurate accounting of income. All office calls should be marked as such, and house calls, should, in particular, be noted.

One more precaution—deposit all income in the bank, and then as cash is needed, issue a check to cash, and mark one's book accordingly. When all money taken in is deposited in this manner, at the end of the year the bank deposits will check exactly with the income as shown in your books. This method eliminates a great amount of work for all concerned, and is especially helpful in the event of an audit. However, the necessity of keeping all canceled checks and receipts cannot be stressed too strongly.

The important thing to remember is this: If you are requested to appear, see your tax consultant first. He is a specialist in this field and has the necessary "know how" gained through training and experience that not only assures the doctor of the best possible course to follow but also relieves his mind of unnecessary worry which might interfere with his professional work.

HAHNEMANN MEDICAL COLLEGE FULLY APPROVED

At its meeting on June 3, the Council on Medical Education and Hospitals of the American Medical Association voted to remove the Hahnemann Medical College of Philadelphia from probation and to restore the school to a status of full approval. This action was based on a detailed survey of the school carried out by the secretary of the Council and a representative of the Association of American Medical Colleges, May 9-13, 1949.

This survey revealed that the deficiencies that were observed in 1945 and which led to the school's being placed on probation have been satisfactorily corrected. From the point of view of administration, curriculum, teaching staff, physical plant, and clinical facilities, this school is now judged to be fully deserving of approval.

The Executive Council of the Association of American Medical Colleges has voted to recommend to the Association that it take similar action restoring the school to full approval at its meeting, Nov. 8, 1949.—*Philadelphia Medicine*, July 30, 1949.

* Article prepared by a tax consultant at the request of the *Detroit Medical News*, which is published weekly by Wayne County (Mich.) Medical Society.

THE BENJAMIN RUSH AWARD

THE Medical Society of the State of Pennsylvania takes pleasure in announcing that Mrs. Leonard D. Doggett of State College, Pa., has been selected to receive the 1949 lay individual Benjamin Rush Award for her outstanding contributions toward the improvement of health conditions in State College, Centre County, Pennsylvania.

The Emergency Aid of Pennsylvania, with its headquarters in Philadelphia, has been chosen to receive the 1949 lay organization Benjamin Rush Award for its outstanding contributions to the advancement of public health in Pennsylvania and to the improvement of health conditions in Philadelphia.

Mrs. Leonard D. Doggett has long been a leader in health activities in Centre County. She was the first woman on the Centre County Hospital board. She is a member of the local Cancer Society board and has been responsible for making cancer dressings for those unable to pay. As chairman of the Health Committee of the Business and Professional Women's Club of State College, she campaigned and promoted better sanitary conditions in restaurants, improved the water supply and sewage disposal, and was back of numerous other public health improvements. Mrs. Doggett has been an active worker in the local Red Cross unit, the local Cancer Society, State College Nurses Association, Centre County Hospital Auxiliary, and many other civic groups. She has given freely of her time and talents to improve public health and individual well-being and to help those with incurable diseases to live more comfortably. Mrs. Doggett has devoted the major portion of her life to serving others, always without pay and often at cost to herself. She is truly deserving of The Medical Society of the State of Pennsylvania's Benjamin Rush Award, which is presented in recognition and appreciation of significant contributions to the advancement of public health in Centre County.

The Emergency Aid of Pennsylvania is a volunteer organization of women organized in 1914. Its purpose is to carry on both at home and abroad emergency relief work for the benefit of the military forces and civilian population of the United States and of their allies.

The organization is sponsored by the Governor of Pennsylvania and the Mayor of Philadelphia and is financed by dues paid by 1984 members and by the proceeds from certain money-raising projects. The Emergency Aid is administered by an executive committee, of which Mrs. H. Norris Harrison is president. Their activities are divided into the following services: emergency, war, medical and health, and civic and welfare.

The Emergency Aid medical and health service has promoted the following projects: provided transportation service for cerebral palsy patients to and from clinics; staffed exhibits at venereal disease centers; assisted in a survey of the relationship between diabetic and tuberculous patients; distributed gifts yearly to all tuberculous patients in Municipal and Philadelphia General Hospitals; mended hospital garments for Municipal Hospital; clothed and paid carfare for patients sent to State tuberculosis sanatoriums; a special relief bureau has served more than 2000 families; sponsored after-school recreation in three public schools, as well as numerous other health and welfare projects.

Such service dedicated to improving health standards, assisting during financial hardships, and bringing cheer and hope to the more unfortunate surely is deserving of The Medical Society of the State of Pennsylvania's Benjamin Rush Award.

These two awards are made yearly by The Medical Society of the State of Pennsylvania from nominations submitted by its component county medical societies. Presentation of the awards will be made at the presidential installation meeting to be held in Carnegie Music Hall, Pittsburgh, on Sept. 27, 1949.

The awards to be presented take the form of a bronze medallion depicting the features of Dr. Benjamin Rush, a native Pennsylvanian, signatory to the Declaration of Independence, who occupied during his life the central place on the stage of American medicine.

The yearly presentation of the Benjamin Rush Award by The Medical Society of the State of Pennsylvania expresses the medical profession's appreciation of the contributions made by all lay

individuals and lay organizations which have collaborated with the profession in the promotion of better health and medical care in Pennsylvania. The award winners exemplify hundreds of public-spirited citizens who voluntarily contribute their time and talents toward improving health facilities in Pennsylvania.

Miniature medallions of Dr. Benjamin Rush will be presented by the local county medical societies in behalf of the State Society to all nominees selected by any county medical society. It is hoped that the lay individuals and lay organizations will consider their nomination by a county medical society a tribute to the work which they have done, and that the medallion will be accepted as a small expression of the thanks which the medical profession feels it owes.

County medical societies which have submitted nominations have been encouraged to make appropriate plans for presentation of local awards at a public meeting, at which time due recognition may be given to the lay individual and lay organization selected.

The briefs which accompanied this year's nominations were statements of generous and whole-hearted public service—a tribute to the accomplishments of free men in a free nation. The response from the county societies this year was a bit discouraging. However, with the presentation of local awards, providing an opportunity for recognition at the local level, it is hoped that greater participation on the part of the county medical societies will be forthcoming next year. The following nominations were submitted this year:

LAY INDIVIDUAL

<i>County</i>	<i>Nomination</i>
Centre	Mrs. Leonard D. Doggett, State College
Erie	Mr. Clyde M. Langdon, Erie
Lycoming ...	Mr. Harry Plankenhorn, Williamsport
Mercer	Mr. Carroll D. Kearns, Sharon
Montgomery .	Rev. Lester K. Kriebel, Pennsburg
Potter	Mrs. Kathryn Dorfeld, Coudersport
Philadelphia .	Mr. Ellis A. Gimbel, Philadelphia

LAY ORGANIZATION

<i>County</i>	<i>Nomination</i>
Centre	Centre-Clearfield Crippled Children's Society
Erie	Erie Lions Club
Lehigh	American Business Club, Allentown
Mercer	Cooper-Bessemer Corp., Grove City
Northampton.	Children's Aid Society
Philadelphia .	The Emergency Aid of Pennsylvania

Medical progress during the past century is deeply indebted to thousands of lay organizations and lay individuals who have fought side by side with the medical profession in its endless battle against disease and suffering. The Medical Society of the State of Pennsylvania greatly appreciates the humanitarian efforts and accomplishments of all individuals and organizations that have volunteered to promote public health campaigns in their own local communities.

It is hoped that each component county medical society will participate in this project next year. It is not too early to begin thinking about who deserves such recognition in your county. Nominations for the 1950 awards must be submitted prior to March 30, 1950. Each nomination should be accompanied by a brief explaining the reason for the nomination.

Alumni Dinners at Pittsburgh

The various medical schools of Pennsylvania are arranging for alumni dinners to be held Wednesday evening, September 28, at 6 p.m. Listed below are schools which have already made arrangements for such dinners, the place of these dinners, and the person to whom requests for reservations should be sent:

University of Pennsylvania—Hotel Roosevelt

C. William Weisser, M.D., 806 May Building, Pittsburgh 22.

University of Pittsburgh—Hotel William Penn

Mr. Frederic W. Fagler, 225 Jenkins Building, Pittsburgh 22.

SPECIAL CONVENTION FEATURES

RELIGIOUS HOUR

HEINZ MEMORIAL CHAPEL
UNIVERSITY OF PITTSBURGH
Fifth and Bellefield Avenues

Sunday, September 25, 1949

3: 45 p. m.

Organ Recital FREDERICK LOTZ, Organist
Symphonic Choral Prelude KARG-ELERT
A Prayer of St. Chrysostom WEAVER

4: 00 p. m.

Processional—God of Our Fathers WARREN

Opening Prayer—

RAYMOND F. BRITTAIN, D.D., Chaplain, Heinz Memorial Chapel.

Hymn—O God, Our Help in Ages Past CROFT

Address—

SOLOMON B. FREEHOF, D.D., Rodef Shalom Temple, Pittsburgh.

Anthem—Brother James' Air BAIN-JACOB

Address—

HOWARD C. SCHARFE, D.D., Shadyside Presbyterian Church, Pittsburgh.

Closing Prayer RAYMOND F. BRITTAIN, D.D.

Recessional—America the Beautiful WARD

Organ Postlude—Electa Ut Sol DALLIER

Music by vested Chapel Choir under direction of Theodore M. Finney, D.Mus.

INSTALLATION MEETING

CARNEGIE MUSIC HALL
Forbes Street and Bigelow Boulevard

Tuesday, September 27, 1949

7:45 p. m.

Organ Recital.

8: 15 p. m.

Call to Order by the President.

GILSON COLBY ENGEL, Philadelphia.

Invocation.

In Memoriam.

MILTON F. PERCIVAL, Philadelphia, Chairman of the Committee on Necrology.
Address of Welcome.

PAUL G. BOVARD, Tarentum, President, Allegheny County Medical Society.

Bestowal of Awards:

Benjamin Rush Group Award and Benjamin Rush Individual Award.

Music by the Orchestra.

Installation of the President.

Address of the President.

E. ROGER SAMUEL, Mt. Carmel.

Address.

Ralph J. Gampell, English physician who fled to the United States this year seeking freedom in the delivery of medical service.

Following the program there will be music by the Pittsburgh "Little Symphony Orchestra" of twenty-five pieces including a golden harp, under the direction of Victor Saudek. The soloists will be Mary Martha Briney, soprano, and Bob Carter, tenor, Pittsburgh's leading concert and radio vocalists.



Heinz Memorial Chapel—Described as an "exquisite gem of architectural achievement," the Heinz Memorial Chapel, the scene of the Religious Hour, stands as a spiritual complement to the giant Cathedral of Learning on the campus of the University of Pittsburgh. The gift of the children of the late H. J. Heinz, the chapel is dedicated to his memory.

MAKE YOUR HOTEL RESERVATIONS EARLY

99th ANNUAL SESSION

THE MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA

September 25, 26, 27, 28 and 29, 1949, Pittsburgh

Hotel rooms are still at a premium, but the Pittsburgh hotels, in cooperation with the Pittsburgh Convention Bureau, have assured us that there will be available ample rooms for those attending our annual meeting if the reservations are made now. Make your plans now to attend the whole session and write directly to the hotel of your choice for reservations today.

HOTEL WILLIAM PENN—General Headquarters

William Penn Way

Single rooms	\$4.50	\$5.00	\$6.00	\$7.50
Double beds	6.75	7.50	9.00	10.00
Twin beds	7.75	9.00	12.00	13.00
Suites	15.00	18.00	22.00	27.00

ROOSEVELT HOTEL—Woman's Auxiliary Headquarters

607 Penn Avenue

Single rooms	\$4.00	\$4.50	\$5.00	\$5.25
Double beds	6.50	7.50	8.00	8.50
Twin beds	8.50	9.00	9.50	10.00
Suites	14.00	17.50	18.00	23.00

PITTSBURGHER HOTEL

428 Diamond Street

Single rooms	\$4.00	\$4.50	\$5.00	\$5.50
Double beds	6.00	6.50	7.00	7.50
Twin beds	8.00			
Suites	18.50			

FORT PITT HOTEL

Tenth Street and Penn Avenue

Single rooms	\$3.50	\$4.00	\$4.50	\$5.00
Double beds	5.00	5.50	6.00	7.00
Twin beds	6.00	6.50	7.00	8.00

SHERATON HOTEL

212 Wood Street

Single rooms	\$4.00	\$4.50	\$4.85	\$5.00
Double beds	5.00	5.50	5.75	6.00
Twin beds	7.00	7.50	8.00	
Suites	9.85	11.85		

WEBSTER HALL HOTEL

4415 Fifth Avenue

Single rooms	\$4.50	\$6.00	\$8.50	
Double beds	7.00	8.50	11.00	
Twin beds	7.00	8.50	11.00	

SCHENLEY HOTEL

Bigelow Boulevard and Fifth Avenue

Single rooms	\$4.50	\$5.50	\$7.00	\$9.00
Twin beds	7.00	8.00	9.00	11.00
Suites	15.00	16.00		



EDMUND ROGER SAMUEL, M.D.

EDMUND ROGER SAMUEL

President-elect

EDMUND ROGER SAMUEL, the one-hundredth president of The Medical Society of the State of Pennsylvania, was born in Mt. Carmel, Pennsylvania, September 25, 1889, the son of Edmund William Samuel, M.D., and Alice Kiefer Samuel. Dr. Samuel was married to Emily G. Snyder in 1917, and has three daughters, Mrs. Mary Alice McCune, Mrs. Margaret Emily Cole, and Miss Dorothy Louise Samuel.

Following his graduation from the Mt. Carmel public schools, Dr. Samuel attended Dickinson College and was graduated from the University of Pennsylvania School of Medicine in 1913. After spending a year as resident physician at the Chester County Hospital and a year as pathologist at the Pennsylvania Hospital, he began the general practice of medicine in Mt. Carmel.

During World War I, Dr. Samuel served as a captain in the Army Medical Corps assigned to the British Expeditionary Forces. During his service he was wounded in action and later was awarded the Purple Heart. He has been active in veterans' affairs and is a past commander of Geist-Berkanksi Post 91 of the American Legion, Mt. Carmel.

He has served the Northumberland County Medical Society in various official capacities, and from 1933 to 1943 represented the Fourth Councilor District as a member of the Board of Trustees and Councilors of The Medical Society of the State of Pennsylvania. He served as chairman of this body from 1941 to 1943. For many years he has represented the State Society as a delegate to the American Medical Association. Dr. Samuel was a member of the Board of Directors of the Medical Service Association from 1945 to 1949. He is a member of the World Medical Association, the American Academy of General Practice, and the American Association of Railway Surgeons.

Dr. Samuel has always been active in local community affairs, having served as president of the following organizations: Kiwanis Club, Motor Club, Fraternity Club, Chamber of Commerce, and Community Concert Association.

Dr. Samuel has been active in fraternal affairs. He is a member of Phi Rho Sigma and Phi Kappa Sigma Fraternities and has been honored with the 33d degree in Masonry.

SCIENTIFIC PROGRAM

Ninety-ninth Annual Session

September 26, 27, 28, and 29

Hotel William Penn, Pittsburgh

Monday Afternoon, September 26

1:00 p.m. to 2:50 p.m.

SYMPOSIUM ON THE PRESENT STATUS OF THE SILICOSIS PROBLEM

BURGESS L. GORDON, Philadelphia, Moderator

URBAN ROOM

1:00 p.m.

The Clinical Aspects of Anthracosilicosis and Its Complications

BURGESS L. GORDON, Philadelphia.

OUTLINE: The term anthracosilicosis is discussed with special reference to the pathology, anatomic complications, and associated infections. The existing criteria for diagnosis and evaluation of disability are reviewed in the light of modern concepts of pulmonary function tests. Disproportion between the signs, symptoms, and roentgenography noted in coal miners with histories of varied periods and types of mining is stressed. Treatment is outlined for symptomatic relief as well as long-term management. Transient function improvement has been noted in certain miners following individual treatments. In a small group observed for several months impairment was lessened; some returned to work.

1:15 p.m.

Evaluation of Function in Pulmonary Disease (Lantern Demonstration).

HURLEY L. MOTLEY, Philadelphia.

OUTLINE: Clinically, pulmonary function was evaluated with respect to the patient's ability to supply oxygen to and remove carbon dioxide from the tissues both at rest and during mild exercise. Physiologic tests necessary to evaluate pulmonary function may be divided into five major groups. Most are of limited value. Arterial blood studies both at rest and during exercise provide very significant data on the magnitude and the nature of the respiratory gas exchange difficulty, but no single physiologic test was satisfactory for the accurate evaluation of disability in all cases. Physiologic tests of pulmonary function provide valuable information to supplement the usual clinical and roentgenologic examination for the appraisal of disability.

1:30 p.m.

Pathogenesis (Lantern Demonstration).

SILAS EVANS, Milwaukee, Wis. (Guest).

2:00 p.m.

Roentgenologic Aspects of Anthracosilicosis (Lantern Demonstration).

WILLIAM J. CORCORAN, Scranton.

OUTLINE: (a) Roentgenographic technique and the different stages of the disease. (b) Average length of time that exposure to free silica takes to produce changes on the roentgenogram. (c) The different stages of non-tuberculous and tuberculous infections that accompany anthracosilicosis. (d) Changes that the disease produces in the mechanics of the chest.

2:10 p.m.

Tuberculosis as a Complication (Lantern Demonstration).

C. HOWARD MARCY, Pittsburgh.

OUTLINE: Tuberculosis is the most common and the most serious complication of silicosis. The death rate from tubercu-

losis among industrial workers exposed to silica dust is higher than that of the population as a whole. The pathologic changes in the lungs resulting from the coexistence of silicosis and tuberculosis have given rise to the term silicotuberculosis. Diagnosis of beginning active tuberculous infection in silicotic lungs is most difficult. Frequently such patients will remain entirely free from diagnostic signs and symptoms of tuberculosis for many years. A worker with silicosis and active tuberculosis should be removed from the job immediately and placed under a regimen of tuberculosis treatment. Prognosis as a rule is unsatisfactory. The presence of silica dust in the lungs of patients in the older age group has already caused irreversible changes of fibrosis, pulmonary emphysema, and adhesions with a resultant lowering of their respiratory reserve. Pre-employment chest x-rays and subsequent periodic chest x-rays of those working in a silica hazard will go a long way toward solving the problem.

2:20 p.m.

Medicolegal Aspects

PENROSE HERTZLER, Esq., Pottsville.

2:50 p.m.—Intermission to View Exhibits

3:10 p.m. to 5:00 p.m.

SYMPOSIUM ON THE NEWER ASPECTS OF CARDIOVASCULAR DISEASE

ANDREW B. FULLER, Pittsburgh, Moderator

3:10 p.m.

Anticoagulant Therapy in Acute Coronary Thrombosis (Lantern Demonstration).

WILLIAM L. MULLINS, WILLIAM R. BAILEY, MARY K. HELZ, STEPHEN R. KIESTER, and JAMES D. PURVIS, Jr., Pittsburgh.

OUTLINE: The report deals with the use of anticoagulants in over 200 consecutive cases of acute coronary thrombosis admitted to the Cardiac Service of Mercy Hospital, Pittsburgh. The mortality and the thrombo-embolic complication of the treated groups are compared with an equal number of cases which did not receive anticoagulants. The mortality in the untreated group was 24 per cent. The mortality in the group treated with anticoagulants was 6 per cent. Clinical thrombo-embolic complications occurred in 15 per cent of the untreated group and in less than 2 per cent of the treated group.

3:25 p.m.

Commissurotomy for Mitral Stenosis (Lantern Demonstration).

ROBERT P. GLOVER, THOMAS J. O'NEILL, and CHARLES P. BAILEY, Philadelphia.

OUTLINE: The term commissurotomy has been suggested by Dr. Thomas Durant for a procedure in which the individual anatomic components of the stenotic mitral valve are surgically separated by incising the commissures. The principle of the operation is that a considerable degree of valvular function can be re-established in a stenotic valve without the production of any increased amount of regurgitation. The mechanical factors concerned are set forth interestingly. Marked relief of the stenosis with considerable increase in valve function can be obtained. A description of the surgical technique with direct digital guidance is presented. Indications and contraindications are proposed. The cases operated upon at our clinic are presented.

3:35 p.m.

The Clinical Aspects of Congenital Heart Disease
(Lantern Demonstration).

RACHEL ASH, Philadelphia.

OUTLINE: The presence of a congenital cardiac anomaly is fairly obvious in the individual who presents cyanosis and clubbing in association with abnormal cardiac findings. The majority of individuals with cardiovascular anomalies are not cyanotic, however. The speaker will discuss the criteria that may be used in picking out from the large group of non-cyanotic individuals with cardiac murmurs those who probably have cardiovascular anomalies. Differential diagnosis of anomalies which may be treated surgically will be stressed.

3:50 p.m.

Angiocardiography and Cardiac Catheterization as
Aids in the Diagnosis of Congenital Heart Disease
(Lantern Demonstration).HARRY F. ZINSSER, JR., Pittsburgh, and RICHARD L.
KENDRICK (by invitation), Philadelphia.

OUTLINE: As a result of the development of surgical procedures to correct certain congenital cardiac lesions, more precise methods of diagnosis were required. Angiocardiography and cardiac catheterization are two of the newer techniques available for the study of such cardiac anomalies. These techniques are discussed briefly, followed by a consideration of their application to the diagnosis of certain important congenital lesions. Among the latter conditions are included only those currently, or potentially, surgically correctable, plus a few others which require special study to differentiate them from operable cases. The presentation includes slides of the angiocardiographic films and catheterization data from typical cases.

4:00 p.m.

The Surgical Aspects of Congenital Heart Disease
(Lantern Demonstration).

JULIAN JOHNSON, Philadelphia.

OUTLINE: This presentation will deal with those congenital cardiac lesions for which surgical treatment is now generally accepted, namely, patent ductus arteriosus, tetralogy of Fallot, and coarctation of the aorta. There will be a discussion of the life expectancy without operation, the risk of operation, and the result in terms of life expectancy after a successful operation. The types of operations will be briefly considered and the age of election for the operation will be discussed in relation to the risk.

4:20 p.m.

Treatment of Heart and Kidney Disease and of Hyper-
tensive and Arteriosclerotic Vascular Disease with
the Rice Diet (Lantern Demonstration).

WALTER KEMPNER, Durham, N. C. (Guest).

OUTLINE: Effects of the rice diet in patients with benign and malignant hypertensive vascular disease, hypertensive arteriosclerotic and rheumatic heart disease, glomerulonephritis, and nephrosis will be reported. The rice diet contains less sodium, chloride, cholesterol, and protein than any other salt-poor, fat-poor, or protein-poor diet. Dangers and benefits of the diet will be discussed. Dangers, especially with regard to the serum electrolyte concentration, can be avoided by continuous observation of the patient's blood and urine chemistry over a long period of time. Beneficial effects are demonstrated by objective criteria such as blood pressure figures, chest films, electrocardiograms, and eyeground photographs. Disregarding any subjective improvements, such as the disappearance of headache, dizziness, shortness of breath, and precordial pain, only measurable criteria were used: decrease in the sum of systolic and diastolic blood pressure of at least 40 mm. Hg.; reduction in heart size with change in the transverse diameter of 18 per cent or more; change in the T 1 wave of the electrocardiogram from completely inverted to upright; disappearance of extensive hemorrhagic or exudative retinopathy. The diet proved beneficial in 62 per cent of 392 patients who followed it for an average of 37 days, and in 81 per cent of 385 patients who followed it for an average of 149 days. A number of characteristic individual cases will be discussed with demonstration of lantern slides showing heart films, electrocardiograms, and eyeground photographs. Abnormally high cholesterol concentrations present in many of the patients with arteriosclerosis, coronary heart disease, and hypertensive vascular disease, in most nephrotics and in many nephritics, are reduced by the diet to lower, often normal values in a majority of the patients who follow the diet long enough. The same is true for the nonprotein nitrogen and urea nitrogen which are found increased in the blood in patients with renal insufficiency. Nitrogen balance studies show that the protein supply is adequate in spite of the low protein intake. This is also proved by the fact that the serum protein does not decrease, but even increases in cases where it was abnormally low to begin with. Many of the patients, in whom the seriousness of their

condition requires the strictest dietary treatment to be continued over a long period of time, are normally active; usually modifications, increasingly liberal, are made after three months without adverse effects on the results obtained. However, modifications should not be made too early and not according to the patient's taste but according to clinical and chemical findings.

Tuesday Morning, September 27

9:00 a.m. to 10:20 a.m.

MEDICINE—SYMPOSIUM ON DIABETES
MELLITUS

GEORGE F. STONEY, Erie, Moderator

URBAN ROOM

9:00 a.m.

Types of Diabetes Mellitus and Their Treatment (Lan-
tern Demonstration).

ARTHUR R. COLWELL, Chicago, Ill. (Guest).

OUTLINE: Successful and efficient management of diabetes mellitus involves, first, the consistent use of a maintenance diet which is not extravagant in its carbohydrate content; and second, a firm belief in the desirability of maintaining relative freedom from abnormal glycosuria insofar as is possible without frequent insulin reactions or intolerable inconvenience. An understanding of the characteristic time action of various insulin modifications together with an appreciation of inherent differences between various types of diabetes is essential for successful application of these policies.

Discussion opened by J. WEST MITCHELL, Pittsburgh.

9:40 a.m.

Treatment of Juvenile Diabetics.

W. WALLACE DYER, Philadelphia.

OUTLINE: Consideration is given to the degree of control desirable in these patients and methods by which it can be obtained. Some discussion is devoted to the extra-medical handling of the juvenile diabetic and the parents.

Discussion opened by THADDEUS DANOWSKI, Pitts-
burgh.

9:00 a.m. to 10:20 a.m.

SURGERY—EYE, EAR, NOSE, AND
THROAT DISEASES

MONONGAHELA ROOM

9:00 a.m.

Ocular Aspects of Systemic Disease.

JAY G. LINN, Pittsburgh.

OUTLINE: There are certain recognized ocular signs which are due to one or more generalized conditions. We shall discuss lid edema, ptosis, squint, congestion of eyeball, mydriasis, miosis, anisocoria, haziness of media, retinal congestion, hemorrhages and exudates, edema of nerve head, pallor and excavation of optic disk. These discussions will, necessarily, be brief but we shall endeavor to be practical.

9:20 a.m.

Acute Obstructive Laryngitis in Children (Lantern
Demonstration).

FRANCIS W. DAVISON, Danville.

OUTLINE: Acute obstructive laryngitis is one of the few real medical emergencies. Few deaths should occur if a correct diagnosis is made and if the serious cases are promptly referred to a hospital properly equipped to treat patients of this type. The differential diagnosis of the six causes of acute obstructive laryngitis will be discussed. All physicians should know that acute supraglottic laryngitis can cause sufficient dyspnea to require tracheotomy four hours following the first symptoms.

9:40 a.m.

Medical Criticism of Modern Automotive Engineering.
FLETCHER D. WOODWARD, Charlottesville, Va.
(Guest).

10: 20 a.m.—Intermission to View Exhibits

10: 40 a.m. to 12: 00 noon

**MEDICINE—SYMPOSIUM ON PEDIATRICS
ENDOCRINOLOGY**

URBAN ROOM

10: 40 a.m.

Hypothyroidism in Infancy and Childhood.

R. MARVEL KEAGY, Altoona.

OUTLINE: The signs and symptoms of cretinism may conveniently be grouped into four categories, as suggested by Gesell, namely: (1) metabolic, (2) infiltrative, (3) skeletal, and (4) developmental. The syndrome of subnormal temperature, slow heart rate, a persistently wide fontanel, dwarfing with disproportionately short legs, and submature and sluggish behavior patterns should arouse a suspicion of hypothyroidism. It further justifies the administration of thyroid substance as a diagnostic test. The clinical picture varies considerably depending on the age of the patient at the time of onset and the duration of the condition. Developmental tests have been shown by Gesell to be valuable both as a diagnostic aid and a prognostic indicator. Only dependable, well-assayed products should be used in treatment.

10: 55 a.m.

Can Mongolism Be Eliminated?

RUSSELL E. SANGSTON, Uniontown.

OUTLINE: Mongolism has been considered by the medical profession to be a congenital defect with a questionable etiology and a hopeless prognosis. Recently Benda has made some interesting observations from which we might gain some hope that mongolism may eventually be eliminated. He has made an extensive study of the prenatal maternal factors in mongolism and feels that they are primarily responsible for this condition. Mongolism is not a malformation nor a monstrosity, but a deceleration of normal growth during the fetal period of six to fourteen weeks. The Mongol's family is usually free of mental defects. The siblings develop normally and have no stigmata of the disease. The main problem in mongolism should be in its prevention. Since it is a decelerating growth deficiency in the prenatal period, therapy must be concentrated on factors which will increase the developmental rate of the newborn. Perhaps it is not too much to expect that in the near future the obstetricians will solve more and more of these threshold hormonal sterility problems, and eventually lead to the elimination of this mongoloid problem.

11: 10 a.m.

Pituitary Disorders in Childhood.

BENJAMIN J. WOOD, Sharon.

OUTLINE: This paper deals with various alterations produced by disturbed function of the pituitary gland in children. Included is a brief discussion of the anatomy and physiology; various clinical syndromes resulting from altered function; effect on growth, sex, nutrition, and metabolism; the relationship of the pituitary to other endocrine glands; diagnostic procedures of value in determining specific pituitary disorders; and corrective measures available at present.

11: 25 a.m.

The Anemias of Infancy and Childhood.

WOLF ZUELZER, Detroit, Mich. (Guest).

10: 40 a.m. to 12: 00 noon

**SURGERY—SYMPOSIUM ON ADVANCES
IN SURGERY**

JOHN H. GIBBON, JR., Philadelphia, Moderator

MONONGAHELA ROOM

10: 40 a.m.

Surgical Aspects of Gastric and Duodenal Ulcer.

JOHN D. STEWART, Buffalo, N. Y. (Guest).

11: 10 a.m.

The Use of Tantalum Gauze Mesh in the Repair of Fascia Deficient Hernias (Lantern Demonstration).

JAMES VICKERS SCOTT, Pittsburgh.

OUTLINE: The repair of incisional or inguinal hernias complicated by marked fascia deficiency has been technically difficult, and the results have been generally poor. The use of tantalum gauze mesh offers a method superior to the employment of fascia lata, fascial flaps, or dermis grafts. Indications for its use, technique of surgical implantation, anatomic and physiologic results obtained, and complications will be given.

11: 20 a.m.

Modern Treatment of Actinomycosis (Lantern Demonstration).

WALTER S. NETTROUR, Pittsburgh.

OUTLINE: A 30-year-old white male was treated for one year with incision and drainage of a large left abdominal wall abscess. A series of iodides, penicillin, and streptomycin resulted in only transient improvement. It was decided to combine antibiotics with radical surgery to rid the patient of the fungus disease. After a week of preoperative streptomycin therapy, the entire scarred area was excised. The process involved the rectus muscles and peritoneum. On opening the latter, about one-half of the stomach was involved with the process extending into the gastrocolic omentum, an ulcer on the lesser curvature of the stomach, and an adjacent subhepatic abscess. The diseased area was removed including a subtotal gastric resection and anterior gastrojejunostomy. The patient made a complete recovery and has been free of symptoms and drainage for one year.

11: 30 a.m.

Recent Advances in Surgery of the Esophagus. A Discussion of Cervical Esophagogastrostomy (Lantern Demonstration).

FRANK F. ALLBRITTEN, JR., Philadelphia.

OUTLINE: Satisfactory surgical treatment for carcinoma of the lower portion of the thoracic esophagus has been developed in the past decade. Only 35 successful resections of the thoracic esophagus for neoplasm had been reported up to 1938. Since that time the excision of the lower two-thirds of the esophagus by transthoracic resection and immediate intrathoracic esophagogastrostomy has offered a reasonable chance of cure and palliation of symptoms. However, resection of an esophageal neoplasm above the arch of the aorta presents difficulty in the reestablishment of the oral intestinal continuity. The development of a successful procedure for the resection of neoplasms in this area is given and illustrative cases cited. Preoperative preparation, replacement of blood lost during the operative procedure, the method of anesthesia, and postoperative care are stressed.

11: 40 a.m.

The Surgical Treatment of Pancreatic and Bile Duct Tumors (Lantern Demonstration).

WILLIAM G. WATSON, Pittsburgh.

OUTLINE: A brief discussion is presented of the types of tumors of the bile ducts and pancreas with their associated pathologic physiology. A historical review of the development of various surgical procedures dealing with these lesions is given. Differential diagnosis with special attention to lesions responsible for obstructive jaundice is considered. The material is illustrated by reference to a group of patients operated upon for the removal or palliation of bile duct and pancreatic neoplasms.

Tuesday Afternoon, September 27

1: 20 p.m. to 3: 00 p.m.

MEDICINE—DERMATOLOGY

URBAN ROOM

1: 20 p.m.

Dermatitis and Fabrics.

LOUIS SCHWARTZ, Washington, D. C. (Guest).

1: 50 p.m.

Skin Diseases in Children.

SAMUEL R. PERRIN, Pittsburgh.

2:10 p.m.

Further Observations on the Use of Undecylenic Acid Administered Orally in the Treatment of Psoriasis (Lantern Demonstration).

SIGMUND S. GREENBAUM and HENRY H. PERLMAN, Philadelphia.

OUTLINE: Noticeable improvement in a series of 17 psoriatic patients to whom undecylenic acid had been administered orally prompted the further study of this unsaturated fatty acid among other psoriatic patients. It was found that, although undecylenic acid administered orally is effective in causing improvement of the lesions in many patients, its action is rather slow. A series of adults, both males and females, was studied for the oral administration of undecylenic acid accompanied by topical therapy either with the same unsaturated fatty acid as a 10 per cent ointment, or with a 3 per cent salicylic and ammoniated mercury ointment, or with 0.25-0.5 per cent anthralin ointment. After complete disappearance of lesions, administration of the acid by mouth was continued, in smaller dosage, for various periods. It appears that the lesions of psoriasis clear much more quickly under the "combined" method of therapy than under that of the acid alone administered orally.

General discussion.

1:20 p.m. to 3:00 p.m.

SURGERY—SYMPOSIUM ON SURGERY OF TRAUMA

SAMUEL P. HARBISON, Pittsburgh, Moderator

MONONGAHELA ROOM

1:20 p.m.

The Treatment of Compound Fractures of the Long Bones.

GEORGE V. FOSTER, Pittsburgh.

OUTLINE: The advent of antibiotics has by no means completely prevented infection arising even when the compound fractures are seen very early. A comparison is made in this paper with a previous series.

1:30 p.m.

Immediate Treatment of Soft Tissue Injuries.

S. MILTON DUPERTUIS, Pittsburgh.

OUTLINE: In the field of plastic and reconstructive surgery our interest centers repeatedly upon the healing of soft tissue wounds. We are convinced that the most effective way to render an early contaminated wound sterile is by gentle mechanical cleansing and irrigation of the tissues with normal saline solution, removal of devitalized tissue, and trimming of torn edges for better healing. Investigate and repair the deeper damaged structures in the early wound. It is never the suture material but the manner in which it is employed that permits accurate healing of the skin edges for a fine line scar. Close the wound edges in layers using fine suture material, particularly for facial lacerations. Moderate pressure dressings minimize the extravasation of blood and serum and contribute to the immobilization of the skin edges for better healing.

1:40 p.m.

Tendon Injuries.

CHESTER A. PHILLIPS, JR., Pittsburgh.

OUTLINE: The anatomy and physiology of the hand as applied to the diagnosis and treatment of tendon and nerve injuries will be presented. The physiology of tendon healing will also be stressed in an effort to bring a better understanding of the proper splinting and physiotherapy necessary in the after-care of this type of injury.

1:50 p.m.

Abdominal Trauma (Lantern Demonstration).

WILLIAM H. ERB, Philadelphia.

OUTLINE: The problem of abdominal injuries can be divided into two main categories: (1) penetrating wounds; (2) non-penetrating injuries. All penetrating wounds into or directed toward the peritoneal cavity should be explored as soon as the general condition of the patient permits. Operative technique and pre- and postoperative care including anti-shock, chemo- and antibiotic therapy, will be presented. In non-penetrating injuries, emphasis will be placed on differential diagnosis and the indications for non-surgical and surgical therapy. The syndrome of blast injuries will be given.

2:00 p.m.

Thoracic Injuries (Lantern Demonstration).

GEORGE P. ROSEMOND, Philadelphia.

OUTLINE: Management of thoracic injuries has been clarified by the accurate recording of experiences gained during World War II. Pneumothorax and hemothorax should be quickly eliminated by the best available method. A foreign body should receive secondary consideration. The possibility of a combined thoraco-abdominal injury must be kept in mind, especially in penetrating injuries. Patients with thoracic injuries are poor surgical risks. Supporting measures with other treatment should be instituted promptly. Avoid early radical surgery if possible. The most important consideration is the rapid restoration of normal pulmonary function by the simplest effective method.

2:10 p.m.

Cerebral Trauma (Lantern Demonstration).

STUART N. ROWE, Pittsburgh.

OUTLINE: This brief review of cerebral trauma may be divided into three parts: (1) comments upon immediate treatment of acute head injuries when first seen; (2) usual régime of therapy and observation for the patient with average mild or moderately severe head trauma; (3) critical changes in patient's condition which suggest the need for surgical intervention. Each of the types of head injury best treated by surgical attack will be presented briefly from the standpoint of diagnosis and treatment and the results usually obtained.

2:20 p.m.

Rehabilitation.

DONALD A. COVALT, New York, N. Y. (Guest).

3:00 p.m.—Intermission to View Exhibits

3:20 p.m. to 5:00 p.m.

MEDICINE—CLINICOPATHOLOGIC CONFERENCE

URBAN ROOM

ELWYN L. HELLER, Pittsburgh, Pathologist

WILLIAM W. G. MACLACHLAN, Pittsburgh, Clinician

KENDALL A. ELSOM, Philadelphia, Clinician

(Review case histories—pages 1105 to 1107, JULY JOURNAL)

3:20 p.m. to 5:00 p.m.

SURGERY—OBSTETRICS AND GYNECOLOGY

MONONGAHELA ROOM

3:20 p.m.

Hysterectomy—Indications and Contraindications.

ELVIN J. BATEMAN, Pittsburgh.

OUTLINE: The function of the uterus. The place of the uterus in the endocrine system. Physiologic and psychic effects of its removal. Recent justifiable and unjustifiable criticisms of hysterectomy. The unfairness of using laboratory reports as sole criteria for justification or criticism of the operation. Discussion of the purposes for which the operation should be, may be, and should not be performed.

3:35 p.m.

Management of Toxemias of Pregnancy in an Open General Hospital (Lantern Demonstration).

JOSEPH J. KOCYAN, Wilkes-Barre.

OUTLINE: Toxemia of pregnancy remains a major problem for the obstetrician. A plan of management that includes all known factors will greatly reduce the incidence and mortality. There are no short cuts in the treatment of toxemia. Hospital obstetric staffs can do much to aid physicians by providing adequate emergency measures. Details of such a program are presented with the ten-year record of a total of 500 cases of toxemia. Eighty-five per cent of the obstetric patients in the Wilkes-Barre General Hospital were attended by a total of 121 general practitioners. The record of the hospital represents a fair sample of work of the physicians in a well-organized community of Pennsylvania.

3:50 p.m.

The Diagnostic Delay Period of Pelvic Cancer.

JOHN Y. HOWSON, Philadelphia.

OUTLINE: Diagnostic delay occurs so frequently in pelvic cancer cases. Ten specific points are proposed as remedial measures for avoiding such delay, namely: adequate history; complete pelvic examination at patient's first visit; knowledge of normal and abnormal reactions of the menopause; proper use of hormones and their relation to a proved diagnosis; careful management of the postmenopausal patient from standpoint of vaginal discharge or bleeding; rational use of cervical biopsy; careful management of cervical polyps; use of x-ray and radium only after an adequately proved diagnosis; management of gross gynecologic pathology and its relation to cancer; and finally, an ever present awareness of the possibility of cancer and an intrepid desire to make an early diagnosis.

4:05 p.m.

Obstetric Hemorrhage—Cesarean Section.

CHARLES A. GORDON, Long Island, N. Y. (Guest).

Wednesday Morning, September 28

9:00 a.m. to 10:20 a.m.

MEDICINE—MISCELLANEOUS

URBAN ROOM

9:00 a.m.

Present Ideas Concerning Body Fluids and Electrolytes (Lantern Demonstration).

THADDEUS DANOWSKI, Pittsburgh.

OUTLINE: Recent studies have emphasized the clinical importance of considering the water and electrolytes of the body as sub-divided into two compartments. The smaller, called the extracellular, consisting of interstitial fluid and of plasma, serves as the environment for the cellular phase. Earlier work acknowledged the existence of pronounced differences in the electrolyte composition of these two phases. Recent contributions from experimental and clinical studies have accentuated the marked circulatory changes which accompany increases and decreases in the chief extracellular electrolytes. Balance studies in which external and internal exchanges have been calculated indicate that in various diseases profound alterations occur in the cellular, as well as in the extracellular, portions of the body water and solutes. These have been directionally and quantitatively defined in infantile diarrhea, in vomiting infants, in adult gastro-intestinal disorders, including ulcerative colitis, in diabetic acidosis and coma, in renal failure, and in subjects receiving nitrogen-mustard therapy.

9:15 a.m.

Some Aspects of the Relation of Cholesterol to Vascular Disease (Lantern Demonstration).

JOHN H. PETERS (by invitation), Pittsburgh.

OUTLINE: The problem is rendered confusing by marked species differences which make interpretation of animal experiments uncertain. Recent development of methods for parenteral fat administration sheds light on acute effects. The fallacies of unjustified correlation of serum cholesterol levels with the degree of deposition in the arterial tree must be stressed. The implications of known facts in present-day therapeutics and prophylaxis will be briefly discussed.

9:30 a.m.

Clinical Manifestations of Hypo- and Hyperpotassemia. SAMUEL BELLET, Philadelphia.

OUTLINE: The significance of hypopotassemia and its effect on the clinical picture has been receiving increasing attention in the past few years. Hypopotassemia may be observed under the following conditions: following treatment of diabetic acidosis; in various states accompanying fluid loss as, for example, vomiting and diarrhea; in Cushing's syndrome and familial periodic paralysis. The syndrome of hypopotassemia in its typical state is characterized by profound weakness, difficulty in respiration, low blood pressure, muscle atonicity, cardiac dilatation, ectopic rhythm, and characteristic electrocardiographic findings. These alterations are usually promptly relieved following the administration of potassium. Hyperpotassemia is usually observed with azotemia. It may occasionally be seen following the administration of potassium in patients with renal impairment. This state is difficult to recognize clinically since its existence is usually

obscured by the underlying disease. The electrocardiogram is of some help in this respect and shows more or less typical changes of this state.

9:45 a.m.

Etiology and Pathology of Rheumatic Fever (Kodachromes).

JOHN EIMAN, Abington.

OUTLINE: The etiology of rheumatic fever is still obscure. In the light of studies extending over the last two decades, it is obvious that several factors must be considered. They act either in sequence or synergistically. Climate, crowding, nutritional deficiencies—especially of vitamin C—and sensitization to various proteins apparently act as conditioning factors. Subsequent infections, most commonly with streptococci, provide the "trigger mechanism." The pathologic changes in the body are widespread and are not confined to a single organ or system. The vascular system and especially the heart are most commonly involved. The lungs and joints are often affected. The primary lesions are seen either in the collagen and elastic tissues or involve all the structures of blood vessels producing a widespread angitis. The pathognomonic lesions are Aschoff's nodes or characteristic granulomatous lesions in the myocardium.

10:00 a.m.

Pennsylvania's State Rheumatic Fever Program.

JOHN P. HUBBARD, Philadelphia.

OUTLINE: In 1945 the General Assembly of the Commonwealth of Pennsylvania passed the "School Health Act" under which periodic examinations are made of all school children. In the same year the Pennsylvania Legislature appropriated \$120,000 annually to the Department of Health for a state-wide rheumatic fever program in which thirteen clinics have been created and more are scheduled. Into these clinics are received large numbers of children, most of whom are referred from school health examinations. In 1948 only about half of the children attending the clinics were listed as having some evidence of rheumatic heart disease. Attention is drawn to the high per capita cost for visits to the clinics, and the suggestion is made that the State would be doing more good at less per capita cost if it were made possible for consultant physicians, with special training and experience in the diagnosis and care of rheumatic fever, to visit the schools and examine doubtful cases on the spot, together with the school physician.

9:00 a.m. to 10:20 a.m.

SURGERY—SYMPOSIUM ON PEDIATRIC SURGERY

JOSEPH A. SOFFEL, Pittsburgh, Moderator

MONONGAHELA ROOM

9:00 a.m.

Emergency Congenital Surgery of the Newborn (Lantern Demonstration).

ELMER S. A. KING, Pittsburgh.

OUTLINE: Omphalocele, diaphragmatic hernia, and congenital atresia of the esophagus will be discussed with reference to the value of early diagnosis, early operation, and preoperative and postoperative management. Surgical technique and methods of approach will be stressed.

9:10 a.m.

Malignant Tumors in Childhood.

JOHN H. WOLF, Philadelphia.

OUTLINE: Neuroblastoma sympathicum and Wilms' tumor will be discussed, as they are the two most frequent neoplasms of the abdomen in childhood. Their pathology, symptoms, x-ray findings, differential diagnosis and treatment, and prognosis will be covered briefly.

9:20 a.m.

Congenital Anomalies of the Urinary Tract in Infants and Children (Lantern Demonstration).

SAMUEL H. JOHNSON, III, Pittsburgh.

OUTLINE: The role played by congenital anomalies of the urinary tract in the production of obscure abdominal pain, pyuria, and fever is reviewed with methods of examination and diagnosis. No patient should be blindly explored, as with modern urologic instruments a reasonably accurate preoperative diagnosis can be made in practically every case.

9:30 a.m.

The Management of Imperforate Anus (Lantern Demonstration).

C. EVERETT KOOP, Philadelphia.

OUTLINE: Imperforate anus is the surgical emergency of the newborn period which allows the greatest latitude in management insofar as time is concerned. Delay in operation beyond the third day of life materially increases the morbidity and mortality because of the physiologic changes in the newborn infant. When the blind rectal pouch is within easy reach (maximum 1.5 cm.) of the perineum, the surgical procedure should be through the perineum, with a minimum of trauma. If at a greater distance than 1.5 cm., two operative procedures are possible. The presence of a rectovaginal fistula permits postponement of operative procedure until conclusion of the neonatal period.

9:40 a.m.

The Etiology and Treatment of Hirschsprung's Disease.

ORVAR SWENSON, Boston, Mass. (Guest).

10:20 a.m.—Intermission to View Exhibits

10:40 a.m. to 12:00 noon

MEDICINE—SYMPOSIUM ON MODERN THERAPY

URBAN ROOM

10:40 a.m.

Medical Rehabilitation of the Physically Handicapped (Lantern Demonstration).

MURRAY B. FERDERBER, Pittsburgh.

OUTLINE: The hemiplegic patient presents a problem to the practitioner. Physical recovery is the immediate problem, but rehabilitation is the ultimate aim. With increasing distances traveled by busy practitioners, it is necessary to devise simple methods to perform such activities that will bring the patient progressively on the road of recovery. It is frequently difficult and expensive to have physical therapists traveling to and from the homes of these patients; and it is incumbent upon the medical profession to illustrate to the families simple methods of carrying out a graded exercise program. This report is intended to illustrate equipment which can be made in the average home, and to demonstrate simple physiologic principles of preventing contractures and atrophy, both of which lead frequently to complete disuse.

10:55 a.m.

Clinical Use of the Newer Antibiotics.

HAROLD A. ZINTEL, Philadelphia.

OUTLINE: Clinical and laboratory experiences with the newer antibiotics will be discussed. Bacitracin and aerosporin or polymixin-B have been demonstrated to be effective antibiotic agents; however, they are nephrotoxic when administered systemically. The development of aureomycin and chloromycetin marks a new era in the history of antibiotic therapy, since these agents are not only effective in the treatment of infections caused by bacteria but are effective in the treatment of infections caused by viruses of the psittacosis-lymphogranuloma group and certain Rickettsia.

The synthetic commercial production of chloromycetin also marks a unique development in the history of antibiotics. Changing ideas regarding the use of penicillin and streptomycin will also be discussed.

11:10 a.m.

Treatment of Hypertension.

WILLIAM A. JEFFERS, Philadelphia.

OUTLINE: In the Hypertension Clinic of the Hospital of the University of Pennsylvania, an attempt has been made during the past year to evaluate various agents for the treatment of hypertension. These have included the rice diet, nitrites, veratrum and dihydroergocornine, as well as certain other less commonly used agents. The results to date indicate a favorable response where one or several of these agents have been used. In the event of severe hypertension, with well-preserved renal function, and no response to the intensive medical therapy, surgical sympathectomy has been resorted to. The rationale of these several measures will be discussed briefly.

11:30 a.m.

The Medical Aspects of Atomic Weapons.

IRWIN M. POCHAPIN, Pittsburgh.

10:40 a.m. to 12:00 noon

SECTION ON SURGERY

JULIAN JOHNSON, Philadelphia, Moderator

MONONGAHELA ROOM

10:40 a.m.

Mammoplasty Procedures in the Female (Lantern Demonstration).

HANS MAY, Philadelphia.

OUTLINE: A number of operations have been devised for reconstruction of breast deformities. Some are performed in one stage, others in two stages. None of the various procedures is applicable for every single type of breast deformity. Plastic amputation of the breast with free transplantation of the nipples is advised for correction of the larger hypertrophic type of breasts. Cosmetic appearance after the reconstruction is most satisfactory. The fear that this operation may lead to cystic degeneration or other dysfunction is unfounded.

10:50 a.m.

The Treatment of Fractures of the Shaft of the Radius and Ulna (Lantern Demonstration).

LEONARD F. BUSH, Danville.

OUTLINE: The discussion will be chiefly confined to the treatment of fractures of the shafts of the ulna and radius by means of open and closed reduction. The types of internal fixation will be discussed along with the causes and treatment of non-unions. The closed type of fractures will be discussed briefly. A résumé of the interesting cases which have been treated at the Geisinger Memorial Hospital and Clinic in the past few years will be presented.

11:05 a.m.

Reconstruction of the Common Bile Duct.

ISIDOR S. RAVDIN, Philadelphia.

OUTLINE: Injuries of the common duct occur with an alarming frequency. In general, they result from the failure to visualize, adequately, the junction of the cystic and common bile ducts. The best time to reconstruct the common duct is immediately following the injury. At such a time, direct end-to-end suture with mucosal approximation will usually give a good result. Whenever the common duct is reconstructed by direct end-to-end suture, the T tube placed in the common duct should never come out at the line of suture, for this will nearly always result in subsequent stricture. The methods used for late reconstruction of the common duct will be discussed, as well as pre- and postoperative care of the patient.

Wednesday Afternoon, September 28

1:20 p.m. to 3:00 p.m.

MEDICINE—MENTAL AND NERVOUS DISEASES

URBAN ROOM

1:20 p.m.

Sex Deviate.

EDWARD E. MAYER, Pittsburgh.

OUTLINE: The sex deviate throughout history has been a public problem. The attitude towards pervers in ancient days contrasted with the modern one. Psychiatry had nothing to offer until the development of psychoanalysis gave the physician a clearer insight into this problem. A digest is given of psychosexual development and the influences which tend to bring on sex deviations. However, the medical profession generally has not accepted the views of present-day psychologic medicine. It cannot be expected therefore that the courts should wholeheartedly do so. The recent legislative attempts to adopt a constructive plan, naturally therefore, produced conflicting opinions. The writer concludes by summarizing his personal opinions on the problem.

1:35 p.m.

The Place of Psychosurgery in the Treatment of Mental Diseases.

FRANCIS C. GRANT, Philadelphia.

OUTLINE: No reduction in cerebral tissue is without its penalty in terms of loss of function; no cranial operation is without danger; the public has been given the impression that psychosurgery can accomplish miracles for the mentally ill; few

neurosurgeons are psychiatrists and fewer psychiatrists can carry out neurosurgical procedures. An effort will be made to review the literature to determine, if possible, which mentally ill patients, at what stage of their illness, and by what surgical technique are most helped by cerebral excision.

1: 50 p.m.

Psychiatric Unit in the General Hospital; Community Needs and Resources (Lantern Demonstration).

ELMER L. HORST, Reading.

OUTLINE: Modern psychiatry demands that we give prompt, effective treatment to psychotic patients. To fulfill this, an increasing number of general hospitals have added psychiatric treatment units. Each community must study its own particular problem. An intensive statistical survey of the author's community reveals that it has one of the highest suicide rates in the United States. Approximately 10,000 of its citizens have had or will need hospitalization for mental disorders. Private psychiatrists are available in the community. To give adequate training to interns and residents, the general hospital like our city hospitals must emphasize emotional problems and early psychiatric therapy. Statistics also show that funds in the community are available. The time has come when the public must decide whether each community will offer therapy or go on "putting people away."

2: 05 p.m.

The Problem of Neuritis.

LOUIS J. KARNOSH, Cleveland, Ohio (Guest).

OUTLINE: To both doctor and patient the term "neuritis" connotes any disease or irritation of a peripheral nerve, and particularly one in which pain is the prominent symptom. Neuritis implies an inflammation of the nerve trunk which rarely occurs or which can rarely be proved. We must condone its incorrect use and accept the term as applied to a vast congeries of painful subjective disturbances referred to one or more peripheral nerve trunks and their branches. This discourse, therefore, shall concern itself with all conditions in which pain is the main presenting symptom. A classification of such "neuritis" is valuable to the clinician only if it is based on an illuminating etiology or at least upon natural therapeutic considerations—the exposure syndromes, polyneuritis, the neuritis of root disease, and pseudoneuritis.

1: 20 p.m. to 3: 00 p.m.

SURGERY—CLINICOPATHOLOGIC CONFERENCE

MONONGAHELA ROOM

ALLEN GRAHAM, Pittsburgh, Moderator

CLINICIANS: James J. Lee, Richard E. Haber, Clarence B. Penrod, and John W. Shirer, Pittsburgh.

(Review case histories—pages 1210 to 1212, this issue)

3: 00 p.m.—Intermission to View Exhibits

3: 20 p.m. to 5: 00 p.m.

MEDICINE—SYMPOSIUM ON VIRUS DISEASES

JOSEPH STOKES, Philadelphia, Moderator

URBAN ROOM

3: 20 p.m.

The Virus Diagnostic Research Laboratory (Lantern Demonstration).

WERNER HENLE (by invitation), Philadelphia.

OUTLINE: The Virus Diagnostic Research Laboratory at the Children's Hospital of Philadelphia was organized as a division in the Virus Research Laboratories. This laboratory is enabled to apply new procedures to its diagnostic work as they evolve in the research laboratories, and to channel specimens of special interest to the individual research laboratories. The function of the laboratory consists of three phases: (1) diagnostic work on specimens from individual cases, (2) studies on outbreaks and epidemics, and (3) research. By the use of serologic procedures, such as the complement-fixation, agglutination, hemagglutination-inhibition, and neutralization tests, the laboratory can aid in the diagnosis of a number of viral and rickettsial diseases. Between October, 1946, and April, 1948, this laboratory has rendered confirmatory or differential diagnoses of cases of influenza, ornithosis, Q fever, atypical pneumonia, mumps, in particular mumps meningo-encephalitis, lymphocytic choriomeningitis, herpes simplex, Rocky Mountain spotted fever, and typhus.

3: 35 p.m.

Viral and Rickettsial Diseases Affecting the Lung.

JONAS E. SALK (by invitation), Pittsburgh.

OUTLINE: During the past year considerable attention has been focused on the so-called "virus pneumonias." This has been due, in large part, to the reports of successful treatment of the "atypical pneumonias" with the new antibiotics, chloramphenicol (chloromycetin) and aureomycin. In view of the very preliminary state of our knowledge of the etiology of the diseases to which attention has been drawn in this way, it is desired to discuss the role of the viral and rickettsial agents as a cause of pulmonary disease in man.

3: 50 p.m.

Viral Hepatitis—Progress and Problems (Lantern Demonstration).

W. PAUL HAVENS, JR., Philadelphia.

OUTLINE: As a result of investigations of recent years, new information has become available on the cause, possible manners of spread and prevention, and the clinical course of at least two forms of viral hepatitis. One of these is called *infectious hepatitis*, the naturally occurring disease; the second has been arbitrarily termed *homologous serum hepatitis* to designate that form of disease produced artificially by the parenteral inoculation of human blood or its products contaminated by a virus of hepatitis. The exact relationship between these two forms of disease is not known. Although they are indistinguishable clinically and pathologically, there is reason to believe that certain differences exist between them, which suggest that they are not identical but similar diseases. In spite of the advances made in our knowledge of these diseases, many important problems await solution.

3: 20 p.m. to 5: 00 p.m.

SURGERY—UROLOGY

MONONGAHELA ROOM

3: 20 p.m.

Testis Tumors.

LLOYD G. LEWIS, Washington, D. C. (Guest).

OUTLINE: The incidence of testis tumors is approximately 1 in 50,000 men per year. Differential diagnosis is accomplished by evaluation of the history and meticulous bimanual palpation of the testis. Tapping of a hydrocele to facilitate palpation is recommended, but testicular biopsy is, we believe, contraindicated. When in doubt, the diagnosis can be confirmed by scrotal exploration. The large majority of testicular tumors are of germ cell origin. Seminoma is a relatively benign, slow growing, metastasizing tumor, singularly responsive to radiation therapy. All other tumors of germ cell origin are teratoid in nature and radioresistant. All such tumors should, in our opinion, be subjected to retroperitoneal resection of the spermatic cord and lymph chain.

3: 50 p.m.

The Care of the Man with Advanced Malignancy of the Prostate (Lantern Demonstration).

AXEL K. OLSEN, Sayre.

OUTLINE: Disabling pain or evidence of actual involvement of the nerve pathways with paralysis and anesthesia are apparently relatively uncommon complications as demonstrated by their occurrence in only 9 of 92 patients treated for carcinoma of the prostate over a period of three and one-half years. Various methods of treatment of pain are discussed—drugs, castration, and x-ray therapy. Relief obtained suggests that surgical control of their pain should be carried out early to be successful, and it is felt that surgery should be advised more often. A report of two illustrative cases is given.

4: 05 p.m.

A Discussion of Prostatic Surgery.

ELMER HESS and HAMILTON P. DORMAN, Erie.

OUTLINE: The history of prostatic surgery; the four surgical approaches to the prostate gland with the merits of each; our criteria for selecting the types of surgery for each type of gland; 142 consecutive cases of prostatectomy performed during 1948 with results and complications. Each of the four procedures has its own merits, and these should be utilized to their fullest extent to give the best functional result to the patient with the least morbidity.

4: 20 p.m.

Lower Urinary Tract Infections in the Female (Lantern Demonstration).

HAROLD E. BROWN, Danville.

OUTLINE: This paper will deal primarily with the syndrome termed by us "chronic urethro-trigonitis" in the female, a definite clinical entity. The urethra in the female corresponds to the posterior urethra in the male. It contains cell nests of Brun in the submucosal layer or other glandular elements, the analogues of the male prostate. Within these structures the above entity originates as the result of numerous intrinsic and extrinsic factors. Incidence is greatest in the married female between the ages of 30 and 50 who has borne children. Symptoms consist of frequency, dysuria, burning, nocturia, urgency, with pain referred to the suprapubic area, lumbar region, costovertebral angles, hips, or legs. The outstanding objective finding is negative urine on routine analysis, while culture reveals the most common offending organisms. Cysto-urethroscopic examination makes the diagnosis. Treatment consists of urethral dilatations, instillations, fulguration, and eradication of foci of infection. The female patient who complains bitterly of bladder distress and symptoms with a negative urinalysis is not a neurotic, but is suffering from the definite clinical entity known as chronic urethro-trigonitis.

4: 35 p.m.

Chemotherapy and Antibiotics in Urology.

STANFORD W. MULHOLLAND, Philadelphia.

OUTLINE: It appears that we have for the first time satisfactory urinary antiseptics. However, there are definite indications for each. When the rules are followed, good results are obtained. Disregarding the rules leads to the development of resistant organisms which show mutations and reactions. The substances now available are reviewed and an attempt is made to place the treatment of urinary tract infections on a scientific and rational basis.

Thursday Morning, September 29

9: 00 a.m. to 10: 20 a.m.

MEDICINE—SYMPOSIUM ON GROSS GASTRO-INTESTINAL HEMORRHAGE

URBAN ROOM

9: 00 a.m.

The Diagnostic Problems of Gross Hemorrhage from the Upper Gastro-intestinal Tract.

HENRY J. TUMEN, Philadelphia.

OUTLINE: "Gross" hemorrhage is defined as bleeding of a severity sufficient to cause recognizable hematemesis and/or melena. Reliance on this statistical fact, however, may lead to failure to discover other lesions which are prominent causes of hemorrhage, notably gastritis, malignant and benign tumors of the stomach, esophageal varices, and small bowel tumors. Direct control of bleeding from esophageal varices is practicable in some instances and may be life-saving. Descriptions are given of the diagnostic procedures available for determining the origin of hemorrhage.

9: 10 a.m.

The Medical Management of Gross Gastro-intestinal Hemorrhage (Lantern Demonstration).

THOMAS A. JOHNSON, Philadelphia.

OUTLINE: This paper is limited to the medical management of gross hemorrhage arising from the upper part of the gastrointestinal tract. Treatment must be based on the probable source and severity of the hemorrhage. No single plan of treatment is applicable to all cases.

9: 20 a.m.

Massive Hemorrhage from Peptic Ulcer.

CALVIN M. SMYTH, JR., Philadelphia.

OUTLINE: Massive hemorrhage from peptic ulcer was for a long time regarded as a medical problem. The realization that a condition is attended by a mortality of from 15 to 25 per cent has led to a careful re-examination of the subject and a change in point of view regarding its management. Statistics which tend to show that the majority of patients are successfully treated without operation are misleading. The importance of early recognition of the case which will not undergo spontaneous arrest will be discussed, and the necessity for surgical intervention before the situation becomes irreversible will be stressed. The author will give his statistics from a series of approximately 50 cases.

9: 30 a.m.

The Present Status of the Treatment of Duodenal Ulcer (Lantern Demonstration).

DAVID J. SANDWEISS, Detroit, Mich. (Guest).

OUTLINE: The treatment of duodenal ulcer falls into two phases: (1) relief from the acute attack, and (2) prevention of recurrences. We have thus far had better success with the first than with the second. The present-day medical regimen yields fairly satisfactory results in acute attacks for approximately 80 per cent of the ambulatory treated patients. Many of those who do not respond to this treatment as ambulatory patients become symptom-free on hospital management. The remaining refractory cases are best treated by subtotal gastrectomy, which, in my opinion, is the treatment of choice at present when surgery is indicated.

9: 00 a.m. to 10: 20 a.m.

SURGERY—SYMPOSIUM ON ANESTHESIA

HENRY S. RUTH, Philadelphia, Moderator

MONONGAHELA ROOM

9: 00 a.m.

Anesthesia for Outpatients.

ROBERT L. PATTERSON, Pittsburgh.

OUTLINE: An evaluation of the surgical and anesthetic risk of the individual outpatient along with a short history and physical examination of these patients. From this data and from the contemplated operative procedure the types and forms of anesthesia to be used will be ascertained. Various anesthetic agents and procedures will be discussed for the more common types of outpatient operative procedures.

9: 15 a.m.

The Management of Spinal Anesthesia (Lantern Demonstration).

WILLIAM F. BREHM, Sayre.

OUTLINE: In considering spinal anesthesia for a patient, the surgeon must view the patient's physical status and proposed operative procedure in relation to the advantages and disadvantages of the anesthetic choice. Indications and contraindications and methods for overcoming contraindications; adverse physiologic effects of spinal anesthesia; suggestions for prevention or reduction; techniques and drugs used indicating the use of various techniques to provide safe anesthesia for long operations or those performed with the patient in unusual or varied positions; the management of the actual anesthetic and untoward effects.

9: 30 a.m.

Recent Advances in Anesthesia for Thoracic Surgery: Some Uses of Procaine Hydrochloride.

D. DWIGHT GROVE, Philadelphia.

OUTLINE: During recent years it has been found that procaine hydrochloride has properties, in addition to those which provide anesthesia for surgical procedures, which have made it useful in a number of clinicopathologic conditions that sometimes occur during the course of anesthesia and surgery. During thoracic surgery, the necessary manipulation of tissues richly supplied with nerve networks to the vital systems of circulation and respiration may produce detrimental reflex activity. These reflexes may result in alterations of respiration and cardiac activity to the extent that cardiac arrest may take place. Procaine hydrochloride used intravenously, by infiltration of the hilum of the lung, topical application to the pericardium and the heart, and by intracardiac injection may prevent or correct cardiorespiratory dysfunction. The method and rationale of applying procaine during anesthesia for thoracic surgery is discussed.

9: 45 a.m.

Evaluation of Analgesics.

EMANUEL M. PAPPER, New York, N. Y. (Guest).

OUTLINE: The problem of evaluating agents and methods which have been utilized in the control of a variety of painful states. The objective efforts which have been made to establish the clinical utility of analgesic substances. The control of pain with procaine, with particular reference to its utilization intravenously and in the completion of selected nerve blocks. Current investigation into the nature and therapy of postoperative pain.

10: 20 a.m.—Intermission to View Exhibits

10:40 a.m. to 12:00 noon
**MEDICINE—PREVENTIVE MEDICINE
 AND PUBLIC HEALTH**

URBAN ROOM

10:40 a.m.

A Future for Preventive Medicine.

PERRIN H. LONG, Baltimore, Md. (Guest).

OUTLINE: It is an interesting commentary that while preventive medicine as an abstract philosophy is well considered in current medical thought, and is always brought to the fore in discussions of medical care, its place in the clinic (or for that matter in the medical curriculum) has never been defined. As a subject in the medical curriculum, its content is as varied as are the departmental titles of those who profess it. It is believed that preventive medicine will not cease to be exotic to the curriculum until its place in the clinic or in everyday practice has been defined, and then proved. In this presentation the concern which preventive medicine should have with the maintenance of health will be discussed, its relation to the treatment of the ambulatory sick will be explored, its role in the prevention of impending serious illness will be investigated, and possibly its function in the field of the medical and social rehabilitation of the injured and the chronically ill will be described.

11:10 a.m.

Public Health Schools and the Medical Profession.

THOMAS A. PARRAN, Pittsburgh.

OUTLINE: History of the development of public health schools in the United States. Form of organization and general objectives. There is a varying emphasis between basic research, training of health personnel, and community service. Likewise, there are great differences in the particular sub-divisions of public health which one or another school emphasizes. The background of Pittsburgh's new School of Public Health. Major fields of interest will include occupational medicine and health with emphasis upon the total relationship of man in an urbanized, industrialized environment. Also training of hospital administrators will be featured because of the larger role of hospitals in the total public health picture of the future. In Pittsburgh there is a great opportunity for leadership by the Medical Center as a whole, including the School of Public Health, in promoting higher standards of health and medical practice in the large surrounding area. The ways by which the School can be of community service in cooperation with the medical profession will be discussed.

11:30 a.m.

The Teaching of Public Health and Preventive Medicine at Hahnemann Medical College.

CHARLES L. BROWN, Philadelphia.

OUTLINE: Rapid advances in the field of public health, especially in communicable disease control and environmental sanitation, in addition to the newer diagnostic aids and treatment, have shifted the emphasis from acute illnesses to chronic illness. Consequently, the degenerative diseases and the socio-economic factors associated with these conditions assume greater importance. The medical student must know of these changes, and the part which they will play in his medical practice. He must know of available voluntary community resources as well as official health agencies. Hahnemann Medical College Department of Preventive Medicine and Public Health has installed such a program.

10:40 a.m. to 12:00 noon

**SURGERY—SYMPOSIUM ON SURGERY
 OF MALIGNANCY**

EDWIN P. BUCHANAN, Pittsburgh, Moderator

MONONGAHELA ROOM

10:40 a.m.

Cancer of the Mouth, Jaws, and Lip.

HENRY P. ROYSTER, Philadelphia.

OUTLINE: Cancer of the oral cavity is a "curable disease," since it may be completely eradicated or arrested for long periods of time, even in the late stages. The outlook for the patient, though far better than in cancer of the lung, stomach, or brain, is still considered by the medical profession to be discouraging, both on the basis of mortality and because of the cosmetic and functional disturbances often present after treat-

ment. This paper proposes a more hopeful view of oral carcinoma and describes records of patients who have been treated by radical surgical excision. Its object is to show what can be done surgically, and in combination with irradiation treatment, rather than to present a statistical review.

10:50 a.m.

Carcinoma of the Esophagus (Lantern Demonstration).

HERBERT R. HAWTHORNE, Philadelphia.

OUTLINE: Results following resection of early malignancies of the esophagus with intrathoracic anastomosis are encouraging. Early symptoms, results of thorough x-ray studies, and esophagoscopic examination with biopsy will be discussed and cell smear methods demonstrated. The immediate benefits of surgery of the lower and mid-thoracic lesions have been sufficiently worth while to encourage the attempt at relief of the high lesions above the aortic arch. In the past two years the high lesions have been successfully treated in many clinics. It is too early to evaluate the end results, but the relief obtained from pain and obstruction are to be considered. Recurrences seldom take place at the site of anastomosis. These procedures on the esophagus can be completed with a fairly low mortality rate if the surgeons have the opportunity to treat the early cases.

11:00 a.m.

Carcinoma of the Breast (Lantern Demonstration).

DONALD GUTHRIE, Sayre.

OUTLINE: Demonstration by slides that cancer education by the profession has greatly reduced the length of time between the discovery of the tumor by the patient and the surgical consultation. Difference in the five and ten-year survival rates between those patients having axillary involvement at the time of operation and those having no axillary involvement. Importance of understanding the anatomy of the breast, and especially its blood supply, if a correct radical mastectomy is to be performed. Postoperative lymphedema of the arm—its cause, prevention, and treatment.

11:20 a.m.

**Carcinoma of the Colon and Rectum—Modern Trends
 in Management.**

JOHN W. STINSON and AUGUST V. CASILLO, Pittsburgh.

OUTLINE: The frequency and operability of colonic cancer. What we usually interpret as symptoms are but complications caused by ulceration, hemorrhage, and stenosis. Clinical findings that should make us suspect the existence of a colonic cancer, and the best means available today for early diagnosis. The effect of its location on the clinical findings. Reasons for selection of the various operative procedures, especially as related to the site of the growth. Stage operations and factors influencing same. The type of case considered suitable for the sphincter-saving operation.

11:30 a.m.

Carcinoma of the Stomach.

GEORGE T. PACK, New York, N. Y. (Guest).

Thursday Afternoon, September 29

1:00 p.m. to 3:00 p.m.

**MEDICINE—SYMPOSIUM ON PROBLEMS
 OF THE NEWBORN**

CARL C. FISCHER, Philadelphia, Moderator

URBAN ROOM

1:00 p.m.

Management of Premature Labor.

WALTER E. STARZ, Pittsburgh.

OUTLINE: The paper will include an analysis of the incidence of premature labor with its causes, the factors in prevention, the choice of analgesics and anesthetics, the preferred methods of delivery of the babies, and the maternal complications.

1:15 p.m.

**Physiologic Problems of the Premature and Newborn
 Infant (Lantern Demonstration).**

CHARLES C. CHAPPLE, Philadelphia.

OUTLINE: The premature infant has a friable brain and a tendency to hemorrhage, making him vulnerable to trauma. His

soft rib cage and few pulmonary alveoli make respiration difficult to initiate and maintain. His blood-forming organs are immature, and his mineral and vitamin storage is low. He cannot stabilize his body temperature, and he is extremely susceptible to infection. The full-term infant has fewer problems, but resuscitative and protective measures are important for him, too. Either group may have apparent or non-apparent congenital defects at birth. Methods for resuscitation, for protection, and for recognition of inapparent defects will be discussed.

1:30 p.m.

Care of the Premature Infant.

EDMUND R. MCCLUSKEY, Pittsburgh.

1:45 p.m.

Congenital Anomalies Following Maternal Rubella (Lantern Demonstration).

ROBERT C. BESWICK, Pittsburgh.

OUTLINE: A brief summary of the history of the rubella syndrome will be followed by the presentation of case reports. These case reports indicate that this is not necessarily an entirely new syndrome, but that it is rather a newly recognized entity.

2:00 p.m.

Infections of the Newborn and Premature Infant (Lantern Demonstration).

STEWART H. CLIFFORD, Boston, Mass. (Guest).

OUTLINE: The fetus may acquire viral or bacterial infection via the mother prior to and during birth. Both premature and full-term infants may develop all the types of infection seen in older infants. With the virtual disappearance of home births, the resultant crowding of hospital nurseries has made newborn infants particularly vulnerable to epidemic outbreaks of infection, especially diarrhea of the newborn. Control of infection in newborn nurseries is relatively simple: block (1) air-borne infection, (2) food-borne infection, and (3) infections acquired through physical contact with infected personnel or material. Diagnosis and treatment of certain viral and bacterial infections of full-term and premature infants will be discussed. Evidence will be submitted to demonstrate that infection can be prevented and controlled in all types of nurseries caring for both full-term and premature infants.

1:00 p.m. to 3:00 p.m.

SURGERY—PATHOLOGY AND RADIOLOGY

MONONGAHELA ROOM

Pathology

1:00 p.m.

The Diagnosis of Cancer—An Evaluation of Some of the Newer Techniques.

ROBERT C. HORN, JR., Philadelphia.

OUTLINE: Study by a competent pathologist of adequate biopsy material, which may be obtained by a variety of methods, remains the best and most widely applicable means of diagnosing cancer. The usual process of pathologic diagnosis has been greatly accelerated by the development of mechanical and technical aids. Most widely used of recently developed diagnostic techniques is the cytologic method. Its status in the diagnosis of cancer of various organs will be discussed. Comment will be made concerning the usefulness of the methods of tissue culture and of heterologous transplantation of tumors in routine cancer diagnosis. A statement will be included regarding the

current status of the iodo-acetate index of serum protein described by Huggins and his collaborators.

1:15 p.m.

Tuberculosis in Infants (Lantern Demonstration).

WILLIAM C. MCCARTHY and JOHN C. HENTHORNE, Pittsburgh.

OUTLINE: In infants a few weeks to a few months old the presence of disseminated tuberculosis suggests the possibility of transmission of the infection during fetal life. Criteria for establishing the neonatal origin of tuberculosis are clearly defined. Relatively few cases meeting these requirements are reported. Two additional cases of tuberculosis in infants are reported. One considered congenital died of disseminated tuberculosis at the age of four weeks. The other died at the age of eight months with it less clearly established that the tuberculosis was congenital.

1:30 p.m.

The Place of Liver Biopsies in the Diagnosis of Liver Disease (Lantern Demonstration).

REGIS A. WOLFF and SAMUEL R. HAYTHORN, Pittsburgh.

OUTLINE: Study of normal livers; diagnostic procedure indications; study of nutritional changes; technique of liver biopsy; correlation with liver function tests.

General discussion.

Radiology

2:00 p.m.

Syphilitic Aortitis.

JAMES JACKMAN, Erie.

OUTLINE: Calcification demonstrated roentgenologically in the ascending aorta, as seen in chest roentgenograms, is usually associated with positive serologic tests for syphilis. Confirmation has been obtained by postmortem findings. Calcification of the ascending aorta is a reliable sign of syphilitic aortitis and as a rule a diagnosis of syphilis can be made on this finding alone.

2:15 p.m.

Modern Radiologic Diagnostic Procedures (Lantern Demonstration).

GEORGE E. FISSEL, Williamsport.

OUTLINE: An explanation of encephalograms and ventriculograms and the criteria for their use will be given. Studies of the salivary glands using opaque material for contrast and known as sialograms will be demonstrated. The value of fluoroscopic examinations of the neck and detailed study of the bronchial tree by means of lipiodol bronchography will be discussed. The recent advances in the study of the heart chambers and the great vessels by means of angiocardiology will be explained. Examples of myelograms will be included.

2:30 p.m.

Recent Advances in Contact Therapy Equipment and Usage (Lantern Demonstration).

RICHARD H. CHAMBERLAIN, Philadelphia.

OUTLINE: Recent developments in x-ray tube design, involving the use of beryllium windows, have made it possible to obtain a wide range of x-ray qualities from the grenz ray type of ray to a moderately short spectrum. Very high intensities are possible. The usefulness of this apparatus in treating superficial skin lesions and certain diseases of the eye is promising. Several advantages in physical consideration, uniformity of dosage, and ease of treatment make this advance worth special attention.

General discussion.

Sunday Tea

Following the Religious Hour, there will be a Tea at the Faculty Club, seventeenth floor of the Cathedral of Learning, University of Pittsburgh. Tickets for the Tea are \$1.00 each, and reservations should be made now. Use the form on page 1232.

THE SCIENTIFIC EXHIBIT

ELWYN L. HELLER, M.D., Pittsburgh, *Chairman*

The Scientific Exhibit of the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania will be located in the Fort Duquesne and Allegheny Rooms on the seventeenth floor of the Hotel William Penn, Pittsburgh. The exhibit will be open Monday from 1:00 p.m. to 5:00 p.m., Tuesday and Wednesday from 9:00 a.m. to 5:30 p.m., and Thursday from 9:00 a.m. to 3:00 p.m.

The exhibit which consists of 26 displays is worthy of the attention of every registrant. The exhibitors have spent much time, research, and effort in order to present to the Society and its guests those phases of medicine which are new, important, and of interest to the practicing physician. The Committee on Scientific Exhibits requests that you visit the exhibits often during the convention.

Artistically hand-engrossed Awards of Merit will be presented to the two exhibitors whose exhibits are adjudged by a review committee as ranking first and second in point of educational value and interest to the general practitioner of medicine. Exhibits sponsored by committees or non-members of the State Society, by outside groups, whether organized medical clinics, non-medical groups, etc., or by previous prize-winning exhibits, are not eligible for competition.

Provision has been made in the scientific programs for a recess to view exhibits.

A complete list of the exhibits follows:

Space 101—Blue Shield: This exhibit will present to the medical profession the pertinent information concerning the non-profit medical care plan in Pennsylvania. Medical Service Association of Pennsylvania, Harrisburg.

Space 102—Inhalation Therapy: This exhibit will consist of charts, photographs, and drawings which illustrate the therapeutic effectiveness of various drugs administered by an inhalation technique employing mechanical and manually operated pressure pumps. A demonstration of the nebulizing apparatus will be part of the exhibit. Stephen D. Lockey, Lancaster General Hospital, Lancaster.

Space 103—Management of Breast Lesions: This exhibit will illustrate, by means of charts, roentgenograms, photographs, photomicrographs, and drawings, the danger of delay in establishing the exact nature of localized breast tumors and the advantages of early diagnosis, particularly in cases of malignancy. The occurrence of mammary cancer in young women

excludes age as a clinical criterion in differentiating benign from malignant lesions; the importance of biopsy examination and pathologic study will be stressed. Thomas A. Shallow, Sherman A. Eger, and Frederick B. Wagner, Jr., Jefferson Hospital, Philadelphia.

Space 104—Collagen Disease: This exhibit will consist of photographs and photomicrographs illustrating lesions of the collagen system produced experimentally in animals by sensitization procedures. Comparison will be made with human diseases of the collagen system and the factors implicating an allergic pathogenesis will be summarized. Leo H. Crip, Lloyd D. Mayer, and Morton L. Hammond, School of Medicine, University of Pittsburgh, Pittsburgh.

Space 105—New Method for Anatomic Study of the Skull: This exhibit will consist of a series of roentgenograms representing an experimental study designed to establish the identity of the various confusing lines and shadows encountered in routine films of the human skull. The findings are based upon radiologic study of intact and disarticulated anatomic specimens and the employment of lead for identification purposes. In this manner the exact features contributed by each component bone of the skull can be determined and the findings applied to skull roentgenograms of the living patient. Lewis E. Etter, Western State Psychiatric Institute and Clinic, Pittsburgh.

Space 106—The Surgery of Mitral Stenosis: This exhibit will present the problems concerning surgical therapy of mitral stenosis with consideration of related pathologic and physiologic aspects. It will include a summary of the literature pertaining to intracardiac surgery. The surgical technique of mitral commissurectomy will be outlined and illustrated with colored pictures and diagrams, and surgical results to date will be summarized. The exhibit will include roentgenograms, charts, photomicrographs, specimens, and drawings. Charles P. Bailey, Robert P. Glover, and Thomas J. E. O'Neill, Hahnemann Medical College and Hospital and Episcopal Hospital, Philadelphia.

Space 107—Anthracosilicosis: This exhibit will consist of charts, roentgenograms, and photographs mechanically operated to demonstrate circulatory and alveolar function with particular reference to disturbances in anthracosilicosis and its complications (emphysema, pulmonary fibrosis, cor pulmonale, and pulmonary tuberculosis). Hurley L. Motley, Leonard P. Lang, Peter A. Theodos, and Burgess Gordon, Barton Memorial Division of Jefferson Hospital, Philadelphia.

Space 108—Interesting Cardiac Problems: This exhibit will consist of a series of interesting and unusual cases of heart disease in which the salient diagnostic features, complications, and therapeutic aspects are graphically illustrated by charts, posters, roentgenograms, and photographs. Examples are: (1) hypersensitive carotid sinus syndrome, (2) rheumatic heart disease, (3) coronary disease, (4) cardiac manifesta-



Pittsburgh by Night—From the heights of Mt. Washington, people from all over the world have observed this impressive sight. It is rightfully considered by thousands as tremendously attractive and unusual and is seldom omitted by the visitor or sightseer. This view is one of the ten wonders of Pittsburgh.

tions of thyroid disease, (5) conduction disturbances, and (6) congenital cardiac disease. Louis H. Landay, School of Medicine, University of Pittsburgh, Pittsburgh.

Space 109—Intracranial Aneurysm: This exhibit will consist of charts, roentgenograms, photographs, specimens, and drawings depicting the diagnostic and therapeutic aspects of intracranial aneurysms. Rudolph Jaeger and William H. Whiteley, Jefferson Medical College and Hospital, Philadelphia.

Space 110—Carcinoma of the Prostate: The prevalence of carcinoma in the prostate in various races and age groups will be shown, as will the types of histopathologic lesions. Methods of diagnosis and treatment will be graphically illustrated. Carcinoma of the prostate is unusual in Hebrews, and is rare in Mongols and the South African Negroes. It is also rare in Caucasians under 40 years of age. The disease increases in prevalence with advance in age of the male. It is thirty times as frequent among male admissions in the ninth decade as in those in the fifth decade. All types of histopathologic cell patterns respond equally to hormonal treatment. William Baurys, Department of Urology, and Charles DeWan, Department of Pathology, Guthrie Clinic and Robert Packer Hospital, Sayre.

Space 111—Vitamin B₁₂: This exhibit will demonstrate by charts, photographs, drawings, and photomicrographs the therapeutic application of vitamin B₁₂ in the management of pernicious anemia, related macrocytic anemias, and the associated neurologic manifestations. Lowell A. Erf and Bruce M. Wimer, Charlotte Drake Cardeza Foundation, Jefferson Hospital, Philadelphia.

Space 112—Anthracosilicosis: This exhibit will consist of charts, posters, roentgenograms, photographs, and photomicrographs which illustrate the clinical, radiologic, electrocardiographic, and pathologic findings of anthracosilicosis in bituminous coal miners. Hyman A. Slesinger, Windber Hospital, Windber.

Space 113—The Use of Radioactive Isotopes in Medicine: This exhibit is designed to demonstrate some of the uses of radioactive isotopes in medicine and medical research. The use of radioactive iodine in the treatment of hyperthyroidism and thyroid carcinoma will be illustrated by charts and photographs. The use

of radioactive phosphorus in blood volume determinations and radioactive sodium and potassium in electrolyte and water balance and in the determination of blood flow will be described. The role of the cyclotron in the production and handling of isotopes will be illustrated. Campbell Moses and A. J. Allen, Radiation Laboratory and the Addison H. Gibson Laboratory of the University of Pittsburgh, Pittsburgh.

Space 114—Medical Public Relations: This exhibit is designed to encourage participation in the National Education Campaign. It will also stimulate the promotion of local public relations programs. Committee on Public Relations, The Medical Society of the State of Pennsylvania.

Space 115—The Doctor: The original study of the painting "The Doctor" by Sir Samuel Luke Fildes will be exhibited through the courtesy of the Guthrie Clinic, Sayre. The portrait was given to the clinic by Mr. Allan P. Kirby, of Morristown, N. J.

Space 117—Diabetes Mellitus: A demonstration of the diagnosis of diabetes by blood sugar and urinalysis. All physicians are urged to visit this exhibit and have a blood sugar examination made. The painting "Diabetes Then and Now" will again be exhibited. Commission on Diabetes, The Medical Society of the State of Pennsylvania.

Space 118—Commission on Graduate Education.

Space 119—Measles Encephalitis: A study of 50 cases of measles with neurologic complications. Charts and photographs will be displayed showing symptoms,



Hungarian Room—one of the Nationality rooms of the Cathedral of Learning, which will be open for visitation from two to four o'clock Sunday afternoon.

signs, laboratory results, and autopsy findings. The neurologic findings and the follow-up procedures including electrocardiograms and psychometric tests of certain cases will be explained. Steven Sawchuk, A. Charles LaBocchetta, Anthony Tornay, Alexander Silverstein, and Augustin R. Peale, Hospital for Contagious Diseases, Philadelphia.

Space 120—The Problem of Bronchial Asthma: The diagnosis of asthma cannot be made without a careful history and investigation. This point will be stressed by the use of roentgenograms of cases ranging from infancy to old age in which a diagnosis of bronchial asthma had been made before being referred for study. It was found after study that the patients were not allergic but were suffering from the presence of a foreign body, benign or malignant tumors of the lung, bullous emphysema, or congenital air cysts. Wilfred D. Langley, Guthrie Clinic and Robert Packer Hospital, Sayre.

Space 121—Special Pathology of Lung Diseases: This exhibit will consist of photographs and photomicrographs, chiefly in color, which illustrate the characteristic pathologic features of various pulmonary diseases including silicosis, bronchiectasis, and lung abscess. Examples illustrating some of the problems concerned with the cytologic study of bronchial secretions in the detection of bronchogenic carcinoma will be included. Samuel R. Haythorn, William H. Singer Memorial Research Laboratory, Allegheny General Hospital, Pittsburgh.

Space 122—Normal and Abnormal Placentas: This exhibit will consist of a collection of approximately thirty fresh, frozen, normal and abnormal placentas together with photographs and photomicrographs. Cardinal, gross, and microscopic features of the various

types of placentas will be shown, and the proper technique of examining them will be demonstrated. Robert L. Breckenridge and Burton L. Wellenbach, Department of Obstetrics and Gynecology and Department of Clinical Laboratories, Jefferson Medical College and Hospital, Philadelphia.

Space 123—The Surgical Treatment of Carcinoma of the Esophagus: Charts, roentgenograms, and photographs will show the surgical treatment of lesions of the esophagus, both high and low. The surgical approach through both the left and right thorax also will be shown. Edward M. Kent and Samuel P. Harbison, School of Medicine, University of Pittsburgh, Pittsburgh.

Space 124—Reconstruction Surgery of the Hand: This exhibit will consist of charts, photographs, drawings, and a continuous projection of lantern slides which illustrate various disorders of the hands and methods of surgical reconstruction. William L. White and S. Milton Dupertuis, Medical Center of the University of Pittsburgh, Pittsburgh.

Space 125—Commission to Study the Control of Rheumatic Fever.

Space 126—Physical Medicine in Arthritis: Demonstration on living subjects of protective body mechanics in various types and stages of arthritis. Slides will be shown illustrating the basis for treatment of altered physiology and pathologic anatomy in various types and stages of arthritis. Emphasis will be on rehabilitation in the acute and early convalescent stages. Simple measures that the general practitioner can use in the home will be stressed. Commission on Physical Medicine, The Medical Society of the State of Pennsylvania.

Installation Meeting

Edmund Roger Samuel, M.D., will be installed as the one-hundredth president of The Medical Society of the State of Pennsylvania in a colorful ceremony on Tuesday evening, September 27, at 8:15, (organ recital at 7:45), in the Carnegie Music Hall, Forbes Street and Bigelow Boulevard. In addition, the 1949 Benjamin Rush Awards will be presented, and Dr. Ralph Gampell, recently a voluntarily displaced physician of London, England, will relate his personal experiences under socialized medicine. Following the formal program Victor Saudek will present in concert Pittsburgh's Little Symphony Orchestra of twenty-five pieces including a golden harp. Two nationally known soloists, Mary Martha Briney, soprano, and Bob Carter, tenor, will sing. This meeting is open to the public, but good seats will be assured to members who request tickets for the section reserved for members on the reservation form (see page 1232). The reserved seats will be held until 8:00 p.m.

THE TECHNICAL EXHIBIT

Sixty-six commercial firms have prepared elaborate exhibits of the newest equipment, pharmaceuticals, appliances, books, and food, which represent their contribution toward the improvement of the practice of medicine.

These manufacturers and distributors have been largely responsible, through the purchase of space, for the financing of this session. Every physician should take time to show his appreciation by visiting each booth.

Due to the lack of space, the following firms could not secure booths, but it is hoped that they will be able to participate in the 1950 session: Audiphone Company, Carnation Company, Commercial Solvents Corporation, Duke Laboratories, S. F. Durst & Company, S. E. Massengill Company, Mine Safety Appliances Company, National Dairy Council, William H. Rorer, Inc., Rystan Company, U. S. Fidelity & Guaranty Company, Warren-Teed Products Company, and Wireway Sales of Pittsburgh.

The technical exhibit will be open Monday from 1:00 p.m. to 5:00 p.m., Tuesday and Wednesday from 9:00 a.m. to 5:30 p.m., and Thursday from 9:00 a.m. to 3:00 p.m.

The Abbott Laboratories, North Chicago, Ill. (Space 29).

A. S. Aloe Company, St. Louis, Mo. (Space 6-A).

American Hospital Supply Corporation, Evanston, Ill. (Space 9).

Ames Company, Elkhart, Ind. (Space 63).

Ayerst, McKenna & Harrison, Ltd., New York City (Space 52).

The Baker Laboratories, Inc., Cleveland, Ohio (Space 31): The Baker display is built around the six-step approach to optimum infant nutrition which leads to the picture of the happy mother and the healthy child. An adjusted protein, two carbohydrates, a modified fat, vitamins, soluble mineral salts and iron, coupled with simplicity of preparation and low cost, provide for complete nutrition and insure cooperation in the home. Baker's Modified Milk, liquid or powder, may be used interchangeably from birth to the end of the bottle-feeding period. May we discuss your infant feeding problem with you?

Beech-Nut Packing Company, Canajoharie, N. Y. (Space 23).

Best Foods, Inc., New York City (Space 39).

The Blakiston Company, Philadelphia, Pa. (Space 32): See Blakiston's new *Gould Medical Dic-*

tionary—the newest, most modern, and most complete book in its field. Hundreds of new words found in no other medical dictionary, an anatomic atlas, and scores of distinctive features make this an essential book for every physician. It is easy to use. It is authoritative. It is accurate. It is a *must* for you. See it. Buy it at the meeting. See also the latest additions to the Blakiston line of text and reference books. Blakiston representatives are always willing and happy to serve you.

The Borden Company, New York City (Space 12).

Burroughs Wellcome & Co., Inc., New York City (Space 51): Among significant products featured will be Globin Insulin with zinc (B. W. & Co.), the intermediate acting insulin; Dexin brand high dextrin carbohydrate, in which the non-fermentable proportion predominates; digoxin, the pure, stable, crystalline glycoside which offers predictable digitalization; and tabloid brand diphenan, the new product for pin worms.

Cambridge Instrument Company, Inc., New York City (Space 41).

Camel Cigarettes, New York City (Space 18): Camel Cigarettes will feature color slides of background data from their newest research. After weekly examinations of the throats of hundreds of men and women smoking Camel cigarettes exclusively for thirty days, throat specialists reported "not one single case of throat irritation due to smoking Camels."

Ciba Pharmaceutical Products, Inc., Summit, N. J. (Space 59): We invite you to visit our exhibit for latest information on Priscoline (formerly known as Priscol), a valuable adjunct to the treatment of peripheral vascular disease. Pyribenzamine, HCL, the anti-histaminic drug for prevention and relief of anaphylaxis and many forms of allergy, will also be featured. Representatives in attendance will gladly answer any questions about these and other Ciba products.

The Coca-Cola Company, Atlanta, Ga. (Space 35).

The F. A. Davis Company, Philadelphia, Pa. (Space 34).

Denver Chemical Manufacturing Co., New York City (Space 8).

DePuy Manufacturing Company, Warsaw, Ind. (Space 6).

The Doho Chemical Corporation, New York City (Space 4): The makers of Auralgan are featuring at this meeting their new sulfa preparation O-tos-mo-san, indicated in the treatment and control of chronic suppurative ears. Also, Mallon, Division of Doho, will introduce their new topical anesthesia, Rectalgan, for relief of pain and itching in hemorrhoids and pruritus. This new therapy enjoys many advantages over the outmoded suppositories and ointments. Representatives will be happy to explain in detail the workings of these medications.



Polish Room in the Cathedral of Learning, another of the Nationality group for visitors to see on Sunday afternoon.

Electronic Surgical Equipment Company, Inc., Philadelphia, Pa. (Space 15).

Endocrine Company, Union City, N. J. (Space 54).

Endo Products, Inc., Richmond Hill, N. Y. (Space 1): A noteworthy addition to the Endo Exhibit will be Hycodan Bitartrate, a newly developed antitussive possessing the cough depressant property of codeine but requiring smaller doses for an effective therapeutic action. Other Endo Council-accepted products to be featured are Mesopin, a gastro-intestinal antispasmodic providing atropine effects without atropine side effects, and Norodin hydrochloride, an improved psychomotor stimulant and antidepressant.

C. B. Fleet Co., Lynchburg, Va. (Space 61): Cordially invites you to visit their booth. Increasingly, during the past fifty years, to the medical profession, sodium phosphate has come to mean Phospho-Soda (Fleet), the pure, stable, aqueous concentrate of the two U.S.P. sodium phosphates.

Robert A. Fulton Company, Pittsburgh, Pa. (Spaces 20 and 21).

General Electric X-Ray Corporation, Pittsburgh, Pa. (Space 47).

Gerber Products Company, Fremont, Mich. (Space 2): Gerber's will present the only complete line of baby foods—Gerber's cereal trio, strained and junior fruits, vegetables, soups, and desserts, plus strained and junior meats prepared from Armour quality beef, veal, and liver. These meats for babies are kept at ready-to-serve temperatures for your examination and comparison. Ask the Gerber professional representative about them.

H. J. Heinz Company, Pittsburgh, Pa. (Space 33): Heinz will be displaying strained and junior foods as well as their wide variety of nutrition material. Doctors will find the products of interest not only for the feeding of babies and other small children but for the feeding in gastro-intestinal cases, pre- and postoperative disturbances, oral troubles, geriatrics, and a number of conditions where strained and junior foods are required.

Hub Surgical Company, Easton, Pa. (Space 14).

The "Junket" Folks, Little Falls, N. Y. (Space 44): The importance of rennet in infant and adult nutrition and the value of rennet desserts in both normal and restricted diets will be explained. Enlarged photos illustrate the action of the rennet enzyme in producing softer, finer, more readily digestible milk curds. Authoritative literature will be available describing dietary applications of rennet products. Complimentary packages of "Junket" Rennet Powder and "Junket" Rennet Tablets for the profession.

Lederle Laboratories Division, New York City (Space 26): You are cordially invited to visit our exhibit where you will find representatives who are prepared to give you the latest information on Lederle products.

The Liebel-Flarsheim Company, Cincinnati, Ohio (Spaces 49 and 50).

Eli Lilly & Company, Indianapolis, Ind. (Space 65): Your Lilly medical service representative cordially invites you to visit the Lilly exhibit. Many new therapeutic developments will be featured and literature on these products will be available. Visiting physicians will be aided in every way possible.

M & R Dietetic Laboratories, Inc., Columbus, Ohio (Space 3): Will display Similac, a food for infants. Their representative will appreciate the opportunity to discuss the merit and suggested application for both the normal and special feeding cases.

Maltbie Chemical Company, Newark, N. J. (Space 68).

McKennan Drug Company, Inc., Pittsburgh, Pa. (Space 19).

McNeil Laboratories, Inc., Philadelphia, Pa. (Space 62).

Mead Johnson & Company, Evansville, Ind. (Space 64): Amigen and Protolysate will be on display at the Mead Johnson booth. Mead Johnson has pioneered the amino acid field commercially; the products have been described in more than four hundred articles in medical literature. Trained representatives will be at the Mead exhibit to discuss details of the new amino acid products. Shown also will be Dextri-Maltose, Pabulum, Pabena, Oleum Percomorphum, and the other Mead products used in infant nutrition. Protinum, a new high-protein product, also will be displayed as will Lonalac for low-sodium diets.

Medical Protective Company, Fort Wayne, Ind. (Space 7).

William S. Merrell Company, Cincinnati, Ohio (Space 25): "Its Name is Nethaphyl" identifies Merrell's new drug for prompt symptomatic relief of bronchial asthma. In eight years of clinical experience, Nethaphyl has proved effective in 85 to 90 per cent of the cases. Combining a more effective bronchodilator, a better tolerated myocardial stimulant, and a mild sedative, it has demonstrated essential freedom from central stimulation or other side effects, effectiveness in epinephrine-fast patients, no increased tolerance or urinary retention, and non-interference with desensitization therapy. In one study, 87 per cent of patients preferred Nethaphyl over other drugs. Merrell representatives will gladly discuss its action and give you samples for clinical trial.

The C. V. Mosby Company, St. Louis, Mo. (Space B).

Thomas Nelson & Sons, New York City (Space 56).

Nestle's Milk Products, Inc., New York City (Space 57).

Ortho Pharmaceutical Corporation, Raritan, N. J. (Space 66).

Parke, Davis & Company, Detroit, Mich. (Space 58).

Pet Milk Sales Corporation, St. Louis, Mo. (Space 45): Specially trained representatives will be in attendance to discuss the use of Pet Milk in infant feeding, and to present many services that are time-savers for busy physicians. Miniature Pet Milk cans will be given to visitors at the exhibit.

Philip Morris & Co., Ltd., Inc., New York City (Space 36): Will demonstrate the method by which it was found that Philip Morris cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject and problems on the physiologic effects of smoking.

Pickering X-Ray Corporation, New York City (Space 30).

The Sanborn Company, Cambridge, Mass. (Space 22): An exhibit of interest to clinicians, specialists, and research men alike—in the fields of cardiology and endocrinology. On display will be working models of such clinical diagnostic instruments as the Sanborn Metabulator, the "all-enclosed" metabolism tester; and the Sanborn Viso-Cardiette, leader among direct wiring electrocardiographs. These will be supplemented by material on more specialized, research-type equipment, including the Poly-Viso Cardiette, multi-channel biophysical research recorder; the Electromanometer, outstandingly useful for a wide variety of venous, arterial, intracardiac, and other "pressure" recordings; and other diagnostic instruments of still more recent development.

Sandoz Chemical Works, Inc., New York City (Space 5).

W. B. Saunders Company, Philadelphia, Pa. (Space 24).

Scheer X-Ray Corporation, Pittsburgh, Pa. (Space A).

Schenley Laboratories, Inc., New York City (Space 48): Will feature Titalac, an extremely palatable antacid with a titration curve very similar to that of milk. Also on display will be Rutaminal, an exclusive Schenley specialty combining rutin, aminophylline, and phenobartital; Orapens-buffered penicillin tablets of varying strengths; Monocillin, a procaine penicillin product producing 96 hour blood levels; and Aquacillin, procaine penicillin for aqueous injection. Samples of various products will be available. Well-informed personnel will be in attendance.

Schering Corporation, Bloomfield, N. J. (Space 69).

G. D. Searle & Company, Chicago, Ill. (Space 40).

Sharp & Dohme, Inc., Philadelphia, Pa. (Space 67).

Smith, Kline & French Laboratories, Philadelphia, Pa. (Space 42): Today, Dexedrine Sulfate (dextro-amphetamine sulfate, S.K.F.) is established as the drug of choice for the treatment of depressive states. It produces the desired improvement of mood without giving rise to undesirable side effects. In weight reduction, Dexedrine is the most effective drug available for control of appetite. Dexedrine makes it easy for the overweight patient to stop overeating. Unlike thyroid, it has no significant effect on basal metabolic rate, blood pressure, or heart rate.

Spencer, Incorporated, New Haven, Conn. (Space 60): On display will be Spencer supports for abdomen, back, and breasts—individually designed to meet the medical indications of each individual patient. Of special interest is Spencer's new *colostomy* support design—an unusually effective aid in training of the colostomy patient. Other special features include the Spencer Abdominal Spring Pad (patented), removable rigid steels for spinal supports, mastectomy breast support with breast form, a "hammock-type" support for antepartum patients. See also Spencer's Blood Pressure Sleeve—fits any size arm, provides quick accurate readings.

E. R. Squibb & Sons, New York City (Spaces 27 and 28).



Cathedral of Learning—This unique building, where the Sunday Tea will be held, is the center of the University of Pittsburgh activities. It is a structure that "expresses, through the characteristic qualities of its architecture, the spirit or purpose of all that should go on within a university." The name was suggested partly by its Gothic architecture, and partly by the idea that it is "a seat or central symbol of creativeness and of achievement in the Pittsburgh district."

This is the tallest schoolhouse in the world. It rises to the height of 41 stories or 535 feet. The topmost roof deck is 1423 feet above sea level.

The Upjohn Company, Kalamazoo, Mich. (Space 43).

U. S. Vitamin Corporation, New York City (Space 46): Enlarged color photographs of common oral lesions of nutritional deficiency including glossitis, cheilosis, gingivitis, and others—as well as improvement following administration of complete vitamin therapy. Also, complimentary copies of illustrated brochure "Diagnosing Vitamin Deficiencies" and other educational literature.

Varick Pharmacal Company, New York City (Space 53): The manufacturers of Digitaline Nativelle, the original digitoxin, plan an interesting and informative exhibit on heart disease. Of special interest are the phonographically reproduced heart sounds of various valvular lesions. Physicians are cordially invited to sit and listen (via individual head sets) to the accurate reproductions of many abnormalities, including auricular fibrillation, gallop rhythm, presystolic murmurs, etc. Enlarged full color kodachromes of many

gross cardiac specimens and photomicrographs of cardiac pathology will be displayed. Literature and information on Digitaline Nativelle will be available, including copies of the Low Sodium Diet brochure.

Westinghouse Electric Corporation, Pittsburgh, Pa. (Spaces 37 and 38).

White Laboratories, Inc., Newark, N. J. (Space 55).

Williams Medical Equipment Company, Pittsburgh, Pa. (Spaces 10 and 11): Will exhibit new Council-accepted portable direct-recording electrocardiograph, new moderately priced x-ray fluoroscope combination, a Jones regular Waterless Motor-Basal, and the recently developed Jones Super-Basal.

Winthrop-Stearns, Inc., New York City (Spaces 16 and 17).

The Zemmer Company, Pittsburgh, Pa. (Space 13).

"CONTRASTS IN METHODS"

The American Medical Association has done an unusual thing! In order to combat misrepresentation of the purposes and methods of its publicity campaign against compulsory federal health insurance, the A.M.A. has sent to every member of the 81st Congress a complete, booklet-form breakdown of the association's plan of action.

Prepared by Whitaker & Baxter, the public relations firm which is directing the A.M.A.'s drive, the booklet carefully blueprints every step to be taken at the county, state, and national level.

If members of Congress take the time to read the plan, the A.M.A.'s professional and lay critics will be wasting their time when they charge the organized doctors with sly, unethical propaganda.

Compare this candid, open position with the statements of Acting Security Administrator J. D. Kingsley when that gentleman testified recently before a Senate committee.

Mr. Kingsley testified that Mr. Truman's compulsory health insurance program would cost \$5,600,000,000.

If the administration were half as frank as the A.M.A. directors, it would instruct all of its witnesses to tell Congress that all cost estimates are at best only informed guesses—and not too well informed at that.

No similar system anywhere ever has remained for more than a year at most within the original estimate. The cumulative costs of such schemes cannot be estimated.

Mr. Kingsley also played a variation of the President's theme that existing voluntary health insurance plans "have proved inadequate." These plans, said the acting security administrator, cover only some 32,000,000 people "with limited hospital care only." His general conclusion was that voluntary health insurance costs too much for most people and cannot pay its way on lower premiums.

That statement of the case is considerably less than

frank. What Mr. Kingsley did not tell Congress, for example, was that the Blue Cross insurance plan was not established until 1934. During fifteen years it has had the phenomenal growth of more than 2,000,000 members a year.

Nor is it true that private plans provide for hospital care only. We now have Blue Shield which insures its members on actual medical service provided by doctors and surgeons. Blue Shield, which has had a somewhat slower acceptance than Blue Cross (largely for the reason that hospital care is usually a much heavier burden of illness than the doctor's bill), nevertheless now has some 10,000,000 members and is growing daily.

The A.M.A. proposes to sell the American people on the idea that voluntary health insurance is preferable in every way to a compulsory scheme administered by government through state and local officials.

The federal government, which ought to be encouraging Americans to provide for their own care from their own incomes, instead belittles private insurance plans by telling Congress that such programs are inadequate.

Actually, in this controversy, the American Medical Association seeks to preserve the traditional American way as opposed to a federal administration trying its best to destroy that way.

If the nation's press intends to give any prizes for honesty of purpose in this battle of words, let them go to the A.M.A.—Editorial, *Chicago Journal of Commerce*, June 2, 1949.

Hotel Accommodations

Pittsburgh has numerous fine hotels where those attending the Ninety-ninth Annual Session may find excellent accommodations. Make your reservations immediately. The Pittsburgh hotels and their room rates are listed on page 1216 of this JOURNAL.

OFFICIAL TRANSACTIONS

Ninety-ninth Annual Session

CALL TO THE 1949 MEETING

The first meeting of the House of Delegates of The Medical Society of the State of Pennsylvania will be called to order in the Monongahela Room, 17th floor, Hotel William Penn, Pittsburgh, at 10 a.m. on Monday, Sept. 26, 1949. Subsequent sessions will be held as decided by the House except the session for the election of officers on Wednesday morning.

Notice relative to parliamentary requirements for consideration of proposed amendments to the constitution and by-laws was published in the May JOURNAL.

Proposed Amendments to Constitution and By-laws

Eligibility for Active Membership

The following resolution embodying an amendment to Article IV, Section 1, of the Constitution of The Medical Society of the State of Pennsylvania, and an amendment to Chapter VIII, Section 2, of the By-laws, was adopted by the Erie County Medical Society at its May 3, 1949 meeting, and is respectfully submitted for consideration and action by the 1949 House of Delegates of The Medical Society of the State of Pennsylvania.

(NOTE: These two proposed amendments involve only deletion of the words "citizens of the United States" and substitution of the words "Doctors of Medicine" in the requirement for eligibility for membership.)

Resolution

WHEREAS, The laws of the Commonwealth of Pennsylvania permit otherwise qualified Doctors of Medicine to be licensed to practice medicine and surgery on the strength of holding first papers for United States citizenship, and

WHEREAS, A number of Doctors of Medicine who are foreign-born but who hold such first papers are duly licensed in the Commonwealth of Pennsylvania and are practicing medicine therein, and

WHEREAS, The Constitution of The Medical Society of the State of Pennsylvania requires full United States citizenship as a prerequisite for membership, thereby denying component county societies the opportunity to accept those legally qualified fellow-practitioners into Society membership with its corollary rights and privileges and mutual advantages; therefore, be it

Resolved, That the Erie County Medical Society proposes that Article IV, Section 1, of the Constitution of The Medical Society of the State of Pennsylvania be amended to read as follows: "The active members of this Society shall be *Doctors of Medicine* licensed to practice medicine in the Commonwealth of Pennsylvania, members in good standing in the component county medical societies, and whose annual assessments in this Society have been paid"; and be it further

Resolved, That Chapter VIII, Section 2, of the By-laws of The Medical Society of the State of Pennsylvania be amended by deletion of the phrase "*citizens of the United States*."

The following proposed amendments to the By-laws are submitted by the Board of Trustees:

CHAPTER II, SECTION 1.—The House of Delegates shall meet on the morning of the day *before that fixed as the first day of the annual session* . . . (amendment involves only omission of the words in italics).

CHAPTER V, SECTION 2.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the morning of the *third* (second) day of the annual session . . . (amendment involves only substitution of the word *third* for the word "second.")

CHAPTER VII, SECTION 11, now reads: The Advisory Committee to the Woman's Auxiliary shall consist of three members. They shall act in an advisory capacity to the Woman's Auxiliary, and shall hold meetings whenever it is necessary to furnish advice to the Woman's Auxiliary on any debatable question regarding the change in their constitution or other functions.

Amend by changing last sentence to read: They shall act in an advisory capacity to the Woman's Auxiliary *whenever called upon by the Woman's Auxiliary regarding its functions or changes in its constitution and by-laws*.

Among the general officers and others to be elected at this session will be:

A trustee and councilor for the First Councilor District, to serve for five years, to succeed Dr. Hugh McC. Miller, Philadelphia, who has served for two years in completion of the term of Dr. Gilson Colby Engel. Dr. Miller is not eligible to succeed himself.*

A trustee and councilor for the Sixth Councilor District, to serve for five years, to succeed Dr. Joseph S. Brown, Lewistown. Dr. Brown has just completed the unexpired term of Dr. Walter Orthner, deceased.

Six delegates and eleven alternates to the House of Delegates of the American Medical Association, to serve from Jan. 1, 1950 to Dec. 31, 1951.

* No longer "in the active practice of medicine" (Constitution, Article VIII, Section 1).

Meeting of the House of Delegates on Monday, September 26, will be held in the Monongahela Room, 17th floor.

Sessions held Tuesday and Wednesday will be in the Pittsburgh Room, Lower lobby.

Reference Committees will meet in rooms 448, 457 and 463, fourth floor.

COMMITTEES OF THE 1949 HOUSE OF DELEGATES

COMMITTEE ON CREDENTIALS

Fred B. Wilson, Beaver, *Chairman*
Dorothy C. Blechschmidt, Philadelphia
T. Lamar Williams, Mount Carmel

REFERENCE COMMITTEE ON REPORTS OF OFFICERS

Charles L. Brown, Philadelphia, *Chairman*
Charles L. Shafer, Kingston
Daniel H. Bee, Indiana
John C. Bryson, Pottsville
Norman C. Ochsenhirt, Pittsburgh

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

Theodore R. Fetter, Philadelphia, *Chairman*
William J. Corcoran, Scranton
Herman A. Fischer, Jr., Wilkes-Barre
Mark K. Gass, Sunbury
Frederick O. Zillessen, Easton

REFERENCE COMMITTEE ON REPORTS OF COMMISSIONS

Wendell B. Gordon, Pittsburgh, *Chairman*
John T. Farrell, Jr., Philadelphia
Hiram T. Dale, State College
Michael Margolies, Coatesville
James A. Welty, Oil City

REFERENCE COMMITTEE ON SCIENTIFIC BUSINESS

Henry F. Hunt, Danville, *Chairman*
Stanley D. Conklin, Sayre
Joseph Van S. Donaldson, Butler
Carl E. Ervin, Harrisburg
William T. Leach, Shenandoah

REFERENCE COMMITTEE ON NEW BUSINESS

Dudley P. Walker, Bethlehem, *Chairman*
L. Dale Johnson, Connelville
Russell B. Roth, Erie
Daniel Ritter, Johnstown
Roy Deck, Lancaster

REFERENCE COMMITTEE ON HOSPITAL RELATIONS

Thomas W. McCreary, Rochester, *Chairman*
John W. Fredette, Pittsburgh
William J. Goetz, Reading
Guy H. McKinstry, Washington
Willard C. Masonheimer, Allentown
Roy W. Mohler, Philadelphia
Henry Walter, Jr., Lancaster

REFERENCE COMMITTEE ON AMENDMENTS TO THE CONSTITUTION AND BY-LAWS

Louise C. Gloeckner, Conshohocken, *Chairman*
Jesse G. Fear, Berwick
Harold B. Gardner, Pittsburgh
Augustus S. Kech, Altoona
John W. Shirer, Pittsburgh

Ex officio: Gilson Colby Engel, Lewis T. Buckman, Walter F. Donaldson

MEMBERS OF THE 1949 HOUSE OF DELEGATES

(The offset names are the alternates.)

ADAMS

Raymond M. Hale, *Secretary* *
John J. Knox, *President*
Raymond M. Hale, Jr.
Byron C. Jones
Eugene Elgin

ALLEGHENY

William F. Brennan, *Secretary*
Paul G. Bovard, *President*

Delegates

(Elected to serve in 1948 and 1949)

William A. Bradshaw	Carl F. Nill
John W. Fredette	Norman C. Ochsenhirt
Harold B. Gardner	John W. Shirer
James Hodgkiss	John E. Weigel
George F. Kowallis	

(Elected to serve in 1949 and 1950)

Frederick M. Jacob	C. L. Palmer
George W. Lang	Glenn H. Davison
George Leibold	George C. Schein
John F. McCullough	Wendell B. Gordon

Alternates

Joseph B. Anderson	James C. Murdock
James Balph, Jr.	William N. Pitchford
John J. Boucek	Paul M. Rike
Edward A. Brethauer	Leo P. Sheedy
Elizabeth R. Childs	James W. Speelman
Leo H. Crip	Oliver E. Turner
Edgar J. Douglas	James R. Watson
William B. Guy	Carl A. Wirts
James M. Henninger	Warren A. Wolf
Harold P. Hook	William C. Wycoff
Clarence H. Ingram, Jr.	Jack Z. Rohm
Karl Zimmerman	John Erving
M. Weir Kneeder	William McNaugher
Paul W. Lane	Leigh L. Darsie
Jay G. Linn, Jr.	Harry B. Updegraff
John W. Leech	Harry E. Borus
Thomas N. Meredith	William K. Nealon

ARMSTRONG

Cyrus B. Sleese, *Secretary*
F. O'Neil Robertson, Jr., *President*

BEAVER

J. Willard Smith, *Secretary*
George R. Boyd, *President*
Thomas W. McCreary
Fred B. Wilson
Jesse H. Swick, II
Herman Bush
John K. Grau
Norman A. Hetzler

* Under the provisions of the revised Constitution and By-laws, adopted Oct. 6, 1948, the secretaries of the component county medical societies are duly accredited delegates with the right to vote. The presidents of the component county medical societies are ex-officio members without the right to vote. In the absence of its secretary, the president of that component county medical society may be seated with the right to vote.

BEDFORD

Joseph A. Eyler, *Secretary*
 John A. Topper, *President*
 John A. Topper
 L. Quentin Myers
 Victor Maffucci

BERKS

Clair G. Spangler, *Secretary*
 Archibald R. Judd, *President*
 Arthur A. Cope
 William J. Goetz
 Leon C. Darrah
 Harold A. Strunk
 Albert E. J. Lohmann
 Myer W. Dashe
 Robert R. Impink
 Mark D. Grim
 Carl E. Sweitzer

BLAIR

George R. Good, *Secretary*
 Robert M. Keagy, *President*
 Ralston O. Gettemy
 Augustus S. Kech
 John O. Prosser
 C. Henry Bloom
 Irvan A. Boucher
 James S. Taylor

BRADFORD

Stanley D. Conklin, *Secretary*
 George E. Boyer, *President*
 Morgan F. Taylor
 Thomas B. Johnson
 Manley Rockman

BUCKS

Walter J. Hendricks, *Secretary*
 Clifford Laudenslager, *President*
 Herman C. Grim
 Frank Lehman
 Allen H. Moore

BUTLER

Joseph Van S. Donaldson, *Secretary*
 Charles B. Turublacer, *President*
 Donald E. Goehring
 Joseph A. Llewellyn
 Joseph Purvis

CAMBRIA

Warren F. White, *Secretary*
 Francis T. Carney, *President*
 John W. Barr
 Daniel Ritter
 Arthur Miltenberger
 William E. Grove
 Joseph P. Replogle
 Joseph W. McHugh

CARBON

John L. Bond, *Secretary*
 Marvin Evans, *President*
 B. Frank Rosenberry
 William R. Bonner
 James J. Dougherty

CENTRE

Hiram T. Dale, *Secretary*
 William L. Welch, *President*
 Joseph A. Parrish
 William J. Schwartz
 Eugene H. Mateer

CHESTER

Francis Jacobs, *Secretary*
 Alfred L. Chicote, *President*
 Michael Margolies
 Irving M. Waggoner
 Fount B. Robinson
 Frank H. Ridgley
 William A. Linberger
 George W. Truitt

CLARION

James M. Hess, *Secretary*
 George P. Davey, *President*
 Theodore R. Koenig

CLEARFIELD

George C. Covalla, *Secretary*
 Maximo J. Tornatore, *President*
 Ward O. Wilson
 Lorenzo G. Runk

CLINTON

David W. Thomas, *Secretary*
 William C. Long, Jr., *President*
 Samuel C. Bower
 Francis P. Dwyer
 Henry N. Thissell

COLUMBIA

Jesse G. Fear, *Secretary*
 G. Paul Moser, *President*
 Joseph V. M. Ross
 Otis M. Eves
 Jacques H. Mitrani

CRAWFORD

Robert G. Pett, *Secretary*
 John P. Hobson, *President*
 John H. Bailey
 James N. Strausbaugh
 Luther J. King

CUMBERLAND

Richard R. Spahr, *Secretary*
 E. Blaine Hays, *President*
 Newton W. Hershner
 Herbert P. Lenton

DAUPHIN

Hamblen C. Eaton, *Secretary*
 A. Harvey Simmons, *President*
 Carl E. Ervin
 Constantine P. Faller
 George L. Laverty
 Charles W. Smith
 Dale C. Stahle
 Luther A. Lenker
 Henry F. Hottenstein
 James S. Forrester

DELAWARE

Walter E. Egbert, *Secretary*
 Walter E. Wentz, Jr., *President*
 Ralph E. Bell
 Joseph F. Dougherty
 S. Irvin Bigelow
 Drury Hinton
 Dennis T. Sullivan
 Edward G. Torrance
 Charles T. Wood
 Ernest W. Egbert
 Newton A. Wyman

ELK

Robert J. Dickinson, *Secretary*
 Augustine C. Luhr, *President*
 Joseph E. Sunder
 William A. Switzer
 Charles E. Hough

ERIE

Russell B. Roth, *Secretary*
 James H. Delaney, *President*
 Elmer G. Shelley
 John F. Hartman, Jr.
 George H. Ledger
 Ralph E. Schmidt
 James D. Weaver
 Herman W. Riester
 Joseph M. Walsh
 Charles R. Leone
 Charles F. Schaaf

FAYETTE

Rudolph E. Medlen, *Secretary*
 Harold L. Wilt, *President*
 L. Dale Johnson
 Ralph L. Cox
 Robert C. Johnson
 George N. Riffle
 Edwin S. Peters
 Robert J. Peters

FRANKLIN

Earl Glotfelty, *Secretary*
 Robert B. Brown, *President*
 Paul A. Clutz
 Robert B. Brown
 Joseph C. Hudson

GREENE

C. Leonard O'Connell, *Secretary*
 Wayne E. Booher, *President*
 William B. Clendenning
 Robert W. Leibold
 Robert T. Gray

HUNTINGDON

Robert H. Beck, *Secretary*
 Charles L. Schucker, *President*
 Donald C. Malcolm
 John M. Keichline, Jr.
 Charles R. Reinert

INDIANA

Harry B. Neal, Jr., *Secretary*
 Warren L. Whitten, *President*
 Daniel H. Bee
 George W. Hanna
 Frederick S. Shaulis

JEFFERSON

E. Nicholas Sargent, *Secretary*
 Raymond F. O'Connor, *President*
 S. Meigs Beyer
 Desiderius G. Mankovich
 John A. Tushim

JUNIATA

Robert P. Banks, *Secretary*
 Samuel F. Metz, *President*
 Stephen I. Dodd
 Penrose A. Shelley

LACKAWANNA

Victor J. Margotta, *Secretary*
 Michael G. O'Brien, *President*
 John P. Donahoe
 William J. Corcoran
 William A. Coggins
 John Lohmann
 John M. Noecker
 Vincent A. Andriole
 Philip E. Sirgany
 John T. Murphy
 Paul C. McAndrew

LANCASTER

Charles P. Stahr, *Secretary*
 Charles W. Ursprung, *President*
 Roy Deck
 Henry Walter, Jr.
 Joseph Appleyard
 Charles H. Witmer
 Harold K. Hogg
 Frank A. Veri
 John L. Farmer
 Harold E. Stauffer
 Charles M. Hoffman

LAWRENCE

Wilbur E. Flannery, *Secretary*
 Charles H. Whalen, *President*
 Charles H. Whalen
 James L. Popp
 Mary Baker Davis

LEBANON

J. Dewitt Kerr, *Secretary*
 Herbert C. McClelland, *President*
 Walter H. Brubaker
 J. DeWolf Silberman
 C. Ray Bell, Jr.

LEHIGH

J. Frederic Dreyer, *Secretary*
 Rowland W. Bachman, *President*
 Robert L. Schaeffer
 Willard C. Masonheimer
 Joseph D. Rutherford
 Morgan D. Person
 Donald E. Stader
 Frederick G. Helwig
 Charles R. Fox
 Maurice W. Miller
 Joseph R. Bierman

LUZERNE

Joseph W. Ehrhart, *Secretary*
 Marvin C. Johnson, *President*
 Frank M. Pugliese

Herman A. Fischer, Jr.
 Louis W. Jones
 Rufus M. Bierly
 Albert R. Feinberg
 Harold C. Smith
 Joseph W. Piekarski
 Peter E. Ringawa
 Lachlan M. Cattanaach
 Hugh Heim
 Joseph J. Kocyan

LYCOMING

Raymond A. Davis, *Secretary*
 James H. Burrows, *President*
 Wilfred W. Wilcox
 Charles S. Tomlinson
 Frederic E. Sanford
 Lloyd R. Forcey
 Charles F. McLane
 Sidney E. Sinclair

McKEAN

Persis Straight Robbins, *Secretary*
 Homer A. Wilson, *President*
 Warren E. Hartman
 Ralph E. Hockenberry
 Robert D. Donaldson

MERCER

William A. Reyer, *Secretary*
 James W. Emery, *President*
 William J. Harrer, Jr.
 John L. Thomas
 Donald Donley

MIFFLIN

John R. W. Hunter, Jr., *Secretary*
 Edward E. Reiss, Jr., *President*
 James R. McNabb
 James G. Koshland
 A. Reid Leopold

MONROE

Harold B. Flagler, *Secretary*
 Evans C. Recse, *President*

MONTGOMERY

Alice E. Sheppard, *Secretary*
 Joseph L. Hunsberger, *President*
 Elwood T. Quinn
 Edgar S. Buyers
 Teofil Babacz
 M. Louise Gloeckner
 Walter J. Stein
 James J. McShea
 Herbert B. Shearer
 Robert E. Brant
 H. Ernest Tompkins
 Ammon G. Kershner
 William S. Colgan
 Thomas T. Kochenderfer

MONTOUR

Howard T. Fiedler, *Secretary*
 J. Reed Babcock, *President*
 Henry F. Hunt
 Walter I. Buchert
 Joseph G. Samolis

NORTHAMPTON

Thomas H. A. Stites, *Secretary*
 Paul E. Schwarz, *President*
 Frederick O. Zillesen
 Dudley P. Walker
 Kenneth W. Kressler
 Anthony J. Sparta
 Irene F. Laub
 Russell S. Rinker

NORTHUMBERLAND

Mark K. Gass, *Secretary*
 William A. Lustusky, *President*
 T. Lamar Williams
 Emily R. Shipman
 Benjamin Schnieder

PERRY

Amos G. Kunkle, *Secretary*
 William H. Gelnett, *President*
 Leonard B. Uish
 Robert N. Reiner

PHILADELPHIA

John Davis Paul, *Secretary*
 Richard A. Kern, *President*

Delegates

(Elected to serve in 1948 and 1949)

William Bates	Pascal F. Lucchesi
William P. Belk	Roy W. Mohler
Dorothy C. Blechschmidt	William Harvey Perkins
Francis F. Borzell	Joseph W. Post
Charles L. Brown	Stanley P. Reimann
Carl J. Bucher	J. Parsons Schaeffer
John T. Farrell, Jr.	Ralph M. Tyson
Simon S. Leopold	Bernard P. Widmann

Alternates

(Elected to serve in 1948 and 1949)

Nathan Blumberg	Charles B. Hollis
Joseph T. Cadden	William G. Leaman, Jr.
David A. Cooper	Charles-Francis Long
Garfield G. Duncan	Philip Q. Roche
Ralph Getelman	Donald C. Smelzer
DeHaven Hinkson	Elsie Treichler-Reedy

Delegates

(Elected to serve in 1949 and 1950)

Theodore R. Fetter	J. Hart Toland
Frederick A. Bothe	Walter S. Cornell
W. Edward Chamberlain	Milton F. Percival
Eugene P. Pendergrass	Louis H. Clerf
Joseph J. Toland, Jr.	Leonard D. Frescoln
Frederick C. Smith	Theodore Melnick
Henry B. Kobler	John V. Blady
Hayward R. Hamrick	Edmund L. Housel

Alternates

(Elected to serve in 1949 and 1950)

Earl A. Daugherty	Robert L. Dickson
John W. Egoille	Jacob B. Bernstine
Edward W. Campbell	William B. Swartley
Rendall R. Strawbridge	Ralph H. Spangler
Ralph W. Lorry	Benjamin D. Parish
Malcolm W. Miller	Robert A. Mathews
Ernest E. Aegerter	Edward Weiss
John C. Howell	Henry L. Gowens, Jr.

POTTER

George C. Mosch, *Secretary*
 Clarence E. Baxter, *President*
 Alfred F. Domaleski
 George C. Mosch
 William J. McGee

SCHUYLKILL

Charles V. Hogan, *Secretary*
 John J. Walsh, *President*
 William T. Leach
 John C. Bryson
 Robert E. Hobbs
 William H. Schlitzer
 William V. Dzurek
 William H. Walters

SOMERSET

Harold G. Haines, *Secretary*
 Harold E. Musser, *President*
 Charles I. Shaffer
 Jerry M. James
 Charles B. Korns

SUSQUEHANNA

Park M. Horton, *Secretary*
 Gordon E. Snyder, *President*

TIOGA

William S. Butler, *Secretary*
 D. Elvio Lewis, *President*
 Thomas Dimitroff
 Eleanor Larson
 Archibald Laird

VENANGO

James E. Hadley, *Secretary*
 Jane M. Marshall, *President*
 James A. Welty
 Thaddeus S. Gabreski
 Thomas Thomas

WARREN

John C. Urbaitis, *Secretary*
 Jacob F. Crane, *President*
 William M. Cashman
 Tom K. Larson
 Joseph R. Sugerman

WASHINGTON

Albert E. Thompson, *Secretary*
 Clarence A. Crumrine, *President*
 Milton F. Manning
 Guy H. McKinstry
 Edwin L. McCarthy
 Michael Krosnoff
 John C. Kelso
 John S. Oehrl

WAYNE-PIKE

Richard A. Porter, *Secretary*
 Clare C. Kenny, *President*
 Harold Koch
 H. Carl Benzenberg

WESTMORELAND

William E. Marsh, *Secretary*
 Russell A. Garman, *President*
 John F. Maurer
 Russell A. Garman
 Willis H. Schimpf
 John R. Liska
 Thomas St. Clair
 Homer R. Mather, Jr.
 Carl R. Limber
 Elmer Highberger, Jr.
 Richard M. Doncaster

WYOMING

William A. Wicks, *Secretary*
 Arthur B. Davenport, *President*
 Charles J. H. Kraft
 William J. Llewellyn

YORK

H. Malcolm Read, *Secretary*
 James E. Throne, *President*
 Wallace E. Hopkins
 Charles L. Fackler
 John H. Trimmer, Jr.
 Phillip H. Minnich
 John L. Atkins
 Edward J. Fisher

REPORTS OF OFFICERS

REPORT OF SECRETARY-TREASURER

To the President and House of Delegates:

Membership

The official membership of The Medical Society of the State of Pennsylvania on August 1, 1949, included 10,569 physicians who paid dues for the current year. The Society has, in addition, 387 associate members who do not pay dues but receive THE PENNSYLVANIA MEDICAL JOURNAL and many other privileges of membership. In 1948, on the same date, 10,343 physicians had paid the year's dues (113 were excused from paying 1948 dues).

One hundred and sixty-one members have been taken by death; one hundred and twelve have been lost by resignation, sixty-six by removal from Pennsylvania.

Thirty-two of the 60 component societies show a gain in membership during 1949; nineteen show a loss, and nine remain stationary.

County society distribution of membership is as follows:

County	Active Members		County	Active Members	
	1948	1949		1948	1949
Adams	27	28	Cambria ..	173	164
Allegheny .	1680	1642	Carbon	33	35
Armstrong .	46	41	Centre	32	34
Beaver	136	136	Chester ...	117	114
Bedford ...	14	15	Clarion ...	25	24
Berks	254	259	Clearfield .	53	49
Blair	127	124	Clinton ...	27	27
Bradford ..	47	51	Columbia ..	44	45
Bucks	88	89	Crawford ..	57	53
Butler	64	72	Cumberland.	44	47

County	Active Members		County	Active Members	
	1948	1949		1948	1949
Dauphin ...	248	250	Mifflin	33	37
Delaware ..	279	294	Monroe ...	33	37
Elk	25	25	Montgomery	324	343
Erie	193	202	Montour ..	37	39
Fayette ...	117	117	Northampton	195	194
Franklin ..	77	77	Northumb'l'd	77	75
Greene	25	26	Perry	11	14
Huntingdon.	28	30	Philadelphia	3162	3182
Indiana	42	43	Potter	10	10
Jefferson ..	57	57	Schuylkill ..	151	153
Juniata	8	7	Somerset ..	31	30
Lackawanna	285	282	Susquehanna	17	17
Lancaster ..	232	230	Tioga	24	27
Lawrence ..	83	81	Venango ..	50	53
Lebanon ...	59	68	Warren ...	51	44
Lehigh	214	223	Washington	143	145
Luzerne ...	376	366	Wayne	25	22
Lycoming ..	144	143	Westmorel'd	202	208
McKean ..	51	53	Wyoming ..	11	12
Mercer	86	95	York	168	168

Total active membership—1948, 10,456; 1949, 10,569.

Medical Defense

Six applications for assistance from the state society's Medical Defense Fund were received and approved since the last report, namely:

No. 374. Application dated September, 1948. Death of two-year-old child following administration of anesthetic by defendant physician at request of dentist for emergency extraction of tooth.

No. 375. Application dated November, 1948. Plaintiff claims perforation of intestine following fulguration of sigmoidal polyp. No commercial insurance.

No. 376. Application dated January, 1949. Plaintiff claims ulcer of ankle following treatment with infra-red light.

Nos. 377-378. Two physicians co-defendants, same case. Application dated June, 1949. Death of patient following treatment for blow over right inguinal ring.

No. 379. Application dated June, 1949. Plaintiff claims physician gave positive diagnosis of pregnancy, which proved false. No commercial insurance.

The only expenditure from the medical defense fund during the past twelve months was \$79.12.

One case was closed—No. 358. Plaintiff claimed that defendant physician had failed to remove cottonoid pledget at time of operation. Settled with consent of trustee and councilor. No commercial insurance.

Annual Audit

All of the accounts of The Medical Society of the State of Pennsylvania have again been audited by Mr. Grant L. Bell, of Scranton.* Any interested member of the Society may see a copy of the report which will be available in the Society's offices in Harrisburg, or Pittsburgh, and in the offices of the Philadelphia County Medical Society.

Veterans Loan Fund MSSP

In our report to the 1948 House of Delegates it was stated that of the 57 non-interest-bearing loans made from the Veterans Loan Fund MSSP six had been re-

paid in full, and one 50 per cent repaid. Since that report seven additional loans have been repaid in full, and on another a small portion has been repaid. All of these repayments have been voluntary and often with expressions of appreciation, as JOURNAL readers may have noted in the "Letters" department. Before January 1, 1950, as instructed by the 1948 House of Delegates, "... the total balance of the authorized 90 per cent together with the names of all outstanding debtors with the amounts involved will be returned to said county society to be disposed of as such county society may designate." In addition, the names of all pledges to the Veterans Loan Fund MSSP with amounts pledged and paid will be supplied to each county society.

1949 Secretaries-Editors Conference

The thirty-seventh annual conference of component county society secretaries and editors, to which other county society representatives were also invited, was attended by 121 county society officers and committee chairmen. Twenty-two state medical society officers and miscellaneous representatives were also in attendance.

The officers who sponsor these annual two-day meetings, while disappointed that 14 county societies were without representation, were highly pleased with the program and the deep interest and faithful attendance displayed by all.

Philadelphia Medicine and many other county medical society bulletins were generous in their quotations and their praise of the speakers and of the arranging committee.

Since all travel and living expenses of those invited to attend these instructive and stimulating meetings are paid, the responsible officers of the State Society cannot be satisfied until all component societies are represented at each annual conference.

Pennsylvania Areas Needing Physicians

We continue our service to communities seeking physicians and to physicians seeking locations in Pennsylvania.

Our latest survey (May, 1949) disclosed a few new communities and we still average about four inquiries a month from physicians, most of them from outside Pennsylvania. We send each of the latter our revised list of alleged "openings" with pertinent comments. We rarely receive a reply from the inquiring doctor, but do hear again and again from the "Chamber of Commerce" of more than one village (1000 or less) which would like to enroll a doctor among its citizens.

The problem is not new but its solution is to date imponderable, largely because in the past twenty years a license to practice medicine in Pennsylvania represents the expenditure of ten years in professional training and of \$15,000 in money before a physician enters medical practice in country or city.

Collecting the A.M.A. Membership Assessment

The announcement, early in January, 1949, that the American Medical Association would for the first time levy a membership assessment (\$25) naturally aroused considerable local comment, much of which was allayed when each county society member (automatically a member of his state society and the A.M.A.) received an explanatory letter and a subscription form from our office. All thereby learned that the purpose of the assessment was to enable the A.M.A. to develop a two-year National Education Campaign. The objective of the campaign is to instruct the public

* The financial section of the report of the Secretary-Treasurer will be published in the September issue of the PMJ. Preprints will be distributed prior to the meeting of the House of Delegates.

regarding the multiple dangers of compulsory federalization of medical, hospital, and related insured services versus the advantages of such services on a voluntary insured basis. Within three months more than 5000 Pennsylvania members had paid the \$25 assessment, and by July 1, 7100 had paid.

To our amazement, as of the latter date, we find a few of the larger component societies and several smaller societies with only 50 to 54 per cent of members paid, while a score of other societies, large and small, have 80 to 100 per cent paid. The average for all counties is 70 per cent. The Education Campaign, planned to run through 1949 and 1950, is well under way and is considered most promising. The response of all county societies will be announced during the convention in Pittsburgh in September, which leaves a period of several weeks for backward county societies to improve their standing so as to have from 85 to 100 per cent paid. County society officers have the names of their procrastinating members. Those who are unable to pay should so inform the president or secretary of their county medical society.

Conclusion

The Secretary-Treasurer, in presenting this his thirty-first consecutive report to the President and House of Delegates, acknowledges with appreciation the helpful consideration and kindly assistance received from the officers of the State Medical Society and all of its component societies, from committee chairmen and members, from the employees of our state medical society, and from the headquarters representatives of the American Medical Association. He urges upon all members of the Society a careful reading of all of the individual reports of officers and committees as published in the August PENNSYLVANIA MEDICAL JOURNAL.

Respectfully submitted,

WALTER F. DONALDSON, *Secretary-Treasurer*

REPORT OF CHAIRMAN OF BOARD OF TRUSTEES AND COUNCILORS

To the President and House of Delegates:

At the meeting held on Oct. 6, 1948, Dr. Park A. Deckard, retiring chairman and trustee and councilor from the Fifth Councilor District, presented the newly elected president-elect, Dr. E. Roger Samuel, and the first vice-president, Dr. Harold B. Gardner.

Dr. Deckard then introduced one new member who had been elected to serve for five years—Dr. James Z. Appel, his successor, and welcomed back to the Board Dr. Charles V. Hogan and Dr. Joseph S. Brown, trustees and councilors from the Fourth and Sixth Councilor Districts, respectively.

At the organization meeting the Board of Trustees elected Dr. Frank A. Lorenzo, trustee and councilor from the Ninth Councilor District, as chairman to succeed Dr. Deckard, and Dr. George S. Klump, trustee and councilor from the Seventh Councilor District, as vice-chairman.

At this meeting Board committee appointments for the ensuing year were announced as follows:

Finance—Drs. Whitehill, *chairman*, Appel, and Walker.

Publication—Drs. Gagon, *chairman*, Altemus, and Hogan.

Building Maintenance—Drs. Conahan, *chairman*, Miller, and Sweeney.

Library—Drs. Klump, *chairman*, and Brown.

Benevolence—Drs. E. Roger Samuel, *chairman*, Laurrie D. Sargent, Conahan, *treasurer*, and Donaldson, *secretary*.

Dr. Donaldson was re-elected editor of THE PENNSYLVANIA MEDICAL JOURNAL, Mr. Lester H. Perry was re-elected executive secretary, and Mr. A. H. Stewart, Jr., was re-elected convention manager and managing editor of the JOURNAL. Dr. Sweeney was renamed as the Board of Trustees' representative on the Advisory Council on Medical Service; and Evans, Bayard & Frick were re-elected legal counselors.

Dr. Gilson Colby Engel, president, appointed Dr. Robert L. Schaeffer, second vice-president, as an ex-officio member of the Committee on Public Health Legislation; Dr. John W. Barr, third vice-president, as an ex-officio member of the Committee on Medical Economics; Dr. Louise Gloeckner, fourth vice-president, as an ex-officio member of the Committee on Public Relations, and Dr. Deckard was appointed vice-chairman of the Committee in Public Health Legislation.

Since the 1948 session of The Medical Society of the State of Pennsylvania held in Philadelphia, excerpts from the minutes of the meetings of the Board of Trustees and Councilors appear in THE PENNSYLVANIA MEDICAL JOURNAL as follows: December meeting—May, 1949, pages 864 to 868; March meeting—July, 1949, pages 1115 to 1121; and May meeting—July, 1949, pages 1121 to 1127. The minutes of the July meetings will appear in the September issue. All meetings were, as usual, well attended by the trustees and councilors, other officers, and the chairmen of the Committees on Medical Economics, Public Health Legislation, and Public Relations.

In addition to generous excerpts from the minutes of our meetings, which appear from time to time in THE PENNSYLVANIA MEDICAL JOURNAL, mimeographed copies of the complete minutes of all meetings are available for reading by Society members in the Harrisburg and Pittsburgh offices of the Society, and in the office of the Philadelphia County Medical Society. Consequently, it is not necessary to repeat in this report the routine activities of the Board.

Finances

Since the fiscal year of the Society closes September 30, it is impossible to print the financial section of the report of the secretary-treasurer in the August issue of the PENNSYLVANIA MEDICAL JOURNAL. It will appear in the September issue, however, and preprints will be provided to all officers and to the members of the Reference Committee of the House of Delegates ten days to two weeks prior to September 26.

No unfavorable comments have come to notice on the purchase in 1948 of real estate adjoining 230 State Street, Harrisburg, to provide space for recent and anticipated expansion of the Society's administrative activities.

During the current year architects' plans for remodeling the headquarters building and the second and third stories of the building more recently acquired have been accepted, and early bids for construction are anticipated. These will undoubtedly exceed considerably the balance in the Building Fund (\$56,160).

On July 1 the first of the U. S. Savings Bonds owned by the Society matured. Costing \$7,500 in 1939, they provide \$10,000 in 1949. A fair return, it might be said, but the purchasing value of today's \$10,000 is only the equivalent of approximately 6650 of the dollars we invested in 1939. That depreciation was

largely due to deficit financing or government spending of dollars that are not matched by revenue. We have had a three-year rest from that, but on August 1 deficit financing was renewed. Therefore, the value of every dollar, whether in bank, bond, circulation, or life insurance, will be depreciated and our society's investments will suffer proportionately. Would that every American could appreciate that for every printing press dollar he or she will have to accept that depreciated dollar conceals a hidden and unavoidable tax. Painless taxes encourage bureaucratic waste. Only with known taxes that hurt will the taxpayer seek a diagnosis as to the cause of his pain and then seek the indicated corrective surgery for governmental budgeting.

Resolution from Columbia County Medical Society

The 1948 House of Delegates referred the following resolution from the Columbia County Medical Society to the Board of Trustees for study and report to the 1949 House of Delegates. The subject has been before the Board at most of its 1949 meetings and the results of its deliberations are herewith respectfully submitted:

WHEREAS, The American Medical Association has condemned by formal resolution the practice of medicine by closed staff institutions which employ physicians on a salary basis, exploiting their services, and which thereby do practice medicine as institutions, the Columbia County Medical Society of the State of Pennsylvania hereby urges the adoption by The Medical Society of the State of Pennsylvania of a similar resolution so that such institutions as exist in this state might be informed that their practices are opposed to the efforts and policies of organized medicine and not contributory to the public weal; therefore, be it

Resolved, That whereas the American Medical Association has condemned by formal resolution the practice of medicine by closed staff institutions which employ physicians on a salary basis, exploiting their services, and which thereby do practice medicine as institutions, The Medical Society of the State of Pennsylvania reaffirms its endorsement of the policies of the American Medical Association in condemnation of institutions engaging in such practices.

That the general subject of medical services rendered in hospitals has long been more or less controversial in character is well illustrated in the review prepared by F. H. Arestad, M.D., associate secretary of the A.M.A. Council on Medical Education and Hospitals, and presented at the Middle Atlantic States Regional Conference in Philadelphia on Nov. 18, 1948. This council reporting to the A.M.A. House of Delegates in 1915 declared that the plan of having fees for private practice go to a university or some special department is clearly unethical and illegal—unethical because the compensation for the professional service rendered by the physician to his patient should be paid to the individual rendering those services, and not to anyone else nor to any institution; illegal because the fees for such services could not be collected in court by anyone except by the individual rendering them.

The subject came up in the American Medical Association's House of Delegates in 1928, and in 1930 the Judicial Council of the A.M.A., after giving several reasons, stated in its report to the House of Delegates that in its opinion the practice of medicine by corporations is detrimental to the best interests of scientific medicine and the people themselves. In 1931 attention was especially drawn to the effect of these actions in the fields of anesthesiology, pathology, radiology, and physical medicine as being the most directly involved in hospital finance, because the earning capacity of these departments is often utilized to cover deficits of hospital sections not operated on a cost for service basis. There have been many subsequent actions in the A.M.A. House of Delegates designed to help clarify the relationship of these special fields to the corresponding hospital functions. The review prepared by Dr. Arestad con-

tinues throughout several sessions of the A.M.A. House of Delegates up to and as late as June, 1947.

The report of a committee of the Board of Trustees of the A.M.A. to the 1949 House of Delegates, as condensed, amended, and revised by the reference committee, appears on page 795 of the July 2, 1949 issue of the *Journal A.M.A.* This report of the reference committee may also be found in the Officers' Department of this issue of the PENNSYLVANIA MEDICAL JOURNAL. It should be read by every member of our 1949 House of Delegates whether he enjoys hospital privileges or not.

Our Board of Trustees submits the following to the 1949 House of Delegates as its reaction to the problem as stated in the 1948 resolution from Columbia County Medical Society:

Resolution

WHEREAS, Medical hospital services may be defined as those services other than administrative, rendered by a registered physician directly or indirectly to or in behalf of an individual patient for the obtaining and interpretation of data, including consultation and advice, for the diagnosis, treatment, and prevention of disease; and

WHEREAS, Such services will embrace the general and special practice of medicine, surgery, and obstetrics, and the practice of the related specialties including anesthesiology, physical medicine, radiology, pathology and clinical pathology including bacteriology, clinical chemistry, and other clinical laboratory specialties; and

WHEREAS, It is accepted as a basic principle of good medical practice that a professional interpretation should accompany the report on radiologic examinations and on materials and tissues examined by the pathologist; and

WHEREAS, Many complaints have been recorded from radiologists, pathologists, and anesthesiologists that hospitals have been applying the profits from these specialized professional services to help recoup deficits in other departments; therefore be it

Resolved, That the medical costs of hospital care be separated from the non-medical costs, as can be done by existing and accepted methods of cost accounting, and that they appear thus separated on the statement submitted to the patient;

That bills for all medical services be rendered in the name of the physician or physicians performing the services;

That a basic principle in the establishment of charges should be that each department be self-supporting. This principle should be so applied that neither the hospital nor the physician rendering the service will exploit the patient or each other;

That the basis of financial arrangement between hospital and physician may be salary, commission, fees, or such other method as will best meet the local situation, with due regard to the needs of the patient, the community, the hospital, and the physician;

That fees for medical services which are collected by the hospital be established by joint action of a representative committee of the staff and the governing body of the hospital and including also the head of each specific department and the hospital administrator.

Public Relations

Public relations, including the implementation of the National Education Campaign of the American Medical Association, has been one of our most important projects during the year just ending. The details of this effort are outlined in the report of the Public Relations Committee; consequently, only brief mention of certain aspects will be made in this report.

At the May 19 meeting of the Board, the chairman was authorized to appoint a committee of three as an Award Committee to act in conjunction with the Committee on Public Relations to select the 1949 recipients of the Benjamin Rush Award—the award presented annually to the layman and to the lay organization who have made the greatest contributions to the health of the people of Pennsylvania during the year. Drs. Appel, Gagon, and Klump were named as members of the Award Committee.

At this same meeting, upon request of the Public Relations Committee, the chairman was authorized to appoint two physicians from the State Society to serve as members of the A.M.A. National Speakers Bureau, and the following were named: Drs. Alfred E. Chad-

wick, New Brighton, and Richard A. Kern, Philadelphia.

Also at the May 19 meeting of the Board, a motion was passed directing the Committees on Public Health Legislation and Public Relations to meet jointly at least twice each year or more frequently if the chairmen deem it necessary. This action was taken for the purpose of developing closer coordination and cooperation between these two important committees.

On July 14, 1949, upon recommendation of the Public Relations Committee, the Board authorized a survey of our public relations program to be conducted by Ketchum, Inc., Pittsburgh, Pa. Such an objective appraisal of our public relations efforts, including the discovery of any weak points in our program and the establishment of guideposts for the future, should prove to be of real value to those charged with the responsibility of directing this important program.

The Building Program

By the time of the annual session it is expected that remodeling of our headquarters building will be under way. The purpose of this work is to combine our original building properly with the recently acquired former Laverty property located next door in order to form an adequate and efficient office layout for our expanding staff.

Support of Blue Shield

During the year the Board of Trustees continued its support of the campaign to secure additional participating physicians for the Medical Service Association of Pennsylvania—our Blue Shield plan. Representatives of the Society emphasized this problem at medical meetings throughout the State, and two letters were sent to all non-participating physicians among our membership. As a result, almost a thousand additional participating physicians were enrolled.

Since legislation passed at this year's session of the General Assembly permits the Medical Service Association of Pennsylvania to set the income limits for its subscribers, MSAP requested the State Medical Society to approve the continuance of the income limits which have existed since the inception of the Association. This approval was granted by the Board on July 15, 1949.

Keystones of Public Health for Pennsylvania

Through your Board of Trustees, the Society accepted responsibility for the distribution of the survey of the Pennsylvania Department of Health entitled "Keystones of Public Health for Pennsylvania." This proved to be quite a task because the requests for copies of the survey report totaled between three and four times the number of copies available. However, careful consideration was given to each request, and the distribution was completed in July. Our 1947 House of Delegates, by formal action, urged and approved the inauguration of this survey.

World Medical Association

On July 15, 1949, the Board authorized a contribution by our society of \$1,000 to the World Medical Association. Other medical societies have contributed amounts ranging from \$50 to \$10,000. The American Medical Association contributed \$50,000. This contribution was "made for the sake of our colleagues in remote and devastated areas and for the people they serve professionally."

State Health Council

In December the Board authorized the Committee on Rural Medical Service to proceed with the organization of a state health council. Details of this activity will be included in both the regular and supplementary reports of the afore-mentioned committee.

The Pennsylvania Medical Journal

The report of JOURNAL activity will be made by the Editor. However, your attention is called to the approval given by the Board on July 15, 1949, to a recommendation from the Editor and Managing Editor changing the annual volume of the JOURNAL from October to September, inclusive, to January to December, inclusive. The change has many practical advantages, including the simplification of the reader's search in a bound volume of the JOURNAL for continuity between annual reports and action on these reports by the House of Delegates.

Committee Appointments

At the Oct. 6, 1948 meeting of the Board, the Advisory Committee on Medical Service (a Board committee) was authorized, consisting of the chairmen of the Committees on Medical Economics, Public Health Legislation, and Public Relations, together with Dr. Frank Hanlon, of Wilkes-Barre; Dr. John Davis Paul, of Philadelphia; Dr. Alfred E. Chadwick, of Beaver; Dr. John J. Sweeney, representing the Board of Trustees, and the President, President-elect, and Secretary-Treasurer.

At the meeting held on Dec. 17, 1948, the personnel of the Committee on the Educational Fund was announced as follows: Dr. James L. Whitehill, Elmer Hess, Louise Gloeckner, and Walter F. Donaldson.

At this same meeting, following a recommendation by President Engel, authority was granted to the chairmen of the Committees on Industrial Health and Hygiene, Medical Economics, and Public Relations, together with the President, to act as a committee to meet with the key men of labor in Pennsylvania to discuss mutual problems. Dr. Engel was asked to serve as chairman of this group. A meeting was held in January with representatives of labor, during which there was a frank and profitable discussion. Although no definite conclusions were reached, every one present considered the meeting to be very much worth while.

At the March 3 meeting of the Board, a special committee was appointed to join with representatives of the Pennsylvania Bar, Dental, and Engineering Societies in opposition to compulsory political insurance legislation. The personnel of this committee is as follows: Dr. James Z. Appel, chairman, William L. Estes, Jr., and William Harvey Perkins with the officers of the State Society as ex-officio members.

At the May 19 meeting, the following committees were appointed: Medical Subcommittee of the Governor's Highway Safety Advisory Committee—Drs. Rufus M. Bierly, James A. Lehman, and Max H. Weinberg; Committee to Study the Problem of the Driver with Heart Disease, as requested by the Governor's Highway Safety Advisory Committee—Drs. Constantine P. Faller, chairman, Luther I. Fisher, Jr., William G. Leaman, Jr., William L. Mullins, and Wilfred W. Winey.

Annual Reports

Each member of the Board of Trustees, being also councilor for his district, has submitted his 1949 report. It is hoped that each member of the House of Dele-

gates and the members of the State Society will read these reports, and that the membership in each district will call upon their trustee and councilor whenever he can be of assistance. The annual reports of all officers and committees are worthy of careful reading by the members of the Society.

Conclusion

To my colleagues on the Board of Trustees, to the general officers of the Society, to the many faithful committee members, and to our employees, I express—in the name of the entire membership—deep gratitude for their devotion to the best interests of the Society.

Respectfully submitted,

FRANK A. LORENZO, *Chairman*

REPORT OF THE EDITOR

To the Board of Trustees:

A total of forty-eight editorials have been published in the twelve issues of THE PENNSYLVANIA MEDICAL JOURNAL which comprise Volume LII. Of these, 25 were prepared by the editor and were unsigned; six by members of the contributing editorial staff were signed with their initials only, namely, Drs. Campbell Moses, one; Howard K. Petry, four; James R. Watson, one; and one by Managing Editor Alex H. Stewart, Jr. Guest editorials, one each, were by Drs. Robert P. Barden, Edward W. Bixby, Leslie A. Falk, Andrew B. Fuller, Julian Johnson, F. Benedict Lanahan, James E. Landis, George F. Lull, C. L. Palmer, and Oliver E. Turner, and two by Max H. Weinberg. There was also a series of six editorials on the subject of syphilis by Drs. Townsend W. Baer, Saul R. Bergad, Joseph J. Hecht (2), Harry W. Woolhandler, and Harold R. Vogel.

The editor's attempt to obtain editorial contributions from chairmen of the State Society's own committees proved entirely fruitless. We repeat here our comment on the subject in last year's report to the effect that a number of the members of the Board of Trustees and Councilors write in editorial vein in their annual reports to the president and House of Delegates, which prompts the editor to repeat the invitation to them to contribute editorial comments for publication in issues of the JOURNAL other than that of August, which contains their annual reports.

Ten years have elapsed since any radical change has been made in the physical appearance of THE PENNSYLVANIA MEDICAL JOURNAL. Since the adoption of color on the cover page of our JOURNAL, such a format has become almost commonplace with state medical society official publications. Some thought is now being given to not only an attractive change in the cover page of THE PENNSYLVANIA MEDICAL JOURNAL but to the use of a better grade of paper, also expansion of line spacing, which is conducive to easier reading and is less tiring to the eye. All of this, it is hoped, will help to increase the number of readers of the JOURNAL and to make our advertising pages more attractive and more productive.

Recent monthly issues of the JOURNAL have closely approached a circulation of 12,000 copies. The income from non-member subscriptions and from purchasers of single journals this year approximates \$1,000, which again reflects growing interest in the JOURNAL as a medium of instruction.

It is a pleasure to report a growing interest in

"Letters" to the editor which appear in the front section of the JOURNAL, and we would remind our readers that the editor depends for these on not only our critics but those who have ideas to express and who at the same time invite discussion.

The editor is duly appreciative of the helpful cooperation received from the officers and members of the Board of Trustees and Councilors, from the editorial staff of the JOURNAL, and from the Evangelical Press.

Respectfully submitted,

WALTER F. DONALDSON, *Editor*.

REPORTS OF INDIVIDUAL COUNCILORS

FIRST COUNCILOR DISTRICT

(Philadelphia County)

To the President and House of Delegates:

The year 1949 marks an auspicious occasion in the life of the Philadelphia County Medical Society, namely, its one hundredth anniversary. A special "birthday" meeting was held on Sunday, January 16, in the Irvine Auditorium of the University of Pennsylvania to commemorate this event, at which the speakers were the Rt. Rev. Cornelius P. Brennan, Ph.D., Rabbi Mortimer J. Cohen, and Bishop Fred P. Corson. The installation meeting of the incoming President, Dr. Richard A. Kern, took place at the society building on January 12. The guest speaker on that occasion was Dr. Paul R. Hawley, Chief Executive Officer, Blue Shield and Blue Cross Commissions.

All of the scientific programs for the year have been arranged with the Centennial Anniversary as their theme. The scientific meeting on February 16 featured a two-act dramatic sketch depicting the progress in medicine during the past 100 years.

The thirteenth annual Postgraduate Institute was held at the Bellevue-Stratford Hotel April 5-8, with another record registration. A feature for 1949 was the two evening sessions—one featuring a clinicopathologic conference, and the other a practical demonstration of atomic energy in action. Dr. Gilson Colby Engel, director of the Institute, and the members of his commission are to be congratulated on the practical program presented. The reaction of both the technical exhibitors and the registrants was most favorable. Those in attendance included physicians from all parts of Pennsylvania as well as other states in the Middle Atlantic district.

The nineteenth annual Health Institute of the Woman's Auxiliary was held at the society building on April 12 with a capacity audience. The morning program featured the subject of "The Family and Public Health," and the subjects, "The Problem Child" and "Human Growth," were discussed in the afternoon. This activity of the auxiliary is attracting more attention each year and its members are deserving of hearty congratulations on its outstanding success. The auxiliary has also established two scholarships for deserving girls interested in following nursing as a career with partial financial assistance from the society.

A special Centennial Dinner was held at the Bellevue-Stratford Hotel on May 11, the ballroom of the hotel being filled to capacity. The guest list included representatives from our own State Society, of other contiguous state medical societies, various county medical societies in Pennsylvania, as well as many local lay

organizations representing the welfare and health fields. The guest speaker at the dinner was the Honorable Lister Hill, U. S. Senator from Alabama.

The society and the woman's auxiliary of the First Councilor District held a combined meeting at the society's building on April 20, at which Dr. Gilson Colby Engel, president, presented handsomely mounted testimonials from the State Medical Society to the following 29 physicians who had been in practice for fifty years: Drs. Joseph W. Anderson, Charles A. Barron, Moses Behrend, Arthur E. Bogart, Andrew Callahan, Frank M. Cleveland, J. Cajetan Flynn, Ella W. Grim, William P. Hearn, George J. Holtzhauser, James W. Kennedy, Henry B. Kobler, George E. Levis, Victor A. Loeb, Henry V. Marvel, George S. Mintzer, Ernest B. Mongel, S. Weir Newmayer, Robert F. Ridpath, Benjamin F. Royer, Charles Schabinger, George J. Schwartz, Jeanette H. Sherman, Malachi W. Sloan, William A. Steel, Samuel Steiner, A. Clarke Stroup, Harry F. Weber, and George C. Yeager. The guest speaker was Dr. W. Edward Chamberlain, whose subject was "The 1948 Medical Mission to Poland and Finland."

Many of the standing committees of the society have been unusually active during the past year.

The Committee on Nervous Diseases and Mental Hygiene arranged a fifth annual series of four lectures for the lay public which were held at the society building and attracted large audiences. Some of the subjects covered were "Advances in the Treatment of Mental Illness," "Family Relationships with the Mentally Ill Person," "The Development of Anxiety," "The Immature Person in Society," and "Psychiatry's Contribution to Better Living." Plans are now under way for another series in the near future.

The Committee on Cancer Control has been working diligently on a plan to encourage periodic physical examinations in physicians' offices. An all-day cancer control program was arranged by the committee at the society building on December 9. The morning session was devoted to a tumor conference, and the techniques of proper physical examinations for the detection of cancer were stressed in the afternoon.

The Committee on Diabetes again cooperated with the Diet Therapy Section of the Philadelphia Dietetic Association in arranging a series of nutrition meetings for diabetics.

The Committee on Heart and Circulatory Diseases arranged a series of three afternoon seminars at the society building which proved very successful.

The Eye Section gave another series of postgraduate conferences on the first Thursday evenings of November, December, January, February, March, and April, three conferences being available each evening. These postgraduate meetings have been given regularly by the Eye Section since 1933 and have always maintained a high degree of interest.

The speakers' bureau has continued to function actively in arranging talks for the laity on a variety of medical subjects. Under the guidance of Dr. Hugh Robertson, a class has been organized within the bureau to train physicians to present the subject of compulsory health insurance most effectively before the increasing number of lay and professional groups interested in the subject.

Such committees as maternal welfare, appendicitis, diabetes, and anesthesia study have continued their mortality studies for the purpose of uncovering preventable factors which will reduce deaths in these fields. The society is a cooperating organization in an impor-

tant study of pelvic cancer deaths under the direction of the Obstetrical Society of Philadelphia. This study has revealed a great deal of important information which should have a significant effect on the reduction of deaths from cancer.

A total of 241 new members has been added to the membership rolls since July, 1948, increasing the total membership to approximately 3400 physicians.

A series of weekly programs was arranged by the society over a local radio station which attracted widespread interest. Consideration at present is being given to a series of television programs which will acquaint the public with the contributions of medicine to the health of the individual and the community.

The society has official representation on a health survey of Philadelphia being conducted by the Department of Public Health, the City Planning Commission, and the Health and Welfare Council.

The society's Blood Bank Advisory Committee has continued to work closely with the local Red Cross organization in its central blood bank program which began in April.

A special planning committee has been formed for the purpose of implementing locally the National Education Campaign of the A.M.A.

The society had the privilege of acting as host to the State Society's centennial meeting which was held in Philadelphia, October 3 to 7. We are looking forward to extending similar cooperation when the state convention returns to Philadelphia in 1950.

During the past session of the State Legislature, the society endeavored to cooperate with the State Society in urging the passage of certain legislation which would redound to the benefit of the people of Pennsylvania and in defeating other legislation which would jeopardize existing high professional standards.

Due to the size of its membership, and its position as a medical center, the Philadelphia County Medical Society is most anxious to provide leadership on behalf of organized medicine in carrying out its responsibilities to implement the plans and objectives of The Medical Society of the State of Pennsylvania and the American Medical Association.

The twenty-fifth annual Strittmatter Award of the society was conferred on Dr. Catharine Macfarlane on April 13 for her distinguished work in the field of cancer. She is the first woman to receive this award.

Respectfully submitted,

HUGH McCAULEY MILLER,
Trustee and Councilor.



SECOND COUNCILOR DISTRICT

(Berks, Bucks, Chester, Delaware, Lehigh, and Montgomery Counties)

To the President and House of Delegates:

All county societies in the district had an increase in membership during the past year. Your councilor views with apprehension the very poor attendance at the annual councilor district meeting. It is discouraging for him to arrange for speakers, and then find that only 87 attend, including the members of the woman's auxiliary. It is even more discouraging at this time when organized medicine faces such a stern fight against the assaults of an organized opponent, who would change the whole complexion of medicine in the United States. It seems to your councilor that the entire membership of the councilor district might have, at any reasonable

sacrifice of time and convenience, profited by attending the meeting and hearing what our State Society and the A.M.A. had outlined as ammunition to fight these attacks against us. This poor showing of interest, plus the fact that only one society in the district (Lehigh) rates satisfactorily in the A.M.A. Membership Assessment Campaign, is very suggestive of indifference or procrastination.

During the past year, *Bucks County Society* observed its one hundredth anniversary with an appropriate program, climaxed by an anniversary dinner at the Doylestown Armory with about 300 persons attending. They produced a centennial volume stressing the history of the society, together with a biography of its members and about 40 photographs of former and deceased members. The committee deserves much praise for its efforts in producing this volume.

Lehigh County Society has done a splendid job in public relations during the past year. Their program on Compulsory vs. Voluntary Health Insurance at the Allentown High School in April was well worthy of emulation by other county societies.

Delaware County Society is preparing for its centennial celebration in 1950, and your councilor hopes that the membership will outdo what Bucks County did in 1948.

In closing, your councilor is receptive to suggestions concerning the annual councilor district meeting, to the end that it will be well attended and conducive of aid to all the members of the Second Councilor District.

Respectfully submitted,

JOHN J. SWEENEY,
Trustee and Councilor.

THIRD COUNCILOR DISTRICT

(Carbon, Lackawanna, Monroe, Northampton, Pike, and Wayne Counties)

To the President and House of Delegates:

In all county societies of this district the membership has increased, except in Carbon County, which remained stationary at thirty-four. All societies are holding meetings regularly as scheduled, and more interest and better attendance have been noted in each county.

There has been an upsurge in the number of members enrolling as participating physicians in MSAP, and the response to the \$25 membership assessment by the A.M.A. has been encouraging, but should be improved rapidly, especially in the larger societies.

The most pleasant part of my report is the activity of the woman's auxiliaries. This year, for the first time in my memory, each county society has an active woman's auxiliary, for which credit is due largely to the efforts of their state president, Mrs. Paul C. Craig, and president-elect, Mrs. Drury Hinton, also Miss Mary Henry Stites, councilor for the Auxiliary in the Third District.

Wayne-Pike County Society. Although this society has only 26 members, it is a pleasure to report its marked activity in all matters pertaining to organized medicine. It was one of the first to report nearly 100 per cent response to the A.M.A. membership assessment.

This year, ground was broken for the construction of a 65-bed hospital in Honesdale.

A woman's auxiliary to the county society was formed a few months ago.

Monroe County Society. This society has increased its membership from 34 in 1948 to 39. Six scientific meetings were held during the year and one combined meeting with the Bar Association. A marked increase in all activities has been noted by the officers and members of the various committees.

During the year the woman's auxiliary was reorganized and has been very active.

Carbon County Society. As usual, the membership of this society has been very active. During the year five combined scientific and social meetings were held.

After many years, the woman's auxiliary has reorganized and is doing very well. It is encouraging to note the number of members and their ladies who attend district and state society meetings.

Once a year during the summer months an all-day outing is held at some prominent resort in the mountains, which is always well attended.

Lackawanna County Society. This is the largest in the Third District (300 members) and continues to be very active. The officers and chairmen of the various committees are constantly on the job. Thirty-seven meetings were held—twenty-four scientific, nine business, three social, and one joint meeting with Alcoholics Anonymous, to which the public was invited.

A gradually increasing individual interest in meeting community responsibilities has been noted. Every health and welfare organization in the county has from two to ten physicians serving actively. The Child Guidance Center has tripled its expendable budget.

More than 27,000 chest x-rays have been taken during the year. A speakers' bureau has been set up with 40 members specially trained to disseminate authentic information on socialized medicine.

The committees in charge of the Red Cross blood donor registry, the heart disease and cancer prevention programs, are all very active. The officers and members of the Lackawanna County Medical Society are acutely aware of our profession's need to meet with the public.

Northampton County Society. The second largest society in the district (196 members) continues to meet nearly all requests from the officers of the State Society. Attendance at the monthly meetings continues to improve and it is encouraging to note the interest that the younger members are displaying.

The joint annual meeting of the Third, Fourth, and Twelfth Councilor Districts was held May 13 in Bethlehem. A fine scientific program was presented by staff physicians from the Guthrie Clinic at Sayre. Eleven doctors who have been in the practice of medicine for fifty years were given testimonials from The Medical Society of the State of Pennsylvania by President-elect E. Roger Samuel. The attendance was fair.

Respectfully submitted,

FRANCIS J. CONAHAN,
Trustee and Councilor.

FOURTH COUNCILOR DISTRICT

(Columbia, Montour, Northumberland, Schuylkill, and Snyder Counties)

To the President and House of Delegates:

There has been a healthy rejuvenation of all the county medical societies in this district and a great demand for speakers on scientific subjects.

We of the Fourth Councilor District feel very proud

that one of our own, E. Roger Samuel, has been elected the one hundredth president of The Medical Society of the State of Pennsylvania. We know that the State Medical Society has been wise in its selection and we predict for Dr. Samuel a successful year. Coming from a physician's family and having had the value of ten years' training as trustee and councilor of the Fourth District and later as chairman of the Board, Dr. Samuel is well oriented. I have valued his aid and advice since succeeding him as trustee and councilor of the Fourth District.

Our four county societies have shown an increased representation in the Graduate Education Institute, which is becoming more interesting and scientific each year.

I would like all society members in the Fourth Councilor District to check their automobile liability insurance and their medical protection liability insurance because I have experienced, as councilor, threats and institution of civil suits to collect damages. I have acted as an arbitrator in cases where a member has been denied admission into a county medical society, and in hospital group practice complaints, and have had correspondence concerning malpractice suits in the district. This is the first time in my six years as councilor that I have been called upon to take part in these discussions.

Our councilor district meeting was combined with the Third and Twelfth Councilor Districts at Bethlehem where we were the guests of Dr. Francis J. Conahan at the Hotel Bethlehem, at which time the scientific program was presented by members of the staff of the Guthrie Clinic. This was in direct contrast to last year when the meeting was held at the end of the Graduate Education Institute and did not work out as expected. My fellow councilors, Drs. Conahan and Gagon, are of the unanimous opinion that we can better serve our constituents by having separate meetings.

The following is a report by counties of the constituent societies in our district:

Columbia County: This county as usual shows a high percentage of attendance at its meetings, which is remarkable when we consider the average age of the physicians in this county medical society. The society reports, as of May 4, an increase in membership—49 members in 1949 compared with 45 members in 1948. Excellent meetings with good speakers on scientific subjects are held alternately at Danville and at Bloomsburg.

Montour County: This society has revised its constitution and by-laws to take care of its present needs. I am very sorry to have Dr. Nicodemus retire as secretary because our business and professional relationship was indeed a pleasure. I am sure the new secretary will carry on with the advice of Dr. Nicodemus.

Again it was our privilege to be a guest of the Geisinger Hospital and Clinic when Dr. E. Roger Samuel, state president-elect, was an honored guest. The clinic, as usual, was well organized and the speakers presented excellent material for those fortunate enough to be in attendance. Montour County Medical Society shows a loss of one member as of May 4, there being 41 members in 1949 and 42 members in 1948. Two members were transferred to the Northumberland County Medical Society.

Northumberland County: This society has been highly honored by the selection of E. Roger Samuel as president-elect of The Medical Society of the State of Pennsylvania. He has been the guiding hand of the

Northumberland County Medical Society for many years and was the unanimous choice of his society for the high office to which he was elected. He has represented his county society for many years as trustee and councilor and in many other positions of trust. We have noticed an increase in attendance of the members at the county society meetings and there has been an excellent array of speakers on scientific subjects. I wish especially to commend the service of Dr. Mark K. Gass as secretary of the society. I have found him to be of great help in solving some of the organizational problems in this county society.

Schuylkill County: This county society has been very fortunate in having as its president a man with a fine reputation and good standing among the physicians in his county as well as surrounding counties—Dr. John J. Walsh. As secretary of the Schuylkill County Medical Society, I believe, from my ten years' experience, that no other president has secured as large an attendance nor provided better speakers than we have enjoyed during the administration of Dr. Walsh.

Our society was saddened by the loss of our 1948 president, Dr. Cyril A. Whalen, who died after a long illness. Up to the time of his death, Dr. Whalen kept in contact with the office of the secretary just as if he were a well man. We shall miss him and, as councilor, I feel that our district has lost one of its great members.

The society showed an increase in membership as of May 4. We now have a membership of 157 as compared with 146 in 1948. We have held ten scientific meetings and one social meeting during the year. Under the direction of Dr. James J. Monahan, the society has conducted weekly radio broadcasts covering scientific subjects, public health topics, insurance problems, and many other subjects allied with the practice of medicine. It is felt that this has been the biggest year in the history of the Schuylkill County Medical Society, and we predict that the attendance record this year will stimulate increased activity in the years to come.

I want to thank the members of the component societies in my district and particularly the secretaries and all committee members and chairmen for their fine cooperation. I wish to extend to the woman's auxiliaries of the district my thanks for their splendid work with the county medical societies. I am happy and pleased that I have been selected to serve for five more years on the Board, for I know of no greater experience than to be associated with the members of the Board of Trustees and Councilors of The Medical Society of the State of Pennsylvania. I particularly want to extend my thanks for the many favors that Secretary-Treasurer Walter F. Donaldson and the office staff at 230 State Street have extended to me at all times during my services as trustee and councilor.

Respectfully submitted,

CHARLES V. HOGAN,
Trustee and Councilor.



FIFTH COUNCILOR DISTRICT

(Adams, Cumberland, Dauphin, Franklin, Lancaster, Lebanon, Perry, and York Counties)

To the President and House of Delegates:

The year 1948-49 is the first year that this councilor has served in this capacity. As a result, not nearly as much was accomplished by him as he desired. However, with the guidance and advice of his able prede-

cessor, Dr. Park A. Deckard, and his executive assistant, Dr. Henry Walter, Jr., he was able to survive.

The first problem presented to the councilor was a request for advice from the Lebanon County Society. This concerned relationship with the staff of the newly opened Veterans Hospital. There was some question regarding members of the staff of the VA Hospital practicing medicine on a part-time basis in Lebanon. Also, the eligibility of these staff members to membership was questioned. Through the good services of the chairman of the Committee on Medical Economics, Dr. Louis W. Jones, the first problem was easily solved. Concerning membership in the county society, it was informed that VA hospital staff members are eligible for membership and that their induction depends upon the decision of the local society.

This councilor attended and spoke to the Cumberland County Society on the A.M.A. National Education Campaign. He was pleased with the attendance and more pleased with the discussion that followed the talk, which was very frank and helpful. It showed that the members of smaller county societies are well informed as to organized medicine and its controversial problems. The determination to organize a woman's auxiliary was gratifying and has since been accomplished. It might be well at this time to point out that Cumberland County was prompt to organize its Education Campaign Committee and subcommittees and they have been very active.

The annual councilor district meeting was held at the Stevens House in Lancaster on May 12. Since the woman's auxiliary preferred to hold a separate meeting, it was decided to begin the meeting with a luncheon and forego the usual morning scientific program as an experiment. An effort was made to have a strong business program. This was accomplished with the cooperation of Drs. Gilson Colby Engel, president of the State Society, Joseph Lawrence of the Washington office of the A.M.A., and Park A. Deckard, vice-chairman of the State Society Committee of Public Health Legislation, all of whom spoke. To lend a little of the scientific to the program, Herbert K. Cooper, D.D.S., director of the Lancaster Cleft Palate Clinic, spoke on the work of the clinic. This clinic is the project which won the 1948 Benjamin Rush Award for its sponsor, the Lancaster Rotary Club. Sixty-five physicians were registered for the luncheon and approximately ten additional physicians arrived later and did not register. From observations made by the councilor at previous meetings, it was determined that this was the usual number of physicians in attendance.

The information submitted in the respective county societies' district censor reports was, as usual, quite interesting. There has been practically no drop in membership in the district, rather a slight increase. Adams and Dauphin were the only counties to report a need for more physicians. All counties reported increased interest and activity by their committees. Two county societies reported that they were in the process of forming a physicians' emergency call system, and both counties now have these in operation.

I am happy to report that two of the county societies in this district (Cumberland and Lancaster) are among the leaders in Pennsylvania (88 per cent and 92 per cent respectively) in the payment of the A.M.A. \$25 membership assessment. The other six societies range from 57 to 80 per cent paid, with an average of 70 per cent. Every effort will be made to bring the procrastinators into line.

It was disappointing to the councilor that no county

reported a meeting held to which the public was invited. If we hope to educate the laity concerning the accomplishments and aims of the medical profession, it is firmly believed that we must arrange programs of interest to them and then invite them to attend the meetings. Such programs could be scientific or on some controversial subject. It certainly would be a good public relations effort.

Respectfully submitted,

JAMES Z. APPEL,
Trustee and Councilor.



SIXTH COUNCILOR DISTRICT

(Blair, Centre, Clearfield, Huntingdon, Juniata, and Mifflin Counties)

To the President and House of Delegates:

Since our last report, one year ago, I have attended all the meetings of the Board of Trustees of the State Medical Society with the exception of the May meetings, at which time I was unavoidably absent. I have visited three of the medical societies of the Sixth Councilor District and hope to visit the others before September.

Our annual councilor district meeting was held on June 30 in Clearfield. I am indebted to Dr. Lorenzo G. Runk, executive assistant of the Sixth Councilor District, who was, in a great measure, responsible for the success of this meeting. I want to thank the Clearfield County Medical Society for serving as host for this meeting, and all who in any manner assisted in making it the success it was; especially are we grateful to those who attended. Our special guests were Drs. E. Roger Samuel, Mt. Carmel, president-elect; Elmer Hess, Erie, past president; Charles L. Brown, dean of Hahnemann Medical College, Philadelphia; and Kenneth E. Quickel, Harrisburg. Also present and on the program were Messrs. Lester H. Perry, executive secretary of MSSP, and Leo E. Brown, executive assistant, and Keith R. Hutchison, Western Pennsylvania representative, of the Committee on Public Relations.

It was a great pleasure to have as our honor guests Drs. Charles J. Stambaugh, Mifflin County, and William C. Brown, Clearfield County, who received their fifty-year testimonials. Upon meeting these men and noting their preservation, one would think, if it were possible, that they had begun the practice of medicine at about ten years of age.

Our district censors' reports indicated that their societies are active and growing. Knowing the support that the Woman's Auxiliary has rendered to the county, state, and national medical societies, it was a privilege and pleasure to welcome to our meeting Mrs. Ralston O. Gettemy, of Altoona, councilor for the Sixth District, and Mrs. Drury Hinton, of Drexel Hill, president-elect of the Woman's Auxiliary. We know that the ladies had a very excellent meeting, which was held separate from our scientific program.

Dr. Hess presented an excellent paper on "The Report of the A.M.A. Council on Medical Service." Mr. Perry's paper on "Local Steps Toward Universal Adoption of Voluntary Sickness and Hospitalization Insurance" and the one by Mr. Brown on "Steps Toward Complete Community Knowledge of Threats from Socialized Medicine" were very instructive and well received.

As first speaker in the scientific part of the program, Dr. Brown presented a paper on "Recent Advances in Treatment as Applied to General Practice." As is the rule, Dr. Brown gave us some "meat for thought." The second paper, by Dr. Quickel, on "Prevention and Treatment of Arteriosclerosis" was instructive and effectively presented.

All my medical life I have been interested in two phases of medicine—the practice of medicine and organized medicine. While I do not know much about either, organized medicine has received the least thought and attention. I believe this is true generally among the profession, and as it should be, but we could and should be more familiar with our organizations and their functions. We could obtain this information by studying the Constitution and By-laws of the State Society, by religiously reading THE PENNSYLVANIA MEDICAL JOURNAL, by attending all the meetings of organized medicine when possible, and by reading the material that we receive from the Secretary-Treasurer of the State Medical Society.

During my short term as a member of the Board of Trustees and Councilors, I have been amazed at the problems with which the Board is confronted and the serious, conscientious, businesslike manner of the Board in its deliberations and conclusions on each question. You have all heard of the "watch dog" of the Treasury; I would say that the Board of Trustees is the "watch dog" of the Medical Society and, believe me, there are some real "watch dogs" as members of this body. At this particular time in the history of the medical profession not only are "watch dogs" needed but the entire profession should be on guard to assist in keeping intact and in force our professional liberty and independence.

Ten years ago I read a paper before the Kiwanis Club of Lewistown on "Socialized Medicine," pointing out the historic results in every country where it had been instigated. I warned them as to the full meaning of the word socialization and cautioned against being misled by the subtle, cunning, conniving, camouflaged propaganda that was being used then and is more cunningly being used today by politicians in high office and position.

As I talk to men in all walks of life, my medical colleagues not excluded, I am impressed with the thought and knowledge that either I am entirely wrong in my reasoning or there are many who do not realize the seriousness of the current threats to our present position in life. There has been a very obvious change in our living conditions in the past twenty years; in fact, there is hardly one phase in our life picture that has not changed. Has this change been uplifting? Has the political shift to the left, with all of its attributes, been for the greatest good of most of our population? I am convinced that, in our own profession, we do not realize the seriousness of this movement, nor the manner in which we will be affected, nor how detrimental it will be to those whom we serve. It well behooves us to use every legitimate means to combat this false doctrine, and to do so we must familiarize ourselves with all questions and answers so we may be able to teach a true gospel of freedom and independence and thus sustain and maintain the American way of life.

Respectfully submitted,

JOSEPH S. BROWN,
Trustee and Councilor.

SEVENTH COUNCILOR DISTRICT

(Clinton, Elk-Cameron, Lycoming, Potter, and Tioga Counties)

To the President and House of Delegates:

It is indeed a pleasant task to prepare a report for this district in 1949. The component county societies have cooperated well in carrying out their increasing responsibilities to each community. The policies and programs of the House of Delegates and of the Society's standing committees have, with rare exceptions, been well implemented.

It is to be remembered that this district is largely rural and distances are relatively great between centers of population. That cohesion of any degree has occurred between the component societies is remarkable. In our opinion this has resulted in large measure because of the widespread interest in the Graduate Education Institute. Registrants at the Williamsport Center represented all of the societies in the district as well as those of several contiguous counties. With this in mind, the councilor district meeting was set up as a brief luncheon program on May 4, the date of the final meeting of the 1948-1949 Graduate Education Institute. Fifty-year testimonials were presented by President Gilson Colby Engel to our guests of honor: Drs. Mary M. Wolfe, Lycoming County; David E. Jacobs, Potter County; and Farnham H. Shaw, Tioga County.

President Engel also made an inspiring address, which was warmly received, outlining the Ten-Point Program and its relationship to current legislative proposals.

SUMMARY OF CENSORS' REPORTS

County	Membership 1948	Meetings 1949	Increased (All Types)	Effective Interest	Activities
Clinton ...	27	26	10	Yes	"Average"
Elk	26	25	4	Yes	Yes
Lycoming .	144	147	11	Yes	Yes
Potter	10	10	12	Yes	Yes
Tioga	28	27	9	Yes	Yes

Lycoming County reports opportunities for a general practitioner in the Trout Run-Ralston area. Potter County reports that a general practitioner is needed in the Ulysses-Genesee region in the northwestern part of the county.

Woman's Auxiliary

The Woman's Auxiliary luncheon arranged by Mrs. Harry W. Buzzerd, councilor of the Seventh District, was well attended and a delightful occasion. Dr. Engel also addressed this meeting. One could hardly avoid receiving the impression that the interest and enthusiasm of the ladies indicated that they were forging ahead of their doctor-husbands in understanding the complexities of the job that is to be done.

This is as fitting a place as any to pay the tribute due Mrs. Paul C. Craig and Mrs. Drury Hinton, president and president-elect, respectively, of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania. Their visits to every county auxiliary in this district have already borne fruit. The members are informed and acting on their information. The addition of Miss Suzanne Treadwell to the Society's staff has greatly strengthened the Auxiliary's program. Mrs. Buzzerd, Seventh District councilor, has spent many days and contributed most of her expenses in carrying out her duties. There can be no question that the po-

tentialities of the Auxiliary have never before been so fully explored and utilized.

County Society Activities

There are several matters of general interest that pertain to individual counties.

The Elk-Cameron County Medical Society has resumed use of the Letter Bulletin service offered by the Secretary-Treasurer's office and, judging from the announcements, the quality of the scientific programs has been improved.

Dr. Lloyd G. Cole, chief surgeon of the Blossburg State Hospital, was honored by lay and professional groups at a meeting held November 18, the occasion of the sesquicentennial celebration of medicine in Tioga County.

The Woman's Auxiliary to the Tioga County Medical Society displayed an exhibit largely devoted to the history of medicine in that county at the centennial meeting in Philadelphia last fall.

The Lycoming County Medical Society is arranging instructions for speakers through the facilities of the Williamsport Technical Institute, a pioneer in all types of vocational education. There will be ten weekly evening sessions, beginning in October, to which interested members in other communities are cordially invited.

Keystones of Public Health for Pennsylvania

In September, 1947, the House of Delegates urged that a survey be made of the Commonwealth's public health administration. The field staff of the Committee on Administrative Practice of the American Public Health Association conducted the survey at the request of the Governor and the Secretary of Health. It contains much material that has state-wide application, but the emphasis on improvement of local public health services bears especially on a rural area such as the Seventh Councilor District. The percentage of population under state administration for these services in the counties of the district is well over the state average of 27.3 per cent, except in Lycoming County. In Potter and Tioga counties it is over 75 per cent.

One of the "urgently needed and the most potentially useful recommendation of the survey" is:

"That the Department of Health immediately decentralize its direct services by developing the state districts on a county or multi-county basis as units with responsibility, authority, budget and staff for administering the state-financed public health program for the district."

There are scores of recommendations in the survey, all quite fully documented. It would be a miracle, indeed, if all were sound. Both individual and group study will be required to understand the general patterns suggested and to select individual recommendations for early action. Some will require legislation; e.g., a program of personnel administration based upon merit is basic to any change in the public health program. There will soon be properly increasing interest and cries for action from lay individuals and health groups. The House of Delegates originally sponsored the idea of a survey and now has a civic responsibility, through its properly constituted committees and commissions, to study the recommendations and bring to them sound professional advice in the public interest.

Respectfully submitted,

GEORGE S. KLUMP,
Trustee and Councilor.

EIGHTH COUNCILOR DISTRICT

(Crawford, Erie, Mercer, McKean, and Warren Counties)

To the President and House of Delegates:

The county societies of the Eighth District during the past year have shown an increasing interest in the new developments in the practice of medicine. The most outstanding work has been done in the field of acquainting the general public with the care and service offered by the physicians. This includes not only research in the diagnosis and treatment of familiar diseases with new drugs but the part that the physician plays in preventive medicine. It also includes the county society plans under which a physician will always be available to render service in case of accident or sudden acute illness.

The societies of the Eighth District use different methods in apprising the public of the National Education Campaign, but all are using the material made available by the Public Relations Committee, either by talks before lay organizations or by radio broadcasts and the distribution of printed information. Mr. Hutchison and Mr. Brown of the State Society Public Relations Committee have given talks at the various county society meetings and have been well received. The woman's auxiliaries have been especially active in this phase of public relations work.

I note from reports at hand that of the 53 active members of my own county society (Crawford) 50 (94 per cent) have paid the A.M.A. \$25 membership assessment. Other societies in the district range from 81 per cent of active members paid downward to 65 per cent. It is hoped that with the vacation season over the average of the Eighth Councilor District may be promptly raised from 76 per cent (August 1) to above 90 per cent.

The membership in this district is about static. Many new physicians have entered practice in the towns and cities, while certain rural areas are still in need of a physician.

Respectfully submitted,

HERMAN H. WALKER,
Trustee and Councilor



NINTH COUNCILOR DISTRICT

(Armstrong, Butler, Clarion, Indiana, Jefferson, and Venango Counties)

To the President and House of Delegates:

The Ninth Councilor District, composed of six western Pennsylvania county medical societies, enrolls a total of 290 members, with 24 members in the smallest society (Clarion) and 72 in the largest (Butler). The latter society showed the largest net gain in membership (8), while Jefferson County Society lost 8 members; Indiana lost one, Armstrong lost four, and Venango gained five.

Clarion County Society was not represented at our 1949 councilor district meeting held June 15 at the Butler Country Club. The program arranged by the Butler County Medical Society provided an attractive combination of scientific medicine and socio-economic topics which were received with rapt attention and deep appreciation for the splendid efforts put forth by Dr. Leo H. Crip of Pittsburgh (Allergy), Mr. Lester H. Perry (MSAP), and Mr. Leo E. Brown (AMA National Education Campaign). Those who attend are

indebted, too, to Dr. E. Roger Samuel for his homespun review of earlier years of medical practice interwoven in his address connected with the presentation of the testimonials for fifty years in practice.

The fact that our comparatively meager district membership (290) must serve a total of more than 425,000 persons, and that 50 per cent of the doctors of the Ninth District are located in the five larger towns whose population combined represents only 25 per cent of the total for the district, should serve to emphasize the need for personalized contacts by our public relations representatives with our members located in the smaller towns and villages more or less remote from the county seats. These doctors need an objective display of our state society's interest in their welfare. The percentage of the population dependent for prosperity on agriculture and the local production of coal, iron, and steel is very large. This affords fallow ground for the growth of state socialism. Especially is this true during periods of wide unemployment. May we not expect personal demonstrations to our members located outside the larger towns from Mr. Keith R. Hutchison of the local possibilities for winning public support of existing voluntary sickness insurance plans rather than proposed compulsory forms under complete government control?

In the comparative listing of county societies of our district, we are proud of the rating of Indiana County, with 93 per cent of its members having paid the A.M.A. \$25 membership assessment. The other societies in the district range from 54 to 73 per cent paid, the average for the entire district being 74 per cent. It is to be hoped that all will pay soon and that none will hold back, because they have not paid their share, from actively distributing to lay people the pamphlets sent to them by the A.M.A.

Respectfully submitted,

FRANK A. LORENZO,
Trustee and Councilor.



TENTH COUNCILOR DISTRICT

(Allegheny, Beaver, Lawrence, and Westmoreland Counties)

To the President and House of Delegates:

During the past year all the county societies in this district have been active and very busy both from a scientific and socio-economic standpoint. They have held good scientific meetings, using both local teachers and some from distant schools, and the meetings have all been well attended. The membership has increased in all four societies.

The annual Tenth Councilor District meeting of the county societies and woman's auxiliaries in this district was held in Beaver Falls and was very successful, with approximately 250 men and women present to enjoy the day's instruction in scientific subjects as well as organizational activities, current and projected, at the state and national levels.

The morning scientific program centered around obstetrics and the care of the infant, with the following instructors from Washington, D. C.: Drs. Lewis K. Sweet, Thomas M. Leonard, and Jed W. Pearson, Jr. After luncheon 19 district members of the Society received their fifty-year testimonial plaques from the State Medical Society, presented by Dr. E. Roger Samuel, president-elect. Then a very instructive explanation of the National Education Campaign of the A.M.A. was given by Mr. Leo E. Brown, and a

résumé of the legislative problems in Washington was given by Dr. C. L. Palmer. The entire program seemed to be well received, and it was the consensus that the Tenth Councilor District meetings be continued in combination with the Auxiliary. It is the plan now to hold next year's meeting in Greensburg, in the month of May.

The annual meeting of the *Allegheny County Medical Society* was held in Pittsburgh on May 24 and was very well attended, but there seems to be some loss of interest in the evening banquet of this meeting. We hope that by next year renewed interest will bring this meeting back to the place where it belongs—one of the largest attended county medical society annual meetings in the country.

The annual clinic of the *Westmoreland County Society*, held this year in Latrobe, was also very successful, as it always has been.

The annual banquet of the *Lawrence County Society* was held on June 1 and was a fine social gathering with the members of the Auxiliary.

The National Education Campaign of the A.M.A. has been well organized in all four counties; there seems to be an increasing interest in this work and we feel quite sure that this district can be counted upon to do its part throughout the coming year and be a help to the Public Relations Committee's endeavors.

In cooperation with the local Red Cross, two societies (Lawrence and Beaver) have each inaugurated a permissive blood bank, and so far this seems to be solving a community need. The 24-hour emergency call service is being considered by all the societies, but not enough work has been done on this as yet. We urge that it be accomplished because this will answer another community need.

The woman's auxiliaries, under the leadership of Mrs. Howard H. Hamman of Greensburg, district councilor, have been unusually active and will be of great aid in the A.M.A. National Education Campaign, perhaps more so than many of the society members. It seems wise for one woman to be assigned to each committee of the over-all planning committee. We sincerely wish to thank the auxiliaries and Mrs. Hamman for the excellent work they have done, and trust that we may have their continued cooperation in the coming year.

We also wish to thank the society officers and committees for being alert and active in the past year, and we urge that during the coming twelve months they work more strenuously than in the past; many days must be given to the work laid out for each of us. We especially wish to thank Secretary Donaldson and the efficient staff, both at Pittsburgh and Harrisburg, for their assistance in trying times, and may we all look forward to a new year when many of the problems must be solved. If we all do our part at the local level, we will win on a national basis and not have to look back with regret, as do our colleagues in England, with the often used quotation of "too little and too late."

Respectfully submitted,

JAMES L. WHITEHILL,
Trustee and Councilor.



ELEVENTH COUNCILOR DISTRICT

(Bedford, Cambria, Fayette, Greene, Somerset, and Washington Counties)

To the President and House of Delegates:

All of the counties in the Eleventh District, and especially the officers, have been hard at work and have had

a conference with Mr. Keith R. Hutchison, public relations representative in the western part of the State. I feel certain that every county has received his suggestions quite well and has followed his instructions in setting up a working program for the A.M.A. National Education Campaign.

The councilor district meeting had not taken place when this report was written, but the program which has been formulated by the Somerset County Medical Society is an excellent one and I feel quite sure that the meeting will be a success. Dr. E. Roger Samuel, president-elect of the State Society, will present the fifty-year awards to four members of the Eleventh District.

The woman's auxiliaries have been quite active during the year. They have taken on quite a bit of the work for the Public Relations Committee, although one might say it has been spotty. I feel that in this area they need some encouragement and possibly someone to help plan their work.

A word regarding the American Medical Association membership assessment. I have received a list of non-paid members in this district, and I must say that I am greatly disappointed in the response from this district. I feel that every member of the American Medical Association should pay this assessment promptly, as it is an indication of how we stand, as a profession, on the question of socialized medicine.

So I wish to remind every member in the Eleventh District to pay this assessment at once and show that we are one hundred per cent against any form of socialized medicine.

While it has been impossible for me to visit each county medical society in this district, due to circumstances over which I have had no control, I have not forgotten the societies and have followed their activities, and I hope to have visited all of them before the State Society convention in September.

Respectfully submitted,

LEARD R. ALTEMUS,

Trustee and Councilor.

TWELFTH COUNCILOR DISTRICT

(Bradford, Carbon, Luzerne, Sullivan, Susquehanna, and Wyoming Counties)

To the President and House of Delegates:

At the conclusion of another year the Councilor can report that interest in the several county societies and in the state organization continues unabated. All members have become more sensitized to the menace to the American way of life that is present in the proposed compulsory health insurance legislation, and because of the wealth of material supplied them by the Committee on Public Relations they are able to discuss the problem before the lay public with more enlightenment than ever before.

Bradford County: This society has a membership of fifty-two, the largest in many years; five new members were added during the year. There were no deaths. The society held ten meetings, one combined with the Valley Dental Society at which a program of mutual interest was presented; only one business meeting was held during the year, and there were no meetings to which the public was invited. The members of the speakers' bureau have been very active, giving talks on health insurance and cancer before numerous lay groups. The society assisted materially in forming the Bradford

County Chapter of the Pennsylvania branch of the American Cancer Society, and aided considerably in the tuberculosis survey of fifteen hundred high school students, a project that the society had sponsored. The woman's auxiliary has been very active. They usually meet at the same time as the county society and have dinner together, a social function that has had a marked influence on stimulating attendance at the meetings of both groups.

Wyoming County: This society has twelve members, having added one new member this year. Happily there have been no deaths. They meet the first Sunday of the month, having the members of the auxiliary as their guests, and follow with a scientific meeting. The society reports that the change of the meeting day from Wednesday to Sunday has boosted the attendance. At the March meeting, the society presented to Dr. Van C. Decker a well-deserved award, a plaque, in appreciation of his more than fifty years of "faithful service to his community." This was truly a most gracious gesture, for too often we fail to extend these tokens of respect to our most intimate friends until they have been called Home. How much better it is to have him hear these fine thoughts while he is still among us.

Luzerne County: This society now numbers 387 members, a loss of three since last year. Sixteen scientific meetings were held, to one of which all the hospital administrators and superintendents were invited. The meeting was a forum type on "Hospital Administration." The subject was thoroughly discussed by both the physicians and the hospital authorities and was mutually beneficial. A meeting was held to which the public was invited to hear a splendid discourse on "Rheumatic Fever" given by Dr. Carl Fisher. Following the paper there was a question-and-answer period. The public displayed keen interest, and your councilor feels quite sure the meeting did much toward furthering a better relationship between the profession and the members of the community. One meeting was held at which the members of the Luzerne County Dental Society were guests to hear Mr. A. S. Cobb, of Harrisburg, speak on "The Medical Bureau and the Economic Side of Your Practice."

The speakers' bureau has been very active, the speakers having made numerous appearances before a great variety of lay groups as well as several radio broadcasts. The society has representation on every health and welfare group as well as most social agencies in the Wyoming Valley.

No report has been received from Susquehanna County.

The councilor district meeting was held in Bethlehem, May 13, in combination with the Third and Fourth Districts. Dr. Conahan of the Third District was in charge of the meeting and had prepared a splendid program of scientific papers, presented by various members of the staff of the Guthrie Clinic, at both the morning and afternoon sessions. In the morning there was also an interesting and instructive graduate program conducted by members of the staff of St. Luke's Hospital. Excluding the essayists and the three councilors, about thirty physicians from a medical population of approximately twelve hundred were in attendance. This raises again in our mind the thought—do the members want councilor district meetings? Certainly the record of attendance at the last four annual combined meetings of these three districts seems to indicate very emphatically that they do not. It is embarrassing to ask busy leaders of our profession to sacrifice their well-filled time to come

some distance and address a mere handful of listeners. It is urged that the House of Delegates discuss the advisability of continuing these meetings at the coming session, and if they vote to continue them, then at least they must feel bound to attend the annual meeting of their own councilor district.

The woman's auxiliaries were most active and extremely helpful during the past year. The assistance given the Committee on Public Health Legislation during the 1949 session of the Legislature, in contacting the public concerning the numerous medical and health bills that were introduced in both branches, was of tremendous value. They have done much toward enlarging our public relations effort and should be given every aid they seek, as well as our deepest gratitude. A member of the Auxiliary recently approached us with the thought that the Auxiliary become affiliated with the Federated Women's Clubs throughout the Commonwealth. We are in complete accord with this thought. Such an affiliation would give to our organizations a splendid public relations contact. The suggestion is referred to the Advisory Committee to the Auxiliary for their consideration.

We have spoken to many members in the district, asking an expression on the question: "Do you think that too many physicians and too few lay individuals are carrying on the effort against the proposed National Health Insurance Act?" Without exception the answer is "yes." All members seem to feel that with physicians being the only speakers against this type of Federal legislation we lay ourselves open to the accusation of creating a "medical monopoly," of fighting only for our own selfish interests, and of being obstructionists. The members feel, too, that more work out in the field must be done by the society's employees in contacting lay groups and in trying to bring into our ranks of public speakers well-prepared individuals from other professional as well as business organizations. It is hoped that these thoughts, too, may receive discussion in the House of Delegates. We cannot and, in fact, should not be asked to stand alone in the effort to defeat this creeping socialism that is overrunning our country. Our fellow citizens must be awakened from the lethargy into which they have drifted by an all-out effort on every individual's part, and it must be impressed on them that federalization of medicine is only "the foot in the door" toward the ultimate destruction of our American way of life. Since we must carry the banner as the group to suffer the first attack, let us carry it proudly and high, but let us also be most emphatic in declaring that this battle is every man's, both in and out of the profession, and not one to be carried on only by the old faithful, but the too few.

Respectfully submitted,

THOMAS R. GAGION,
Trustee and Councilor.

REPORTS OF STANDING COMMITTEES

COMMITTEE ON MEDICAL ECONOMICS

To the President and House of Delegates:

VA Fee Schedule

The agreement and fee schedule negotiated between this committee and others with the Veterans Administration finally became effective January 1, 1949. Before its expiration on June 30, 1949, it was renewed for one year from that date. The agreement and this schedule

as amended and corrected appeared in the June, 1949 issue of THE PENNSYLVANIA MEDICAL JOURNAL.

VA Physicians in Private Practice

This committee wishes to inform the House of the ruling of the Veterans Administration concerning the private practice of medicine by full-time Veterans Administration physicians. The quotation is verbatim from VA Technical Bulletin 5-51:

"3.h. Private Practice by Full-Time Members of the Department of Medicine and Surgery.

"(1) The establishment by a full-time member of the Department of Medicine and Surgery of an office for the purpose of engaging in private practice is prohibited.

"(2) Private practice by full-time members of the Department of Medicine and Surgery in civilian communities, the needs of which are being satisfactorily met by civilian practitioners, will be restricted to emergency consultation practice with such civilian practitioners when legal requirements are otherwise met, and to emergency medical, surgical, or dental services necessary to save life or limb or prevent great suffering for which civilian practitioners are not immediately available."

National Foundation for Infantile Paralysis

The Committee on Medical Economics has studied carefully the request of the National Foundation for Infantile Paralysis that we form a state-wide fee schedule for consultative or direct medical care, physical therapy, and surgery in the treatment of indigent or semi-indigent patients aided by the Foundation.

As the result of our study we made the following recommendation to the Board of Trustees:

"Inasmuch as the National Foundation for Infantile Paralysis has already approved the policy of paying hospitals, nurses, physical therapists, and occupational therapists at their local actual rate, we believe that physicians should be reimbursed at their local prevailing rate and, therefore, we do not recommend the formulation of a state-wide fee schedule for the National Foundation for Infantile Paralysis at this time."

Increase in Telephone Rates

This committee made an exhaustive study of the proposal by the Bell Telephone Company to increase telephone rates throughout its various exchanges. As the result of our study we found that there was no evidence of discrimination against Doctors of Medicine in the proposed increase, and further found that more concessions had been made to Doctors of Medicine than to any other group. Therefore, we concluded that there was no sound or logical basis on which our society should protest this increase to the Public Utilities Commission.

United Mine Workers Health and Welfare Fund

This committee, together with members of the Board of Trustees, the Commission on Industrial Health and Hygiene, and the presidents and secretaries of some of the directly affected county medical societies, met with Pennsylvania Area directors, Drs. Falk and Brinkley, of the United Mine Workers Health and Welfare Fund.

This fund is now prepared to pay the medical and hospitalization fees for all union members and their dependents, except those already covered by checkoff contracts. At the present time medical care will be furnished as follows:

1. Members of the United Mine Workers of America who are receiving disability benefits, pensions, or widows' assistance from the fund are entitled to medical care. The services which they may receive and the method by which they identify themselves are as follows:

a. *Services to which this group is entitled.*—This group is eligible to receive all necessary medical care. This includes home and office care, hospitalization and medical care in the hospital, prescribed drugs, specialist services, and any other services for which there are medical indications.

2. Members of the United Mine Workers of America and their dependents who are not covered by hospital checkoff contracts are entitled to hospital care as follows:

a. *Services to which this group is entitled.* This group is eligible to receive hospitalization and medical care in the hospital. The patient is responsible for the cost of any other services.

As the result of this meeting our committee found as follows:

The broad program as outlined by Drs. Falk and Brinkley, area physicians representing the United Mine Workers Welfare and Retirement Fund for the State of Pennsylvania, seems to be entirely within the framework of the recommendations that the Commission on Industrial Health and Hygiene and the Committee on Medical Economics made to the Board of Trustees in March, 1947 (see page 1279, this issue.) Those present approved the broad principles as outlined for the operation of the fund.

The possibility of the formation of a fee schedule at state and county levels was discussed. It was the consensus that:

1. At the present time the Health and Welfare Fund is not asking for a state-wide fee schedule, and that such a state-wide fee schedule should not be considered at this time.

2. For the present, fees to be paid should be those paid to the doctor for like services in the community.

3. Any county medical society that may so desire may establish a fee schedule agreement with the fund.

4. If one or more of the county medical societies desire to draw up such a fee schedule, it is requested that such a schedule, prior to its adoption, be referred for review to the Committee on Medical Economics of the MSSP.

In regard to the public relations which may be involved in the approval of such a program by The Medical Society of the State of Pennsylvania, the following statement was unanimously approved by those present:

Inasmuch as we, as a committee, seem to be favorable to the program as outlined by the area administrators, and in order that no one—especially legislators—may feel that by endorsing this program this committee is thereby endorsing governmental or socialized medicine in any form, this committee wishes to make plain that it favors this program because it does not interfere with good principles of medical practice and it may help to overcome any existing deficiencies of medical care in certain areas.

Respectfully submitted,

DUDLEY P. WALKER

NORMAN C. OCHSENHIRT

JOHN T. FARRELL, JR.

THOMAS W. MCCREARY

LARUE M. HOFFMAN

EDGAR W. MEISER

Ex officio: JOHN W. BARR

LOUIS W. JONES, *Chairman*

COMMITTEE ON PUBLIC HEALTH LEGISLATION

To the President and House of Delegates:

1949 Legislative Session

The 1949 regular session of the Pennsylvania Legislature was an exceedingly confusing one.

Mental Health. There was a meeting on January 3 with the Governor at which transfer of the Bureau of Mental Health from the Department of Welfare to the Department of Health was discussed. President Engel felt that the discussion in the meeting indicated that the Governor was willing to have the State Medical Society draft a bill transferring this bureau and have it introduced as an administrative measure.

The Committee on Public Health Legislation then proceeded to draft the bill. In discussing the provisions to be inserted into the bill with Secretary of Health Norris W. Vaux, Dr. Vaux indicated that he did not favor transferring the local administrative boards for the state mental institutions and state-owned hospitals. It was also found that Secretary of Welfare Charlie R. Barber was not in favor of the transfer under any conditions.

In order to clarify the question, another meeting was held in the Governor's office, at which time Governor Duff, Secretary of Health Vaux, Secretary of Welfare Barber, Dr. Elmer Hess, and your chairman discussed this question. It was found that Secretary Vaux did not favor transferring the boards, Secretary Barber was still opposed to the transfer under any conditions, and the Governor was noncommittal; therefore, the Committee on Public Health Legislation recommended that the whole question be dropped because it did not seem advisable to introduce a bill without the support of the various departments concerned.

There were 67 bills introduced into the Senate and 94 bills introduced into the House that had health or medical care provisions in them, or a total of 161 bills. It is obvious that at this time only the important bills can be discussed.

Licensing of Nurses. House Bill (H.) 18 providing for the licensing and registration of practical nurses was referred to the House Committee on Professional Licensure. The House of Delegates, the Board of Trustees, and the Committee on Public Health Legislation of the State Medical Society had all approved this bill. So much opposition developed, however, that it was indefinitely postponed in the House Committee.

After this, the representatives of the nurses' organization requested your chairman to have Senator Chapman introduce a similar bill with amendments providing for the continuation and exemption of present and future practical nurses practicing in rural areas. Senator Chapman introduced Senate Bill (S.) 497 which passed the Senate and again lodged in the House Committee on Professional Licensure, where it remained.

It was surprising to note the various groups and individuals who opposed this bill. All the reasons given seemed to affect some local institutions, hospitals, or some local area, and it was extremely difficult to convince all of them that no interference in their particular cases would result.

Masscurs' and Chiropractors' Bills. H. 221 providing for a State Board of Massage and H. 312 and 313 creating a State Board of Chiropractic Examiners and regulating their practice were referred to the House Committee on Professional Licensure.

Your committee requested the House Committee to conduct a hearing on each of these bills. We also submitted statements giving the reasons for our objections.

In spite of all our requests, we were denied a hearing. All three bills were reported from committee as committed. We then informed the speaker and majority and minority floor leaders of our objections to these bills.

The bill providing for a State Board of Massage reached the postponed calendar and was defeated on final passage.

The chiropractic bills passed the House by a vote of 174 to 21. After they had been released from the Committee on Professional Licensure, we were informed by the Speaker that they would receive some treatment whereby they would be recommitted; and we were asked not to have our county societies contact their representatives over the week end.

This request had previously been made in the 1945 and 1947 sessions. In both years we were requested not to contact our county societies because the bills would be taken care of, and in both cases the promises were kept. Therefore, in this session, when we were again asked to keep quiet regarding these bills, we did so. However, in spite of promises, H. 312 and 313 were presented for final passage and passed.

The bills were then referred to the Senate Committee on Education. A statement was placed on each senator's desk giving the reasons for our opposition to these bills and we were granted a hearing on request. An extremely strong case against the bills was presented by Dr. Charles L. Shafer, chairman of the State Board of Medical Education and Licensure, Dr. Wesley Richards, a member of the Board, the Department of Public Instruction, represented by Mr. Dorr E. Crosley, Deputy Superintendent of Public Instruction, and the Department of Health, represented by Secretary of Health Vaux. Your committee also presented a statement.

The chiropractors were represented by one individual who, in the opinion of the committee, presented a rather weak case.

The committee voted 7 to 5 to report the bills out of committee and placed them in a subcommittee consisting of Senators Wagner and Haluska to draft amendments.

Mr. Crosley presented the subcommittee with amendments. Very few were adopted, and the bill was reported out of committee and placed on the Senate calendar. After two readings, the Republican caucus decided to have the bill remain on the calendar and not be voted upon in order that it could be allowed to die on the calendar. The next day the Republican caucus reversed its action and decided to have an open vote on the floor of the Senate, at which time H. 312 creating a Board of Chiropractic Examiners passed the Senate 26 to 24, but H. 313, regulating their practice, failed to pass because of a tie vote. The Lieutenant Governor refused to cast the deciding vote. On May 23 the Governor signed H. 312, and it is now Act No. 525.

This leaves the chiropractors with a very empty proposition because H. 312 provides for the appointment of the board only and does not assign them any duties.

The power of the chiropractors was amazing in this session of the Legislature. This has been due to several factors. It was learned late in the session that the CIO had passed a resolution favoring the licensing of chiropractors. Many legislators argued that since many other groups had a licensing board, why not the chiropractors? They do not realize that all drugless

therapists, such as chiropractors and others, may be licensed now by the Board of Medical Education and Licensure, provided they conform to minimum educational requirements; more than 400 have been licensed in Pennsylvania.

Osteopaths in MSAP. H. 450 and 451, sponsored by the Osteopathic Association, were introduced into the House by Mr. C. C. Smith, the Republican "whip," and Mr. Samuel Kurtz, vice-chairman of the House Committee on Insurance, to which these bills were referred.

These bills included doctors of osteopathy in the Medical Service Corporation Act in such a way that doctors of osteopathy could render medical service.

The Committee on Public Health Legislation immediately asked for a public hearing, which stirred up considerable dissension. On behalf of MSAP, their attorney, Mr. Hafer, requested the Board of Trustees of the State Medical Society to withdraw our request for a public hearing. Mr. Hafer suggested a number of items which, in his opinion, the State Medical Society would not desire to bring out in a public hearing. The Committee on Public Health Legislation, however, indicated that it was perfectly willing to go into a public hearing and also suggested amendments to keep osteopaths within the scope of their own act so far as their services rendered under MSAP might be concerned.

Your committee and your Board of Trustees were able to have the proper amendments inserted into the bills requiring osteopaths to keep within the practice limitations of their own law, thus separating their practice from the practice of doctors of medicine.

Income Limitations in MSAP. H. 1291 and 1292 give the Medical Service Association, with the approval of the Board of Trustees, the privilege of changing income limitations of subscribers depending upon general economic conditions.

H. 450, 451, 1291, and 1292 have all passed the House and Senate and have been signed by the Governor. They are Acts 123, 124, 334, and 332, respectively.

Dr. Thomas R. Gagion, trustee and councilor, had his vote recorded in the negative on the question of osteopaths being included in MSAP and on the amendment to the Medical Service Act whereby the income limitations are changed.

Dentists in MSAP. S. 834 and 835 amend the act providing for regulation of nonprofit medical service corporations by including in the plan certain limited dental services only.

Inasmuch as we agreed to admit the osteopaths within the scope of their practice law into MSAP, the Committee on Public Health Legislation, at its meeting on April 19, decided that they should not oppose admitting the dentists for a limited type of service.

Both S. 834 and 835 were enacted and are now Acts No. 378 and 379.

Coroners' Laboratory. The State Medical Society sponsored H. 502 providing a laboratory in the Department of Health for the use of coroners. This bill passed the House and Senate, but was vetoed by the Governor.

Animal Experimentation. S. 278, the animal experimentation bill, was finally recommitted to the Senate Committee on Public Health and Welfare. This bill proved to be extremely controversial. The senators were ravaged with threats of all kinds by mail, telephone, and telegram advising them not to vote for this bill.

The provisions of this bill are important and public sentiment must be developed in the next few years in its favor. There is no reason to be discouraged after considering past events. In 1945 we had an extremely difficult time preventing the passage of an antivivisection law. In 1947 we first introduced the bill providing for humane and sanitary experiments upon animals and had a little difficulty preventing the passage of an antivivisection bill.

In the 1949 session the antivivisectionists' own bill received no consideration. Our bill was released from the committee and passed two readings in the Senate, which is considerable progress, especially when it was such a controversial issue.

Osteopaths Sign Commitment Papers. Mr. C. C. Smith introduced H. 529 making osteopaths qualified physicians under the Mental Health Act. This bill would annul the decision of the Supreme Court which held that osteopaths were not qualified physicians in the State of Pennsylvania and, therefore, ineligible to sign commitment papers.

This bill was reported from the committee, passed the House by a majority of only three votes, and was referred to the Senate Committee on Public Health and Welfare, where it remained.

In addition to the afore-mentioned bills, the following bills in which we were interested passed the Senate and House, were signed by the Governor, and are now acts:

S. 2 establishing a recreational camp at Indiantown Gap Military Reservation—Act No. 9.

S. 54 further regulating contributions made by county commissioners towards funeral expenses of deceased service persons and their widows—Act No. 253.

S. 105 increasing the salaries of cabinet officers (including the Secretary of Health)—Act No. 192.

S. 156 repealing the act prohibiting the use of adulteration or imitation of dairy products in charitable or penal institutions—Act No. 48.

S. 229 appropriating \$500,000 to the Department of Welfare to reimburse state-aided hospitals for part of cost of training student nurses—Act No. 86A.

S. 330 appropriating \$125,000 to Pennsylvania State College for nutritional investigation—Act No. 87A.

S. 340 amending the act relating to dentistry by regulating the practice of dental hygienists—Act No. 150.

S. 444 adding to the act for prevention and treatment of mental disease by providing for outpatient and psychiatric clinical services—Act No. 90.

S. 917 amending the act permitting the personnel of state-owned mental hospitals to certify as to condition of patients by including managers of Veterans Administration hospitals—Act No. 421.

S. 945 amending the act relating to the public school system by providing for examination and clinical treatment of pupils by psychologists and psychiatrists—Act No. 269.

H. 81 eliminating requirements for local registrars of vital statistics to endorse permits for disposition of bodies of persons whose death occurs outside of the State—Act No. 18.

H. 144 prohibiting any unlicensed person, association, etc., from engaging in an activity for which a license is required—Act No. 106.

H. 145 eliminating the requirement that the Department of Public Instruction appoint members of advisory committees from lists submitted by state associations—Act No. 202.

H. 146 providing for and reorganizing the conduct of executive and administrative work of the Commonwealth

by the Executive Department, and further providing for membership of certain state boards and commissions—Act No. 193.

H. 190 imposing requirements on hospitals receiving state aid by limiting the power of state-aided hospitals to increase staff—Act No. 172.

H. 220 providing for compilation of statistics on rehabilitation of alcoholics by the Department of Health—Act No. 213.

H. 229 authorizing board of school directors to appropriate monies for payment of medical expenses and insurance for participants in school athletics—Act No. 178.

H. 325 amending the act relating to nonprofit corporations by further evaluating the method of approval of joint plans of merger—Act No. 127.

H. 537 authorizing the Secretary of Health to make necessary rules and regulations for the proper enforcement of the act regulating the use of drugs—Act No. 376.

H. 602 providing for a deficiency appropriation to the Department of Labor and Industry for use by the State Board of Vocational Rehabilitation—Act No. 2A.

H. 680 amending the act regulating the sale and possession of sulfanilamide and its derivatives—Act No. 59.

H. 792 authorizing the Secretary of Health to make rules and regulations for the enforcement of the act regulating the sale and possession of penicillin. The action of penicillin is sometimes uncertain and should be regulated by proper means in the Department—Act No. 173.

H. 991 amending the act relating to milk by defining skim milk—Act No. 403.

H. 1018 amending the act authorizing administrative boards within the Department of Public Instruction to admit to examination applicants under age 21 by further regulating the professional examination—Act No. 231.

H. 1048 amending the act defining liability of employer to pay damages for injuries by changing rates and compensation—Act No. 409.

H. 1050 amending the act providing for and reorganizing the conduct of executive and administrative work by the Executive Department by authorizing the cancellation of any certificate obtained through fraud or misrepresentation—Act No. 210.

Studies by Joint State Government Commission. This commission was established through legislative action and consists of 20 to 24 members with equal representation from the House and Senate. Its purpose is to study controversial subjects in the interim between legislative sessions in order to present to the next session of the Legislature any suggestions and legislation as a result of its investigation.

It is important that the Committee on Public Health Legislation cooperate with the Joint State Government Commission; therefore, your committee has already offered to assist the commission in the study of the mental health code and the study of existing as well as previously proposed legislation pertaining to the regulation and licensure of those desiring to diagnose and treat human ailments.

Legislative Bulletins and Articles Distributed

The Committee on Public Health Legislation mailing list (circulation—500) received copies of four legislative bulletins which contained lists of bills introduced during the period covered by the bulletins, comments concerning the bills, and information on Federal legislation.

There have been numerous letters, telegrams, and telephone conversations with the various county medical society and woman's auxiliary officers during the legislative session requesting them to contact their legislators concerning important bills.

The following papers were written and distributed by the committee to the mailing list for use in discussion before lay organizations, the first five of which were edited by the Committee on Public Relations:

- Attitudes, Legal and Social, Toward Animal Experimentation
- Medical Research in Terms of Human Life
- Veterinarian Tells How Animals Benefit by Experimentation
- Progress in the Treatment of Pneumonia (animal experimentation)
- Medical Research—Insulin (animal experimentation)
- "The Nation's Health—a Ten-Year Program" (Oscar Ewing report)
- Comments on "The Nation's Health—a Ten-Year Program"
- Summary of "The Issue of Compulsory Health Insurance" (Brookings report)

Petitions

Petitions requesting signatures in favor of proper animal experimentation were distributed on request to the county medical society woman's auxiliaries to be sent when necessary to members of the State Legislature and the Federal Congress; 3332 petitions providing for a total of 69,972 signatures were requested.

The Committee on Public Health Legislation also suggested to county medical societies that they have petitions printed requesting doctors to secure the signatures of their friends, patients, etc., permitting the local county medical society to use their names in case of necessity in legislation concerning medical service or public health. Allegheny County Medical Society deserves mention, as its members secured 15,390 signatures.

Both petitions were fairly effective and were used on a number of occasions.

Meetings

During the past year the State Society Committee on Public Health Legislation held three meetings—December 18, February 16, and April 19. All meetings were well attended with the members offering valuable suggestions as to policies and procedures, for which your chairman is very appreciative.

Federal Grant-in-Aid Funds

The following table indicates the amount of Federal funds granted in the State Department of Health for the various activities under the Social Security Act.

Conclusions

It is believed that the following reasons may be partially responsible for this extremely difficult legislative session:

1. Some members of the State Medical Society proceed with their own ideas regarding legislation without consulting the Committee on Public Health Legislation. This is proper in a democratic organization; however, the state committee has the facilities and personnel to draft bills, amend bills, and act as consultant in any legislative measures that

PENNSYLVANIA DEPARTMENT OF HEALTH FEDERAL GRANT-IN-AID FUNDS (Fiscal Year 1950)

U. S. Public Health Service—general health program	\$687,987
U. S. Public Health Service—venereal disease control	330,091
U. S. Public Health Service—tuberculosis control	277,119
U. S. Public Health Service—heart disease control	128,796
U. S. Public Health Service—cancer control	168,077
U. S. Public Health Service—water pollution	36,240
Children's Bureau—maternal and child health services	449,094
Children's Bureau—aid to crippled children	250,993
Grand total	\$2,328,397

may be considered by any member or group of members.

The committee is perfectly willing to give all credit to anyone or any group of members who may propose a laudable legislative proposition.

2. There has been a definite animosity in our legislative halls toward the medical profession. The profession is believed to be a monopoly and the limited licensees play the part of underdogs, repeatedly and emphatically declaring that they are discriminated against by the medical profession.

3. There is considerable complaint concerning the lack of service and overcharging by physicians. It is claimed that at certain times and in certain areas it is difficult to obtain a physician, and when he does respond, he does very little objectively and collects a high fee.

All these factors entered into the last session of the Pennsylvania Legislature, and it behooves the Committee on Public Health Legislation to call attention to these complaints and try to develop means of eliminating them.

The membership of our Society must be thoroughly informed that limited licensees, such as chiropractors, naturopaths, etc., can be licensed now under the Medical Practice Act if they conform to minimum educational requirements and apply for a license. Over 500 of them have already been licensed in this state.

Political leaders inform your chairman that doctors are very reluctant to register and vote. We must have an intensive campaign urging doctors and their families to be practical in politics, namely, to register and vote.

Various reports indicate a half-hearted local approach to our legislators. It is necessary for each member of the Committee on Public Health Legislation representing a particular councilor district to become more active during the pre-primary and election periods by assisting the local county medical society officers and committee chairmen in contacting legislative candidates before and after election, informing them in plain clear language what we stand for.

During the interim between legislative sessions and election periods, the membership, and particularly the Committees on Public Health Legislation of the component county medical societies, must keep in closer contact with their individual legislators and Federal Congressmen and let them know that we are interested in what they are doing.

The Committee on Public Health Legislation consults many committees of the State Medical Society. If a bill is introduced affecting the functions of a certain committee, we send a copy of it to the committee concerned and request an opinion, then transmit that opinion to the members of the House and Senate Committee to which the bill has been referred.

Your chairman wishes to express his sincere appreciation of the excellent cooperation of these committees and of many of the county medical societies and their woman's auxiliaries, also of the services of Mr. James H. Thompson, attorney for the committee.

Your chairman desires especially to thank Senator Leroy E. Chapman, a physician from Warren County, and Representative George J. Sarraf, a physician from Allegheny County, for their excellent advice and cooperation during the entire legislative session.

It is hereby recommended that these two gentlemen receive some recognition from the House of Delegates or the Board of Trustees indicating our appreciation of their valuable assistance and the thanks of the membership of the Society.

Respectfully submitted,

JOSEPH W. POST	LUTHER J. KING
JOSEPH D. RUTHERFORD	CHARLES A. ROGERS
WILLIAM J. CORCORAN	WILBUR E. FLANNERY
J. STRATTON CARPENTER	MILTON F. MANNING
HENRY WALTER, JR.	HERMAN A. FISCHER
LORENZO G. RUNK	GILSON COLBY ENGEL
HERMAN C. MOSCH	WALTER F. DONALDSON

C. L. PALMER, *Chairman*
 PARK A. DECKARD, *Vice-Chairman*
 ROBERT L. SCHAEFFER, *Ex officio*

COMMITTEE ON PUBLIC RELATIONS

To the President and House of Delegates:

To enumerate the activities of your Committee on Public Relations in an annual report may be informative, but to translate these activities into a description of the influence they have exerted in stimulating county medical societies and the individual practicing physician is infinitely more important. The dawning realization of the importance of public relations in the minds of physicians can best be reported on by those to whom this report is directed.

What we have *done* has little significance. More important is the *result* of our labor. Your task must be to interpret the following report in relation to the services rendered your county society, its activated public relations program, and the perceptible influence our combined programs have wrought in molding public opinion.

The unexpected political upset of November 2 greatly altered the plans of our committee and necessitated the channeling of our major efforts into the campaign against socialized medicine. However, we have attempted to keep our long-range public relations objectives in view and have planned our program so as to capitalize on the county society organization, established to combat government sickness insurance.

Our task has been twofold—first, selling the importance of medical public relations to the profession, and second, selling the profession to the public, both of which are equally difficult. The job of selling any commodity depends upon the need, demand for, and quality of the product. Without question there is a need for good medical public relations; the demand is far greater outside the profession than within, and the quality is primarily dependent on the type of professional

and humanitarian service rendered to the public by each and every practicing physician.

The tools and techniques used by your Committee on Public Relations during the year 1948-1949 were as follows:

Public Relations Reporter—Journal (P. R. Page)

The promotion of our public relations program within the profession has been spearheaded by our "Public Relations Reporter," sent periodically to the county medical society officers and public relations committees. It has been geared primarily to encourage county society activity, to promote the State Society's program—as a continual reminder of their public relations responsibilities, and to suggest the tools successfully used to implement local programs. The JOURNAL "P. R. page" has been directed to the entire membership, emphasizing the need, importance, and proven techniques used in promoting a medical public relations program. Herein an effort was made to spread the truth that good medical public relations can best be promoted by the individual physician. Many of you have regularly received the "Public Relations Reporter" and all have had the opportunity to read the JOURNAL "P. R. page." They speak for themselves.

Personnel

During 1949 three new employees were added to the public relations staff. The primary reason for enlarging our personnel was to increase the services rendered to the county medical societies and to the Woman's Auxiliary. On February 7 Mr. Keith R. Hutchison was employed as a field representative to serve the 26 county medical societies in western Pennsylvania. One week later, Miss Suzanne Treadwell joined our staff to help in the promotional activities of our program and to assist the Woman's Auxiliary in the promotion and implementation of its program under the supervision of the Committee on Public Relations. Mr. Gar Young was employed as eastern field representative on April 25. All spent the first four weeks of their employment becoming familiar with the activities of the state and county societies and the philosophy of our public relations program. During the first four months of field work, our staff employees have made 158 visits to 48 of the component county medical societies and auxiliaries, assisting them in the promotion of their public relations program.

It is not the intention of the committee that the staff employees assume the complete responsibility for promoting the public relations program of the county societies, but that they encourage, suggest, and assist in the implementation of this program. Many county societies have been exceedingly cooperative and appreciative of this service, while others seem reluctant to invite the assistance of our staff.

The increased interest and cooperation from the county societies personally contacted by staff members indicate that through this medium of approach our over-all public relations program will be greatly enhanced.

National Education Campaign

The Board of Trustees of The Medical Society of the State of Pennsylvania charged the Committee on Public Relations with the responsibility of promoting in Pennsylvania the National Education Campaign of the American Medical Association, which is designed to combat socialized medicine. A large portion of the committee's activities during the year 1949 has been directed to this end.

Following the directive of Whitaker & Baxter, employed by the A.M.A. to direct the National Education Campaign, Pennsylvania is cooperating to the fullest extent of its resources. A detailed report of campaign activities has been submitted periodically to the Board of Trustees and our committee has relied heavily upon their counsel in the implementation of our campaign program.

Briefly, the campaign has been organized at the "grass roots" level. Each county medical society is being encouraged to participate in this campaign by establishing (1) a speakers' bureau, (2) a press and radio subcommittee, (3) an endorsement subcommittee, and (4) a personal contact subcommittee. Each has been charged with definite responsibilities to educate the local citizenry to the dangers of compulsory sickness insurance and the merits and availability of voluntary sickness insurance. Our staff is using every conceivable technique to encourage the county medical societies to organize their local campaign on this basis. Progress to date has been only moderately successful. Approximately 22 county societies have, at this writing, organized their memberships into a fighting unit. The promise of committee appointments and their activation have been forthcoming from many other societies visited by our field representatives. We are hopeful that with perseverance, and the services we are able to render, the majority of the county societies will prepare to effectively meet the challenge to our present system of medical practice. The specifications, the tools, and the material have been provided. We now appeal to you as representatives of the component county medical societies of this state to exert your influence and prestige toward encouraging the county medical societies to cooperate in the National Education Campaign so that Pennsylvania will be fully mobilized.

Campaign literature and pamphlets have been distributed in quantities well over 1,500,000 to the profession and laity by your committee. There is every indication that popular opinion is swinging away from the acceptance of compulsory government medicine. Nevertheless, our activities are not being curtailed; they are being intensified. Forty-six lay organizations, 18 county medical societies, and 18 woman's auxiliaries have adopted resolutions condemning compulsory sickness insurance and endorsing voluntary sickness insurance and have notified their Congressmen and the President of the United States regarding their sentiments. Editorial comment in the daily press overwhelmingly supports voluntary prepayment plans, but at the same time expresses opposition to the high cost and unavailability of adequate medical care in some areas. Radio broadcasters have been most cooperative in making time available to the local county societies to explain this controversial issue to their listening audience. Speakers' bureaus, where organized, are filling many engagements. Some have inaugurated public speaking courses and study groups to better prepare the speakers for appearances before the public.

Dr. William Bates, of Philadelphia, representing the House of Delegates of the A.M.A. on the Campaign Coordinating Committee, reports that Pennsylvania ranks among the upper one-third of the states in cooperation with the N.E.C. and distribution of campaign literature. If we can achieve this place with only one-third of our county societies actively engaged in this campaign, we should be able to top the list when the remainder of the societies get their campaigns functioning. To this end, we have set our goal.

Other Activities

"Your Health" Column. The "Your Health" column continues to be a popular and integral part of our public relations program. This column is now regularly appearing in 45 daily papers, 96 weeklies, 4 farm magazines, 4 foreign language papers, and 5 house organs. It is prepared by the publicity assistant of the Committee on Public Relations and maintains a high standard of health education information.

Daily Dozen. This new health feature is now being furnished primarily to house organs. However, some daily and weekly newspapers not using the "Your Health" column find this new feature newsworthy. It is likewise a health education medium and is made up of one dozen short factual statements of one column width. This feature is currently being published in 8 daily papers, 30 weeklies, 54 industrial house organs, and 1 farm journal.

Radio. Thirty Pennsylvania radio stations are currently broadcasting, on a weekly basis, the quarter-hour health education transcriptions prepared by the A.M.A. and placed through the Committee on Public Relations. In addition, five stations are broadcasting a live 15-minute program entitled "Your Doctor Speaking." Suggestive scripts for these programs are furnished by the State Society. All of these programs are under the sponsorship of local county medical societies. Such splendid cooperation on the part of these 35 Pennsylvania radio station owners and managers warrants our heartfelt thanks. All of these programs are aired on a public service basis in the interest of better health and medical care in Pennsylvania. It would seem appropriate for each county society indebted for such service to personally express its appreciation to these public-spirited citizens.

Emergency Medical Care Service. The fact that one of the major criticisms of the medical profession has been based upon the patient's inability to get a physician in an emergency prompted the Committee on Public Relations to promote the establishment of Emergency Call Service in all counties. It has been gratifying indeed to learn from a recent survey that 26 county medical societies have sponsored such a service, either in their principal city or covering a specific service area. Other county societies are making similar plans. In the opinion of the committee, this service is invaluable as a public relations medium.

Poster Contest. The school health poster contest, under the supervision of the Committee on Public Relations, has been actively supported by the Woman's Auxiliary as one of its major projects. They have done an excellent job in spite of a late start and their unfamiliarity with the task. An increasing interest has been shown on the part of many schools and much favorable publicity has been forthcoming. We are confident that the Woman's Auxiliary will be of tremendous assistance in this undertaking and will be glad to assume all the responsibility delegated to it by the county societies.

Motion Pictures. Nine new health films have been added to our film library during the past year—four purchased outright and five on a loan basis. The number of showings increased from 114 during 1947-48 to 182 during the current year, an increase of 60 per cent. Our films are being used extensively by the Woman's Auxiliary, which makes arrangements for showing at schools, P.T.A. meetings, women's clubs, and other

public gatherings. A new film booklet listing the films available on a free loan basis from The Medical Society of the State of Pennsylvania has been prepared and widely distributed. The knowledge of the availability of these films promises to greatly increase their use during the coming year.

Benjamin Rush Award. The Benjamin Rush Award will again be presented this year to the lay individual and the lay organization selected from the nominees submitted by our component county medical societies. We are somewhat disappointed in the response of the county societies to this project. Only ten have seen fit to thus honor the lay individual and organization within their county who have made significant voluntary contributions in the field of public health. In order to stimulate interest in this matter, we are making available to the county societies a 2¼ inch miniature medallion of the Benjamin Rush Award for presentation to eligible nominees submitted. The county societies are being urged to arrange for the presentation at a public meeting with appropriate praise and encouragement for continued participation on the part of laymen and lay organizations in the public health field. Presentation of the Benjamin Rush Award at the state level will take place on Tuesday evening, Sept. 27, 1949, at our convention's presidential installation meeting.

Centenarian Project. Our centennial promotional project of last year met with so much success that it was decided to continue the presentation of testimonial plaques to all oldsters reaching the age of five score years during 1949. To date, eight such testimonials have been presented and eight are scheduled for presentation during the remainder of the year. The county medical societies have made all local arrangements and in many cases the family physician has made the actual presentation. Appropriate news coverage of these events has done much to enhance the local public relations program.

News Releases. Keeping the public informed of the activities of the county and state medical societies has been an integral part of our public relations program. However, in addition to the preparation of news stories, which have averaged three a week during the past year, much emphasis has been placed on the importance of establishing a friendlier relationship between the local press and the county medical society. Representatives of the county society are being encouraged to call upon the local editor, ask how they can help him, and learn what he wants in the way of news stories. Personal contact with the press is most important in the promotion of our public relations program. A manual entitled "The Doctor and the Newsman" has been prepared through the cooperative effort of staff members of the Committee on Public Relations and has been distributed to all county society press committees to be used as a guide in promoting a closer relationship between the medical profession and the fourth estate.

To our good friends of the press, we wish to express our thanks for their splendid cooperation and trust that a closer liaison may be established between the doctor and the newsman.

Woman's Auxiliary

The Woman's Auxiliary to The Medical Society of the State of Pennsylvania has been of inestimable value and assistance to the Committee on Public Relations in

the promotion of its program. Actually, the major portion of their program is of a public relations nature. Consider the following activities: promotion of Blue Shield; cooperation in the National Education Campaign; distribution of literature; scheduling and filling speaking engagements; promotion of the health poster contest; scheduling our motion pictures; sponsoring public health meetings, and many other worth-while activities. The pamphlet "Your Family's Future Health," which our Woman's Auxiliary initiated, has received high commendation, not only within the state but on the national level.

The Auxiliary has proved without doubt that it is willing, interested, and capable of serving the county medical societies in the promotion of their public relations programs. The time spent by the Committee on Public Relations in assisting the Woman's Auxiliary has returned amazing dividends.

Summary

A summary of the outstanding activities of 1948-49 should include the following:

1. Our campaign against socialized medicine.
2. The distribution of a million and a half pieces of campaign literature.
3. The addition of three new staff members.
4. The promotion of public relations programs in county medical societies.
5. Cooperation with the Woman's Auxiliary.
6. Extension of our health education program.
7. Radio—"Your Health" column—"Daily Dozen."
8. Health poster contest—film library.
9. Benjamin Rush Award—centenarian project.
10. Convention and Farm Show exhibits.

Recommendations

As a result of a careful analysis of the Society's activities, the prospective economic conditions, and the attitude of the public towards our present system of medical practice, the Committee on Public Relations respectfully submits the following recommendations for your consideration:

1. That all county medical societies promote a vigorous public education campaign to combat socialized medicine. This can be accomplished by enlisting the support of every practicing physician; by obtaining the support of lay groups; by organizing the local societies into a trained fighting unit; by supporting the entire National Education Campaign, not only through the payment of the \$25 A.M.A. membership assessment but through contributions of time and talent.
2. That every county society cultivate a good relationship with the press and radio managements in their respective counties.
3. That a definite program be launched to correct the underlying causes which have influenced too many American citizens into believing that the Federal Government can render better service than our present system of medical practice.

The Committee on Public Relations wishes to express to the President, the House of Delegates, and the Board of Trustees, its appreciation of the cooperation and encouragement accorded the committee during 1948-49.

To the staff assigned to the Committee on Public Relations—Mr. Leo E. Brown, executive assistant; Mr. Roy Jansen, publicity assistant; Miss Suzanne Treadwell, staff assistant; Mr. Keith R. Hutchison, western

field representative; Mr. Gar Young, eastern field representative; Miss Catharine Saltsman and Miss Ruth Raub, secretaries—the committee is especially grateful for their loyalty, willing application to their many tasks, and sincerity in the promotion of the Society's public relations program.

Respectfully submitted,

Ex officio

GILSON COLBY ENGEL
E. ROGER SAMUEL
FRANK A. LORENZO
JAMES L. WHITEHILL
WALTER F. DONALDSON
M. LOUISE C. GLOECKNER

ALLEN W. COWLEY
ARCHIBALD LAIRD
J. HART TOLAND
LEO H. CRIEP
JAMES M. MAYHEW
FREDERIC B. DAVIES
J. VAN S. DONALDSON
SAMUEL B. HADDEN

HOWARD K. PETRY, *Chairman*

◆
COMMITTEE ON ARCHIVES

To the President and House of Delegates:

The committee, as usual, is glad to acknowledge contributions, submitted for its files, of all written items dealing with records and functions of the Society and its component societies.

We herewith acknowledge receipt, since our report to the 1948 House of Delegates, of the following:

A list of physicians who have practiced medicine in Monroe County since 1802, received from Dr. Charles S. Flagler, and originally compiled by Dr. Joseph H. Shull, who was born in 1848 and died in 1944.

A copy of a History of Chester County Medical Society.

The story of the Centennial Celebration of Lycoming County Medical Society.

A bound copy of the History of Bucks County Medical Society.

Bulletin of Tioga County Medical Society, Volume III.

The Memorial Gavel presented to our state society at its Centennial Celebration in Philadelphia, October, 1948, by the Georgia State Medical Association (story on page 147 of November, 1948 PENNSYLVANIA MEDICAL JOURNAL).

During the year the transactions of the Society for a number of years were handsomely bound; and the charter of our society, issued seventy-five years ago, which has been preserved in a metal cylinder and is beginning to crease, was framed under glass and will be kept in the fireproof vault in a special box.

The files of the Committee on Archives have proved to be a helpful source of material for the History of Medicine in Pennsylvania which will be issued in a few months, and the histories of fifty of the sixty component societies in the vault have been culled for fact and function.

The committee is very appreciative of the fine cooperation received from the librarian Mrs. Virginia Garvin.

Respectfully submitted,

ELWOOD T. QUINN
CLARENCE R. PHILLIPS
WALTER F. DONALDSON, *Chairman*

◆
COMMITTEE ON MEDICAL BENEVOLENCE

To the President and House of Delegates:

During the past twelve months the Medical Benevolence Committee has given financial assistance to 29

direct beneficiaries, of whom eight were widows of former members, with small children; ten were widows without dependents; nine were ill or aged physician members; and two the daughters of deceased members. During the twelve-month period nine new beneficiaries were approved by the committee for assistance from the fund, two of them for temporary assistance only; two were approved for increased benefits; one beneficiary was discontinued; one died.

The Medical Benevolence Committee again wishes to pay tribute to the members of the state and county woman's auxiliaries for their ever-increasing efforts in behalf of the benevolence fund, as manifested by their annual contributions which have been steadily increasing throughout the years and are climaxed this year by a total of more than nine thousand dollars. For many years the benefits from the fund available to any one of our beneficiaries may have seemed small, but we are happy to say that it has been possible to increase these amounts, due solely to the generosity and interest of the woman's auxiliaries.

Attention is also called to the growing number of small but appreciated "in memoriam" gifts to the benevolence fund. Only two contributions were received from members of the State Society.

Contributions from the woman's auxiliaries during this fiscal year totaled the handsome sum of \$9,140.33, and included memorials from individuals and from county auxiliaries to the late Mrs. Jefferson H. Wilson, Beaver County; Mrs. Lydia Recher, Berks County; Mrs. Ralph Worrall, Bucks County; Mrs. F. A. Fetherolf, Lehigh; Mrs. L. R. Hazlett and Mrs. Mildred Reese, Luzerne; to the late Drs. Homer J. Rhode, Berks County; J. C. Lee, Indiana; Charles Long, Luzerne; Harry F. Leibert, Northampton; William Burrill Odenatt and C. J. Swalm, Philadelphia; and to the infant son of Dr. and Mrs. Frank McNutt, Ford City.

A detailed report of contributions to the Benevolence Fund will be found in the financial report of the State Society's secretary-treasurer to be published in the September issue of the JOURNAL.

The report of the treasurer of the Medical Benevolence Committee follows:

Balance on hand Sept. 1, 1948 \$21,315.77

RECEIPTS

Contributions from woman's auxiliaries	\$9,140.33
Contributions—miscellaneous	60.00
Interest on deposits and investments	4,950.56
	14,150.89
	\$35,466.66
Disbursements to beneficiaries	14,010.00

Balance on hand Sept. 1, 1949 \$21,456.66

Respectfully submitted,

LAURRIE D. SARGENT
FRANCIS J. CONAHAN, *Treasurer*
WALTER F. DONALDSON, *Secretary*
E. ROGER SAMUEL, *Chairman*

◆
COMMITTEE ON EDUCATIONAL FUND

To the President and House of Delegates:

This is a preliminary report from the Educational Fund Committee authorized by the 1948 House of Del-

legates with the adoption of the new constitution and by-laws and later appointed by the Board of Trustees.

Immediately following the last meeting of the House of Delegates, at the reorganization meeting of the Board of Trustees, the Secretary-Treasurer was authorized to set aside \$2.00 from each member's dues to inaugurate this endeavor and as of Aug. 1, 1949, this new special fund has credited to its account \$21,183.86.

The committee as appointed met first on March 4 and began structural formation of rules and regulations in regard to administration of this fund, which are submitted at this writing. A supplemental report will be presented during the coming session of the House of Delegates. The following rules were discussed and are submitted by the committee:

1. Applications will be received beginning January 1, 1950.
2. Such applications shall apply only to the beginning of the school year in September, 1950.
3. All applications to be reviewed by the Educational Committee must come through the secretary of the component medical society of the county in which the applicant resides. The secretary with one other member of that society will sponsor the applicant.
4. All applications must be submitted on a form supplied by the Secretary-Treasurer of The Medical Society of the State of Pennsylvania and when returned to the secretary of the committee must contain the grades of the applicant and the endorsement of the principal of the school last attended by the applicant and of the college entrance board if available.
5. The committee may advance to the credit of the approved applicant a maximum of (not yet determined but approximately \$700) per school year, payable to the school, or in part to the applicant, at the discretion of the committee. Such advance for each succeeding year must be recommended by the committee after examination of grades and the advice of the dean of the school concerned as to the student's fitness to continue. No advance of funds shall cover more than one year.
6. In order that the fund may continue adequate to meet the needs of an increasing number of demands on it, each applicant must agree to begin to repay, without interest, as much of the money advanced as possible, beginning not later than three years after being gainfully employed subsequent to the time of graduation or separation from school.
7. Until experience justifies a change of policy, not more than one-third of the money available July 1, 1950, and succeeding years, shall be allotted to approved applicants entering the freshman class in college, the balance to be allotted for the assistance of those approved for promotion to or original entrance to more advanced classes in college.
8. The Educational Fund Committee "may solicit donations, legacies, and repayments to be added to the Educational Fund" and will supply to such contributors periodic reports covering the finances of the committee.
9. The committee shall have power to employ and expend monies needed to underwrite the administrative expense. The by-laws provide that these "shall be met from the Society's general checking account."
10. Each applicant must provide proof of acceptance as a candidate for a degree from the school to which the advance shall be given.

11. Only under extenuating circumstances may this fund be used in any way to continue any candidate's education in high school and then only for the amount of money determined by the committee as necessary.

12. Each advance for educational training shall be predicated on the assumption that it will eventually be returned without interest to the "Educational Fund of The Medical Society of the State of Pennsylvania."

With this preliminary report the committee solicits confidence and pledges that all plans will be in readiness by January 1, 1950.

Respectfully submitted,

ELMER HESS
LOUISE C. GLOECKNER
WALTER F. DONALDSON, *Secretary*
JAMES L. WHITEHILL, *Chairman*

COMMITTEE ON NECROLOGY

To the President and House of Delegates:

It is the sad duty of your Committee on Necrology to report the death of one hundred and sixty-one members.

We are not unmindful of our dependence on the Supreme Architect of the Universe and our prayer to Him is, "If we forget Thee, do not Thou forget us or our bereaved friends."

The names of our deceased members are published monthly in THE PENNSYLVANIA MEDICAL JOURNAL and also in the annual roster of the Society. Therefore, none are being mentioned specifically by name in this report. A study of the age at death of these members may be found of interest.

Four were between 30 and 40 years of age; nineteen between 40 and 50; twenty-five between 50 and 60; thirty-six between 60 and 70; fifty-six between 70 and 80; twenty between 80 and 90; and one was 91 years of age.

Respectfully submitted,

WALTER F. DONALDSON FRANCIS S. MAINZER
HERMAN A. GAILEY HUGH R. ROBERTSON
M. FRASER PERCIVAL, *Chairman*

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

To the President and House of Delegates:

The present year has seen an increased emphasis and focusing of the activity of The Medical Society of the State of Pennsylvania on the field of education and public relations. Recognizing the fact that the Woman's Auxiliary was in a position to render outstanding service in this field, President Engel deemed it wise to encourage this development by nominating the chairman of the Public Relations Committee of The Medical Society of the State of Pennsylvania to the position of chairman of the Advisory Committee to the Woman's Auxiliary.

The Woman's Auxiliary has rendered a tremendous service to our society during the past year. Under the dynamic leadership of its president, Mrs. Paul C. Craig, it has gone zealously to work and has achieved notable success. The attractive pamphlet "Your Family's Future Health," devised and distributed by the Auxiliary,

has attained national notice and approval. County auxiliaries have been organized for action on the basis recommended by the National Education Campaign Committee, and in many counties are working shoulder to shoulder with the county medical society. Mrs. Drury Hinton, president-elect of the auxiliary, has gone ahead organizing new auxiliaries in counties where none had existed before, until now there are but two counties in which the doctors' wives are not enlisted in an organized effort to meet the challenge of socialized medicine propaganda.

The program of the Auxiliary has become a dynamic aggressive approach to the problems of public health, with decreasing emphasis on merely social activities.

While your committee has had but one meeting during the year, its individual members have been in frequent conference with the officers of the State Auxiliary. There has been a constant spirit of enthusiasm and co-operative helpfulness and a commendable desire to do a real job.

Your committee desires to take this opportunity to thank the Woman's Auxiliary to The Medical Society of the State of Pennsylvania for a job not only well done but superbly done. We trust that every county society and every county society advisory committee will recognize the great potentialities for help in legislative, educational, and public relations programs existing in the Woman's Auxiliary and will guide, encourage, and cooperate with our leadership in their efforts.

Respectfully submitted,

LOUIS W. JONES*

ADOLPHUS KOENIG

HOWARD K. PETRY, *Chairman*

COMMITTEE ON HOSPITAL RELATIONS

To the President and House of Delegates:

The committee held an organizational meeting on July 14, 1949, at the headquarters building in Harrisburg. Those present were: Drs. Elmer Hess (chairman), William Bates, William F. Brennan, Charles L. Johnston, Thomas W. McCreary, and Pauline K. Wenner.

The following recommendations were made to the Board of Trustees:

1. That the Board of Trustees of The Medical Society of the State of Pennsylvania set in motion the machinery necessary to establish within each county medical society a standing Committee on Hospital Relations, with the following recommended membership: the chairman of the Board of Censors; the chairman of the Grievance Committee, if there is such a committee; and three other members of the county medical society and the legal counsel of the county medical society, as an advisor, if available.

This committee shall hear all controversies between physicians and lay organizations, such as hospitals and clinics, concerning business relationships between the two. The efforts to settle such controversies should be attempted through the good offices of this committee.

2. That, where a controversy cannot be settled amicably at the county level, the portfolio shall then be transmitted to the Board of Trustees of The Medical Society of the State of Pennsylvania for appropriate action. If the Board of Trustees is unable to take definitive action, it may then refer the portfolio to the standing Committee on Hospital Relations, with an explanation of its action and as to why it was necessary to

refer the controversy to this committee, along with the legal opinion as expressed to the Board of Trustees by its legal counsel.

3. That the Committee on Hospital Relations be privileged, upon receipt of the portfolio, to call a hearing at which witnesses for both sides shall be heard.

4. That when hearings are held, all necessary expenses for the functioning of this committee shall be defrayed by The Medical Society of the State of Pennsylvania.

5. That hearings shall be held whenever possible in the headquarters building of The Medical Society of the State of Pennsylvania, Harrisburg, Pa.

6. That the work of this committee shall be under the department of the staff secretary, as now represented by Mr. Robert L. Richards.

7. That, upon completion of the hearing, the portfolio, the opinions of the committee and its recommendations, plus a poll of the vote, be returned to the Board of Trustees of The Medical Society of the State of Pennsylvania for its disposition of the case.

8. That a request be sent to the Legal Department of the American Medical Association that a copy of the laws of the various states on the subject of the corporate practice of medicine be sent to every licensed hospital in the State of Pennsylvania for its information.

Respectfully submitted,

LOUIS E. AUDET

WILLIAM BATES

WILLIAM F. BRENNAN

CHARLES L. JOHNSTON

THOMAS W. MCCREARY

PAULINE K. WENNER

ELMER HESS, *Chairman*

COMMITTEE ON MILITARY AFFAIRS

To the President and House of Delegates:

Our committee has had no function to perform during the year and consequently has no report of activities to submit. We believe, however, that a committee on military affairs of a state medical society should have an *assigned function*, provided that it be the same function in every state medical society, and provided further that this function be integrated at the top with that of such a committee of the American Medical Association, and in each state with the function of a committee on military affairs in each county medical society.

A major function that such an organization of committees could perform is the preparation and annual revision of a list of county medical society members from the standpoint of their probable availability or non-availability for service in case of war or major disaster. Those in the same county could best gather and keep up to date such information about physicians as their age; professional skills, training and certification; teaching and institutional connections and consequent status of availability; linguistic ability; previous foreign sojourn; marital and familial status; obvious physical incapacity; present affiliation with and experience in a military establishment; etc.

The experiences during the recent war are so vivid in the memory of the majority of physicians that no brief is necessary to convince them of the need for such accurate information in making the best and most efficient use of medical personnel in time of emergency.

Respectfully submitted,

CONSTANTINE P. FALLER

GERALD N. FLUEGEL

JAMES M. HENNINGER

EDWARD LYON, JR.

RICHARD A. KERN, *Chairman*

* Resigned May 19, 1949.

COMMITTEE ON PSYCHIATRIC SERVICES TO CRIMINAL COURTS

To the President and House of Delegates:

In the past year your Committee on Psychiatric Services to Criminal Courts actively collaborated with the Joint Medical Legal Committee of the Pennsylvania Bar Association and with others in the preparation of legislative proposals dealing with criminal offenders. Two such bills were considered by the Assembly. Senate Bill 74 introduced by Senator Ruth authorized county commissions, singly or in combination of two or more counties, to create psychiatric clinics for our Common Pleas Courts. The bill passed the Senate, but was killed in the Judiciary Committee of the House. A second bill, House Bill 1289, was introduced by Representatives Bloom and Robertson and provided for the commitment of persons alleged and determined to be psychopathic offenders. This bill was intended as a legislative remedy for the courts in dealing especially with sexual offenders. The bill was referred to the Joint State Government Commission for further consideration and future recommendation to the 1951 Assembly.

The committee is pleased to submit charts representing a survey of existing psychiatric court facilities and of enacted and proposed legislation dealing with so-called psychopathic sex offenders. (Some of these comparisons may be found on page 1280 of this issue of the JOURNAL.)

Our committee is indebted to Ralph C. Busser, Jr., Esquire, chairman of the Joint Medical Legal Committee of the Pennsylvania Bar Association, for his valuable assistance and cooperation, to Manfred S. Guttmacher, M.D., of Baltimore, for the chart of psychiatric court facilities, and to Erwin W. Roemer, Esquire, president of the Chicago Bar Association, for the preparation of the survey of legislation proposed and enacted concerning sex offenders.

The committee petitions for continuance.

Respectfully submitted,

FREDERICK H. ALLEN	ROBERT H. ISRAEL
FREDERICK S. BALDI	RODNEY KIEFER
HERBERT H. HERSKOVITZ	LEROY M. A. MAEDER
PHILIP Q. ROCHE, <i>Chairman</i>	

COMMITTEE ON TELEPHONE DIRECTORY CLASSIFICATIONS

To the President and House of Delegates:

This year your committee has experienced more than the usual number of requests for aid in purging the names of cultists from the telephone listings of bona fide doctors of medicine. It would seem that as the cultists increase in number the more they would like to enjoy the prestige of aligning themselves with members of our profession. The membership is urged to communicate at once with our committee when questionable listings are noted.

The cooperation of The Bell Telephone Company of Pennsylvania is gratefully acknowledged.

Respectfully submitted,

ERNEST W. LOGAN	RICHARD J. CAMPION
T. LAMAR WILLIAMS, <i>Chairman</i>	

COMMITTEE ON RURAL MEDICAL SERVICE

To the President and House of Delegates:

The Committee on Rural Medical Service has held no meetings this year.

On request of the A.M.A. Committee on Rural Medical Service, the State Society committee is endeavoring to organize a general health council. The main purpose of such a council is to develop suggestions concerning ways and means of improving sanitary and health conditions throughout the State.

Thirty-eight state-wide organizations have submitted names of representatives, and an organization meeting will be held September 20.

Dr. Milton F. Manning, of Beallsville, a member of the State Society Committee on Rural Medical Service, represented the committee at the National Conference on Rural Health in Chicago, February 4 and 5.

Continuation of this committee is requested.

Respectfully submitted,

MILTON F. MANNING	LUTHER Q. MYERS
ORLO G. MCCOY	MORGAN D. PERSON
C. L. PALMER, <i>Chairman</i>	

COMMITTEE ON WORKMEN'S COMPENSATION LAWS

To the President and House of Delegates:

The State Legislature, which convened in regular session during 1949, had under consideration numerous bills proposing amendments to the Workmen's Compensation and Occupational Disease Laws. Both of these laws contain identical provisions for medical and hospital care under clause 306 (f). Your committee prepared an amendment to this portion of the laws which provided for unlimited medical and hospital care at the prevailing charge in the community for like services to other individuals. The chairmen of the respective committees of the Legislature and other proper authorities were acquainted with our proposals.

The 1939 session of the Legislature amended the then existing laws which provided for medical and hospital care for a period of sixty days by adding an additional thirty-day period of treatment "on petition of the claimant." The cost of medical services, then limited to \$150, was increased by \$75 for the additional thirty days. The cost of hospital services has been based on the prevailing charge in the hospital. The amendment enacted by the Legislature of 1949 has granted a straight ninety-day period of medical and hospital treatment; the maximum allowance for medical care is now \$225; for hospital care it remains as "the prevailing charge." Thus beginning July 1, 1949, the Workmen's Compensation and Occupational Disease Laws authorize the employer to furnish medical and surgical services, medicines and supplies "during the first ninety days after disability," at a cost not to exceed two hundred and twenty-five dollars.

The changes of import in the amended laws all pertain to liberalization of cash indemnity benefits for loss of time by the injured workman or for resulting disability or death. These increases approximate a 25 per cent "across the board" liberalization. Beryllium poisoning has been added to the list of compensable occupational diseases.

Thus Pennsylvania remains, insofar as medical and hospital care of its industrial injured is concerned, one

of the backward states in the nation. About half of the states provide for unlimited medical and hospital care under their workmen's compensation acts. This list includes all the states with which the industrial state of Pennsylvania competes. Amendments to the Workmen's Compensation and Occupational Disease Laws which propose liberalization of medical and hospital care have been supported by labor; they have been opposed by the lobby representing industry. Political maneuvering ensues, a compromise bill results, and this is enacted. The labor leaders, pointing to liberalization of cash indemnity, then say, "we put in a thumb and pulled out a plum"; the industrial lobbyists say, "that will cost a lot of money, but we have avoided an increase in medical and hospital costs." Excepting some individual leaders of industry whose progressive attitudes stamp them as humanitarians, the rank and file of Pennsylvania's employers remain content with a scrap heap for mutilated human derelicts.

An interesting and significant trend is observed in the field of physical and vocational rehabilitation of these relicts of industrial accidents. Welfare funds of the United Mine Workers are being used to study and control anthracosis; a constructive approach has been made to improve the physical condition of miners paralyzed by traumatic lesions of the spinal cord; vocational rehabilitation is being provided for amputees. Leaders of other labor unions have had their thoughts directed into similar humane channels and are thinking along constructive lines. One of these gentlemen recently presented considerate reasons why the union was better qualified to administer these functions than was industry, the state, the insurance carrier, or Federal governmental agency. The welfare funds which labor is demanding from employers in current wage negotiations will, if and when granted, be spent in part to provide physical and vocational rehabilitation for the industrially crippled.

Provision should be made for some standing committee of this Society to act as its representative in negotiation with representatives of labor if and when such programs are initiated.

Respectfully submitted,

EARL F. HENDERSON
LOYAL A. SHOUDY

SCOTT A. NORRIS
JOHN C. HOWELL

GEORGE L. LAVERTY, *Chairman*

REPORTS OF COMMISSIONS AND SPECIAL COMMITTEES

COMMISSION ON ACUTE APPENDICITIS MORTALITY

To the President and House of Delegates:

The 1947 survey to be reported this fall is the third of the series of fifth-year surveys planned by the commission at the time of its appointment to furnish, first, data for the educational campaign to inform the public of the dangers of delay and administration of laxatives, and second, to call the attention of the profession to some gross omissions as well as errors of commission in managing patients suffering with perforated appendices, especially those suffering with spreading peritonitis.

Our field worker, Mrs. Elizabeth W. McIlvain, is a graduate nurse of long experience, which fact has made possible accurate abstracting of the clinical records. The same group of 189 hospitals contacted in the 1937 and 1942 surveys again cooperated with our field worker by having their appendicitis peritonitis charts available

on a prearranged date. The abstracted cards have been studied by the same personnel who worked out the statistical material and prepared the report for the two previous surveys. It was necessary to allow over two years to complete the 1937 and 1942 surveys. The 1947 survey will be in the hands of the printers perhaps two months under two years. The reason this amount of time is required is that all case records are not on file in the record room until the third and in some cases the fourth month of the year following the patient's sojourn in the hospital. It requires these three months, however, to complete request correspondence with the hospitals and the itinerary arrangements for the field worker. As the number of cases of appendicitis peritonitis is reduced, it follows that the time required for the field worker to complete the survey and for the commission staff to analyze the abstracted cards and write the report will also be reduced. However, borderline or questionable cases are abstracted by the field worker and discarded after study by the staff, if found to be other than appendicitis peritonitis cases.

We do not have a final count at this time for 1947, but we are hoping that there has been a reduction in the number of cases since the 1942 survey. Statistics for 1937 and 1942 were as follows:

	1937			1942		
	Number of Cases	Deaths	Mortality Per Cent	Number of Cases	Deaths	Mortality Per Cent
Spreading Peritonitis ..	2342	608	25.96	566	233	41.17
Local Peritonitis ..	1080	13	1.2	1577	12	.76

The staff felt that overenthusiasm for the sulfa drugs, with an accompanying overdosage, was responsible for the high mortality of spreading peritonitis in 1942. While the number of surgeons who used sulfonamides is less than in 1937, they are still used and to great excess in the peritoneal cavity and in the wounds of patients who have been operated upon for perforated appendices. The proper place for this statement may not be in this report, but if only one surgeon who has acquired the habit of placing this poison in the peritoneal cavity of the young, middle-age, or old would read this and heed the warning, it would be worth while. It cannot be too emphatically stated that no drug or compound has been discovered which, when placed in the peritoneal cavity, will kill microbes on the one hand and not produce cell irritation on the other. This is true not only of the sulfa drugs but of penicillin and streptomycin as well. With the sulfa drugs, however, we are dealing with not only a local tissue irritant but one which when placed in the peritoneal cavity often produces changes in other organs which, not infrequently, induce death.

We wish to emphasize again that our gains in this campaign, which started in 1928 in Philadelphia, have always been made by reducing the number of cases of peritonitis, not by reducing the mortality in the peritonitis group.

The continuation of the Commission on Acute Appendicitis Mortality is advised.

Respectfully submitted,

FREDERICK A. BOTHE
RAYMOND J. GARVEY
CHARLES V. HOGAN
HARVEY F. SMITH
JAMES Z. APPEL
ENOCH H. ADAMS

CHARLES L. YOUNGMAN
HUGH R. ROBERTSON
WILLIAM L. BROHM
LEO D. O'DONNELL
JOSEPH P. REPLOGLE
LACHLAN M. CATTANACH

CECIL F. FREED, *Co-chairman*
JOHN O. BOWER, *Chairman*

COMMISSION ON CANCER

To the President and House of Delegates:

Summarizing the work of the commission during the past year, as chairman, I would like to emphasize certain phases which I consider important and helpful in what is being accomplished:

1. The cooperation of our president, Dr. Gilson Colby Engel, and of our secretary, Dr. Walter F. Donaldson, has proved most helpful in the things that we tried to accomplish during the past year.

2. The establishment of the coordinating committee representing the American Cancer Society (Pennsylvania and Philadelphia Divisions), the State Department of Health, and the Commission on Cancer of The Medical Society of the State of Pennsylvania has prevented and corrected a great deal of overlapping and reduplication of effort. This group, now headed by Dr. Ralph D. Bacon, of Erie, a member of this Commission on Cancer, has detailed the various phases of the cancer program. It should not only continue to prove its worth but no doubt will develop a more systematic setup and accomplish even greater results.

3. The various subcommittees of the commission are intensively studying such matters as thorough oncologic instruction in the medical schools of Pennsylvania, education of laymen and professional audiences, the presentation of papers on oncologic subjects combined with research work, and an effort is being made to work out some plan for the care of advanced inoperable cases of malignancy. There is need of additional available funds for the proper execution of these efforts. The Committees on Tumor Clinics and Cancer Detection Centers have brought their work to the forefront by systematizing and setting up certain definite requirements for the establishment of local clinics and centers. These committees are headed respectively by Dr. Russell B. Roth, Erie, and Dr. Catharine Macfarlane, Philadelphia. They have urged the use of special forms for the examination of apparently well people who are fearful of cancer. The forms particularly emphasize thorough and complete examinations and supply a long felt need which has been greatly neglected or entirely overlooked. These forms are being widely used and approximately 3000 have been forwarded throughout the State of Pennsylvania to the various centers. A "summarization record" of each case is sent to Harrisburg for recording and follow-up when necessary.

4. It is urgent that the budget for the coming year be continued the same as the past year. We are hopeful that our expenses will not be as great in the year 1949-50 as in the two previous years. The commission is heartily in favor of sending *The Cancer Bulletin* to each member of the State Medical Society for one year. It is their hope that the postal rates will be such that the Board of Trustees will endorse this feature since the requisite subscriptions have been paid by the Pennsylvania Department of Health. Their value to the general practitioner particularly is bound to be very great and we believe that by such cooperation and the wise expenditure of funds necessary for the mailing of these bulletins, The Medical Society of the State of Pennsylvania will retain its control of all phases of the cancer problem.

5. The Wainwright Tumor Clinic Association, now formally adopted by the Commission on Cancer, held its annual meeting at the new research laboratories of the Lankenau Hospital in Fox Chase, Philadelphia, under the able direction of Dr. Stanley P. Reimann on April 20.

6. To conserve time and space, further details of the commission's work and progress will be omitted. I am happy to state that the Commission on Cancer is now augmented by two ex-officio members from the Pennsylvania State Dental Society, namely, Drs. Leo Shonfield, Pittsburgh, and Lester W. Burket, Philadelphia. They have both taken a most active interest in the work and it is hoped that the state dental profession will continue its representation and helpful counsel. The directors of the Wainwright Tumor Clinic Association are also ex-officio members of this commission and are regular attendants at the meetings. This combined group has been most cooperative and welcomed suggestions from those officers of the State Society who have visited us on various occasions. Drs. Vaux and Bristol from the State Department of Health, as well as Dr. Macfarlane and Mr. Nicodemus from the Philadelphia Division, and Dr. John H. Harris and Mr. Leo Gerber from the Pennsylvania Division of the American Cancer Society have been of great help in the formulation and execution of the work of the Commission on Cancer of The Medical Society of the State of Pennsylvania.

I should like to make certain recommendations as to membership of this group for the coming year and want to thank my colleagues for their kind consideration. As chairman of the Cancer Commission, I appreciated the support that the Board of Trustees has given us and assure them that all the members of this commission are duly appreciative.

Respectfully submitted,

HORACE B. ANDERSON	ZOE ALLISON JOHNSTON
JOHN L. ATLEE, JR.	N. VOLNEY LUDWICK
RALPH D. BACON	EDWARD LYON, JR.
DANIEL H. BEE	CATHARINE MACFARLANE
JOHN V. BLADY	H. FRED MOFFITT
JAMES BLOOM	STANLEY P. REIMANN
S. GORDON CASTIGLIANO	WESLEY D. RICHARDS
LEROY E. CHAPMAN	RUSSELL B. ROTH
PERK LEE DAVIS	LEWIS C. SCHEFFEY
GEORGE W. HAWK	FORD M. SUMMERVILLE
ROBERT C. HORN, JR.	ANDREW J. WATERWORTH
	J. WILLIAM WHITE

MARTIN S. KLECKNER, *Chairman*

COMMISSION ON CHILD HEALTH

To the President and House of Delegates:

Early in October, 1948, State Secretary of Health Norris W. Vaux publicly stated that he would endeavor to carry out any suggestions we would make regarding child health conditions in the Commonwealth. Because there had been a recent increase in diphtheria cases in many areas in the State, we considered methods of meeting this situation. We consulted with Dr. Pascal F. Lucchesi, chairman of the State Society Commission on Public Health and Preventive Medicine, with Dr. Hubley R. Owen, of Philadelphia, and with representatives of the Pittsburgh Department of Health. Finding that a "program for immunization against diphtheria, tetanus, and whooping cough," as approved by the State Health Department in September, 1948, had been endorsed by representatives of the health departments in Philadelphia and Pittsburgh, including the board of education in each city, we decided to add our endorsement and proceeded to recommend to Secretary Vaux that he enclose with each birth certificate being sent to parents living in Pennsylvania a card advising them to see their family doctor about: (1) regular

physical examination during the first year of life; (2) supervision of diet, weight, growth, and development, physical and mental hygiene, etc.; (3) immunization against preventable diseases, especially diphtheria, tetanus, and whooping cough, the method used to be subject to the practice of the family doctor. Such a card already being sent to parents residing in Philadelphia and Pittsburgh.

In November our commission was represented at a session in Harrisburg of the Pennsylvania Dental Society devoted to the prevention of dental caries.

We prepared an article for publication in THE PENNSYLVANIA MEDICAL JOURNAL in an endeavor to overcome the difficulties which confront state institutions in securing resident physicians.

We took action recommending to the members of The Medical Society of the State of Pennsylvania the advisability of routine periodic tuberculin testing at the ages of 3, 6, 9 and 14 years.

We congratulated the chairman of the State Society Committee on Graduate Education, expressing appreciation of the three days of pediatric instruction included in their 1948-49 program, and offered to cooperate in supplying clinical material for use by the instructors throughout the State.

A communication addressed by the committee to Secretary-Treasurer Donaldson was forwarded to the State Board of Medical Education and Licensure requesting an increase of six weeks or longer in the length of time a rotating internship must be devoted to pediatrics. Charles L. Shafer, M.D., chairman of the State Board of Medical Education and Licensure, presented this request to the Board at its December 17 meeting. The Board found it inadvisable at that time to change the pediatric requirement.

Based on the belief that 75 per cent of the children in Pennsylvania are cared for by general practitioners of medicine, we expect to explore this question further and may later make more emphatic recommendations to the State Board of Medical Education and Licensure.

All the members of this commission have been very active and really cooperative and, as chairman, I would therefore like to recommend that the three members (Drs. Gilmartin, Gannon, and Quinn) whose terms expire in 1949 be reappointed for three more years.

I would also like to recommend that Dr. Carl C. Fischer, of Philadelphia, be appointed chairman of this commission, effective September, 1949, when the commission will meet again in Pittsburgh.

Respectfully submitted,

NORBERT D. GANNON	PHILIP S. BARBA
G. BERNARDIN QUINN	WILLIAM W. BRIANT, JR.
ELWOOD W. STITZEL	CARL C. FISCHER
RALPH M. TYSON	ELEANOR R. STEIN

JOSEPH A. GILMARTIN, *Chairman*



COMMISSION ON CONSERVATION OF VISION

To the President and House of Delegates:

The Commission on Conservation of Vision feels that it has had a worth-while year, yet not as strenuous as the previous two years. We now believe that our glaucoma program instituted several years ago has borne fruit. Many inquiries are being received, and medical society programs on the subject of glaucoma are still being presented throughout the State.

The Pennsylvania Academy of Ophthalmology and Otolaryngology has increased in membership, and at its April meeting in Harrisburg the many words of commendation on the committee's endeavors to preserve vision and help those debilitated because of defective eyesight encouraged us to put forth further efforts.

Secretary Walter F. Donaldson, of the State Society, has guided us and been very helpful in the execution of our various endeavors, among which was the card sent to each member of the Society in August, 1948, reading as follows:

THE MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA

Every Doctor of Medicine, regardless of his special field of practice, should be vitally interested in the early recognition of GLAUCOMA because of its insidious and frequently tragic result in total blindness.

Vision lost by glaucoma may not be restored.

Once diagnosed, control can usually be maintained. This requires close cooperation and case management between the family doctor, the patient, and the ophthalmologist. . . .

(Signed)

COMMITTEE ON CONSERVATION OF VISION.

We believe that conservation of the vision of the people of our Commonwealth requires constant vigilance and publicity among the medical profession as well as the laity.

The too often repeated statement that optometrists perform 85 per cent of refractions is no longer correct if our moderate survey of the past year is at all reliable. Careful ophthalmologic examinations by physicians will save many eyes with serious defects if seen early enough.

The testing program comparing the use of penicillin and silver nitrate in the eyes of the newborn being carried out by the large clinics through the cooperation of the Department of Health should be complete in another two years. We should then know which is most efficacious in preventing ophthalmia neonatorum.

Most of the members of our committee attended a meeting on December 16, in Harrisburg, called by the Committee on Public Health Legislation to consider legislative proposals regarding the controversial subject of "rebates" and the dispensing of eyeglasses. The members of the various committees represented agreed that the laity should be given every consideration in the dispensing of glasses.

Another meeting at which ophthalmologic care for indigent school children was carefully and fully discussed was held in Harrisburg. Fees as well as the medical personnel to do this work were recommended and satisfactory progress is being made.

We urge all practicing ophthalmologists and otolaryngologists to attend the meetings of the Pennsylvania Academy of Ophthalmology and Otolaryngology. It is now a potent and efficient body of specialists making great strides in cooperation with members of The Medical Society of the State of Pennsylvania.

Respectfully submitted,

PAUL C. CRAIG	JAY G. LINN
GILBERT L. DAILEY	JOHN B. McMURRAY
GEORGE F. J. KELLY	WARREN C. PHILIPS

JOSEPH F. BUZZARD, *Chairman*

COMMISSION ON DEAFNESS PREVENTION AND AMELIORATION

To the President and House of Delegates:

Through the efforts of three committee members, deafness clinics are established in the cities of Reading, Pittsburgh, and Philadelphia: in Reading, by Dr. James E. Landis; in Pittsburgh, by Dr. Kenneth M. Day; and in Philadelphia, by Dr. Douglas Macfarlan. Another clinic is in the process of being established at the University of Pennsylvania.

The commission is still waiting for the American Academy of Ophthalmology and Otology to cooperate in a state program uniform for the nation.

The Pennsylvania State College is conducting a summer course on deafness and speech defects.

Rehabilitation of the deafened veteran is continuing efficiently. The center for this work is in the Naval Hospital in Philadelphia.

The state-federal rehabilitation program for adults is still in effect, but it has been retarded by the lack of funds.

The State Department of Public Instruction is handling efficiently individual cases of deaf and hard-of-hearing school children.

Respectfully submitted,

SAMUEL T. BUCKMAN	JAMES E. JAMES
EDWARD H. CAMPBELL	CLINTON J. KISTLER
FRANCIS W. DAVISON	JAMES E. LANDIS
KENNETH M. DAY	THOMAS B. MCCOLLOUGH
ROY DECK	JOHN R. SIMPSON

DOUGLAS MACFARLAN, *Chairman*



COMMISSION ON DEFENSE OF MEDICAL RESEARCH

To the President and House of Delegates:

Following the annual session of the State Medical Society in Philadelphia in 1948, and in anticipation of the convening of the State Legislature in January, 1949, the members of your commission gave of their time and in sundry ways continued to interest and inform professional and lay groups, as well as to confer with legislators on the importance of and need for the use of animals in the furtherance of scientific medicine. In this activity the chairman of your commission was frequently in communication with Dr. C. L. Palmer, chairman of the Committee on Public Health Legislation. This proved helpful in coordinating the work of the two groups with reference to legislative procedures.

Since the report made to the president and House of Delegates in 1948, there has been much greater participation by professional and lay groups, including women's societies, clubs, and auxiliaries, and many more legislators and individuals generally have come to the front in support of legislation bearing on the use of animals in advancing the cause of medicine in its varied and manifold applications. Many are coming to see more clearly that not only man but life below man would be benefited by an effective law bearing on animal study and experimentation. It is to be hoped that this spirit will not only continue but be productive in the enactment of a satisfactory law.

As anticipated, an antivivisection bill was introduced in the General Assembly of Pennsylvania, Session of 1949. This was known as Senate Bill 345. Had this bill been enacted into law, it would have prohibited "operations or experiments upon any living dog or cat

for any purpose other than healing or curing such dog or cat." This bill, introduced by Senators Lane and Haluska, was an extreme antivivisection measure and was meant to prohibit the use of dogs and cats secured from whatever source in the promotion of medical science and research. The reader must understand that this bill would not only have prevented the use of cats and dogs from the public pounds but also those from all other sources. In other words, the use of cats and dogs in this State would have been wholly outlawed had Senate Bill 345 been enacted into law.

Fortunately, the bill was opposed and gained little favor, with the result that it died without any advance in the Senate Committee on Public Health and Welfare, to which it had been referred.

A bill bearing on proper animal experimentation under humane regulations, sanitary conditions and supervision, was carefully prepared under the direction of the Commission on Defense of Medical Research, the Committee on Public Health Legislation, both of The Medical Society of the State of Pennsylvania, and the Pennsylvania Society for Advancing Medical Research. Certain features of the bill had been adapted from suggestions by the National Society for Medical Research; however, in order to satisfy local state requirements and meet other local needs, the bill finally emerged in a form differing in certain fundamentals.

The bill was introduced as Senate Bill 278 by Senators Chapman and Stiefel and was written as an act "to establish regulatory measures and licensure for stated institutions and to make available to such institutions for scientific investigation, experiment or instruction, unclaimed and unredeemed dogs and cats impounded in public pounds in any city, county, borough or township within the Commonwealth." Schools or colleges of medicine, dentistry, pharmacy, veterinary medicine, agriculture, medical diagnostic laboratories, pharmaceutical laboratories, hospitals, and other educational or scientific establishments having to do with the investigation of or instruction concerning the structure or functions of living organisms, the causes, prevention, control or cure of diseases or abnormal conditions of human beings or animals . . . were given consideration in this bill.

All users of unredeemed, stray impounded dogs and cats were to be licensed, and the licensing authority was to be the Department of Health of the Commonwealth. Stray impounded dogs and cats according to the bill could be released to a licentiate after ten days. The licensing authority was directed to appoint an advisory committee consisting of two representatives of the licensed institutions, two representatives of the Society for the Prevention of Cruelty to Animals, and two representatives of the general public. The licensing authority was given the right to inspect or investigate in person or by agent or agents any institution to which a license was granted. Disobedience to the law might result in the forfeit of the license.

The foregoing are some of the important provisions of Senate Bill 278. It should again be noted that the bill applied only to the use of stray cats and dogs impounded in public pounds after a period of ten days and no less than five days anywhere even should a local law allow a shorter time. The bill had nothing to do whatsoever with the use of dogs and cats from other sources. The bill was referred to the Committee on Public Health and Welfare on February 14, and was reported as amended on March 8. It passed first reading on March 8 and second reading on March 9. It was then "over in order" for a number of days and on

March 21 was recommitted to the Committee on Public Health and Welfare. Even during the last weeks of the legislative session it was believed that the bill would again be moved to the Senate floor for the final vote, but owing to the crowded program this was not accomplished.

This highly worthy and equitable bill was supported by many people and groups and by newspapers widely. Splendid editorials were written concerning its worth; for example, witness those appearing in the *Philadelphia Inquirer* and the *Sunday Bulletin* of Philadelphia. The bill should have been enacted into law.

Respectfully submitted,

JOHN H. HARRIS CALVIN M. SMYTH, JR.
CAMPBELL MOSES J. PARSONS SCHAEFFER, *Chairman*

EMERGENCY DISASTER MEDICAL SERVICE COMMITTEE

To the President and House of Delegates:

This report covers the activities of the committee from April, 1948 to July, 1949. The committee held its last meeting in Harrisburg on April 18, 1948. At the request of the chairman of the committee, Dr. Irwin M. Pochapin attended the semi-annual meeting of the Council on National Emergency Medical Service of the American Medical Association in Chicago on March 21, 1949. The following is a report of this meeting:

Civil Defense. Dr. Norman C. Kiefer, Medical Services Advisor, Civil Defense Planning, Office of the Secretary of Defense, outlined the essential procedures necessary to organize the nation for self-defense. He called attention to the fact that the proper development of all the components of civil defense requires a period of three to five years in order that the people should be adequately prepared. He stated that there was no organized civil defense in Hiroshima or Nagasaki and no organized civil defense in Germany due to the unwarranted and arrogant attitude exhibited by the German military forces.

The medical health services will have to be organized in detail to cover all the branches of the healing arts as well as the allied branches dealing with sanitation and hygiene. The medical services will have to consider all eventualities following the military use of special weapons.

Dr. Kiefer stated that it is desirable that the governor of each state appoint the state health officer as the head of the state civil defense setup. It is only in this manner that direct authority for the control of all the agencies involved in preparing for and maintaining civil defense can be developed and obtained without conflict and confusion.

The following suggestions were made by Dr. Kiefer as necessary steps to initiate civil defense:

1. Take action to alert the various state health groups.
2. Develop a comprehensive civil defense plan on a state level, but not in too great detail at present.
3. Survey the extent and locations of all available equipment and supplies, such as hospitals as well as structures which can be used for hospitals following and during any emergency.
4. Participate in a nation-wide program for training in medical aspects of new weapons of warfare and the training of every organization for allied service.

Medical Activities of the National Security Resources Board. Dr. James A. Crabtree, medical director of the National Security Resources Board, Washington, D.C., stated that the Board advises the President concerning the economy of the country in regard to the eventuality of war.

The main functions of the Board are (1) to assess the Nation's needs in a future war, (2) to assess the Nation's means in a future war, and (3) to coordinate the Nation's needs and means.

The medical division of the Board consists of five technical and professional men. This division has made considerable progress since its organization less than one year ago.

The medical division has obtained the following essential information: data from the AMA, nursing associations, dental associations, pharmaceutical associations; inventories of health supplies; inventories of health facilities, such as production, distribution, and storage of supplies; inventories of available drugs. Our capacity for manufacturing drugs is excellent, but that for manufacturing surgical instruments and equipment is not so good.

The medical division must also make estimates of proposed needs for various materials in time of war.

Armed Forces Medical Advisory Committee. Dr. Richard L. Meiling, member of the Armed Forces Medical Advisory Committee, Office of Secretary of Defense, stated that this committee is purely advisory and has no other function, but that the joint staff has recommended that an independent Medical Advisory Committee be established.

This committee is charged with the planning of the reorganization and conservation of available medical facilities for the joint armed forces. In February, 1949, this committee was requested by the Secretary of Defense to study the problem of medical and dental procurement for the purpose of initiating economy of medical personnel.

Dr. Meiling stated that, of 4000 letters sent to the younger doctors, 585 replies were received to date, and among these replies 51 men stated that they are willing to serve immediately, while 13 others stated that they would be willing to serve in 1950.

The rest of the morning and afternoon sessions were taken up with a discussion of the Medical Officer Procurement Program. It is impossible to crystallize a report of these discussions, since the problem is very complex and has many ramifications.

Respectfully submitted,

THEODORE P. EBERHARD	EMEROLD M. RALSTON
FREDERIC B. DAVIES	CHARLES WM. SMITH
DONALD W. GRESSLEY	ALLEN J. HANNEN
IRWIN M. POCHAPIN	

EDWARD L. BORTZ, *Honorary Chairman*
THEODORE R. FETTER, *Chairman*

(NOTE: This report was prepared by Dr. Pochapin at the request of Chairman Fetter.)

COMMISSION ON DIABETES

To the President and House of Delegates:

Our commission desires to report a fairly active year. We believe that much has been accomplished, but there is still considerable to do. Every effort has been made to bring the subject of diabetes before the general practitioner and in this we have achieved considerable success.

Three meetings were held during the year: in Phil-

adelphia on October 5, in Pittsburgh on January 5, and in Philadelphia on April 21.

The commission again sought to have at least one program in each county medical society devoted to some phase of diabetes, and agreed to furnish speakers to address the various societies on request. To date we have received requests to supply speakers for the following county medical societies, most of which have been filled: Beaver, Columbia, Fayette, Greene, Jefferson, Lancaster, Lawrence, Luzerne, Northampton, and York. Each county medical society program committee was contacted. We feel that this is an important contribution to the advancement of the understanding and treatment of diabetes.

The commission again requested an opportunity to participate in programs at the 1949 convention of The Medical Society of the State of Pennsylvania in Pittsburgh. The following has been arranged:

Dr. J. West Mitchell will open the discussion on the paper of Dr. Arthur R. Colwell of Chicago, who will present a paper on "Insulins." Dr. W. Wallace Dyer will present a paper on "Childhood Diabetes," and Dr. Thaddeus S. Danowski will open the discussion on his paper.

Through the generous cooperation of your Board of Trustees, the Diabetes Commission will again have a scientific exhibit at Pittsburgh. The various laboratory procedures for the diagnosis and treatment of diabetes will be shown and the blood sugar technique will be demonstrated; any doctor or other person attending the convention will have an opportunity to have his blood sugar estimated. Our painting, "Diabetes—Then and Now," will be on exhibition again, and a legend will accompany the picture.

A subcommittee has been appointed to prepare short articles at the request of the editor of THE PENNSYLVANIA MEDICAL JOURNAL.

The drive for the detection of unknown diabetics will be opened Oct. 19, 1949. Our commission will officially request the Public Relations Committee of The Medical Society of the State of Pennsylvania to publicize this drive through the newspapers and radio, and county medical society bulletins and THE PENNSYLVANIA MEDICAL JOURNAL will also be requested to cooperate.

A subcommittee has been appointed to work out a plan for handling future requests for speakers from the county medical societies.

It was decided that the next meeting of the Diabetes Commission will be held in Pittsburgh during the 1949 State Medical Society convention.

The commission thanks the Board of Trustees for its support and liberality in allotting funds to carry on its work.

This year the commission again extends thanks to Secretary-Treasurer Walter F. Donaldson for his helpful suggestions and advice and for cheerful cooperation.

Also, the commission deeply appreciates the very helpful secretarial assistance given by Mr. Robert L. Richards.

Respectfully submitted,

LOUIS E. AUDET
JOSEPH H. BARACH
JOSEPH T. BEARDWOOD, JR.
EDWARD L. BORTZ
W. WALLACE DYER
C. C. CAMPMAN
THADDEUS S. DANOWSKI
EARL A. DAUGHERTY
L. DALE JOHNSON

ANGELO L. LUCHI
FRANCIS D. LUKENS
J. WEST MITCHELL
CAMPBELL MOSES
PAUL F. POLENTZ
CHARLES R. REINERS
REDDING H. RUFE
JAMES A. SHELLY
HARRY S. THOMAS

GEORGE F. STONEY, *Chairman*

COMMISSION ON GRADUATE EDUCATION

To the President and House of Delegates:

The Commission on Graduate Education, in cooperation with the medical schools and hospitals of the State, has completed the second annual program of the Graduate Education Institute. Ten lecture days of eight hours each were arranged in ten centers throughout the State in the period between September 21 and May 5. The subjects presented and the number of hours devoted to each subject were as follows:

<i>Subject</i>	<i>Total Hours</i>
Abnormal Obstetrics	8
Cardiovascular and Gastro-intestinal Diseases	8
General Medicine	8
Geriatrics	8
Office Gynecology	8
Pediatrics	24
Respiratory Diseases	8
Surgery in Office Practice	8

The final number of registrations for the 1948-49 program totaled 1085. Of this number, 234 used the G.I. Bill of Rights to pay for their \$25 fee. Ten associate members, who are not required to pay a registration fee, were enrolled in the course. Final registration figures for the ten centers were: Allentown 162, Clearfield 49, Erie 62, Harrisburg 189, Johnstown 94, Lancaster 145, Oil City 55, Washington 86, Wilkes-Barre 118, and Williamsport 125.

The 217 faculty members, secured from the medical schools and hospitals in the State, were paid a \$50 honorarium for each lecture day, in addition to receiving reimbursement for their travel expenses. Their lectures, from the standpoint of time, totaled 800 hours.

During the sessions given in the fall of 1948, questionnaires were distributed to the registrants in all of the centers. The commission encouraged constructive criticism and requested suggestions for subject material for future programs. According to the statistical results, the 1948-49 program was satisfactory to 99 per cent of those answering the questionnaire. The subject material for the 1949-50 program was chosen from the suggestions received and a brochure is presently being prepared to be distributed to the membership on or about August 1, 1949.

At the request of the Berks County Medical Society, an eleventh center will be added in Reading for the 1949-50 program. The commission has also made arrangements to alternate the Wilkes-Barre center with one to be established in Scranton every other year. This has been approved by both sponsoring county medical societies.

The commission expects to present a suitable certificate of attendance to all registrants who attend 70 per cent of the lectures comprising the first three programs. In view of the fact that the third year's program will be completed next spring, the commission recommends that an evening be set aside during the 1950 session of the Society in Philadelphia to appropriately recognize those members who are entitled to these certificates. It is the opinion of the commission that such recognition of postgraduate work will do much to encourage continued attendance at the Graduate Education Institute programs.

The commission has also been responsible for a number of programs which have been presented by county medical societies and has arranged special seminars upon request from county societies. It is the intention of the commission to make available to any county society the best in medical education.

In addition to the regular graduate education program and county society seminars, the commission has prepared a special course in electrocardiography to be given in Harrisburg one day each week for seven weeks during the months of November and December. There will be a registration fee of \$35 for a minimum of 30 and a maximum of 60 registrants. The faculty will be paid the usual \$50 per day honorarium plus expenses, and it is expected that the course will be self-supporting. If successful in Harrisburg, this special type of program will be rotated in other centers throughout the State during the coming year.

Respectfully submitted,

WILLIAM BATES

CHARLES L. BROWN

ROBIN C. BUECKI

ROSS K. CHILDERHOSE

SAMUEL P. HARBISON

WILLIAM S. McELROY

WARREN C. PHILLIPS

CHARLES WM. SMITH, *Chairman*

COMMISSION ON INDUSTRIAL HEALTH AND HYGIENE

To the President and House of Delegates:

It had been expected, as reported to the House of Delegates on June 30, 1948, that this commission would be responsible for promoting one-day conferences on industrial health in certain areas of the State. At that time it appeared that conferences in Erie, Harrisburg, and Wilkes-Barre were probable. The only one of these areas in which any interest was shown by the local organizations was at Erie, and there the plans fell through completely because of inability to arrange for a conference with a sufficiently well-informed lay speaker. This commission therefore regretfully abandoned the idea of promoting these conferences throughout the State until such time as further groundwork may point up their value to the local industries and the county medical societies.

Following the failure of this part of our program, a meeting of the commission was called in Harrisburg on Feb. 4, 1949, to explore that part of the industrial medical field in this state which the commission could till with profit. It was the sense of this meeting that our endeavors might best be directed toward making available to interested persons, at the level of the local community, methods whereby in-plan medical service might be established. It was further suggested that this could best be accomplished by devising a pamphlet showing step by step the reasons for medical service in industry and the technique of acquiring it. While this report is being submitted, a pamphlet has gone to press which represents the joint effort of the members, co-chairmen, and chairman of this commission. It is entitled "abbreviated Outline of the Industrial Health Program in Pennsylvania for Industrial Health Committees of Component County Medical Societies." It is planned that this pamphlet be made available to the presidents, secretaries, and committees on industrial health of the component county medical societies; to the executive secretaries of the larger Chambers of Commerce in this state; to the Bureau of Industrial Hygiene, Pennsylvania Department of Health; to the Council on Industrial Health of the American Medical Association; and

to the Bureau of Industrial Hygiene, United States Public Health Service, Washington, D.C.

The commission, through its various members, has been represented in the following activities throughout the year:

Co-chairman Daniel C. Braun attended the ninth annual Congress on Industrial Health of the A.M.A. in Chicago on January 18 and 19 and reported on activities there to the commission and to the Board of Trustees of the State Society.

On January 27 an informal dinner meeting between representatives of The Medical Society of the State of Pennsylvania and representatives of the larger trade unions throughout the State was held to explore common fields of interest. This commission was represented at that meeting by Dr. Glenn S. Everts, our Philadelphia member.

On May 15 our State Medical Society arranged a meeting between the area administrators of the U. M. W. Welfare and Retirement Fund and certain representatives of the State Society. At this meeting our commission was represented by Dr. Braun, the western area co-chairman.

In addition to the above-named activities representing the commission, the individual members have been active in various associated endeavors.

On October 29 Chairman Long addressed a meeting of the Philadelphia Friends of the Deaf as part of Philadelphia Hearing Week on the subject of "The Importance of Hearing in Industry."

In February Co-chairman Braun placed before the Allegheny County Medical Society's Committee on Industrial Health and Hygiene a program for fostering health in Allegheny County industries similar to that shown in the Commission's pamphlet.

On April 7 Co-chairman Harley addressed a Cincinnati Conference on Industrial Health on the subject of "Industrial Health in Williamsport." Earlier in the year Williamsport had been the scene of a meeting for industrialists and physicians regarding "Alcoholism in Industry," addressed by Dr. Robert V. Seliger of Johns Hopkins University, Dr. John L. Norris of the Eastman Kodak Company, and by the leader of the local Alcoholics Anonymous group. An attendance of 250 interested persons was reported.

As a result of our meeting on February 4, the future activities of this commission were laid down as follows:

1. Members of the commission should become more active in their own localities, especially meeting with the members of the county medical societies to interest them in industrial health and inform them of its features and importance. It was suggested that as a particular aim Dr. West should organize Altoona as a hub in industrial health activity for that area of the State.

2. The aims of the commission in furthering conferences on industrial health and adequate courses in industrial health in the medical schools of the State and in the new University of Pittsburgh School of Public Health will continue to be pushed unabated.

Respectfully submitted,

GLENN S. EVERTS

FRED J. KELLAM

JACK C. REED

WILLIAM B. WEST

ANDREW J. GRIEST

T. LYLE HAZLETT

DONALD J. McCORMICK

JAMES D. STARK

HERMAN A. FISCHER, JR.

EARL F. HENDERSON

DAVID N. INGRAM

CHARLES A. LEHMAN

DANIEL C. BRAUN, *Co-chairman*

JOHN P. HARLEY, *Co-chairman*

CHARLES-FRANCIS LONG, *Chairman*

COMMISSION ON MATERNAL WELFARE

To the President and House of Delegates:

The commission herewith submits its report for the year 1948. At a meeting held during the annual State Society convention in Philadelphia, it was decided that a more concentrated effort should be made in the study of maternal deaths in Pennsylvania occurring from the following causes: those from obstetric hemorrhages, excluding ectopics and abortions, and those in which cesarean section played a part. For this special purpose new short forms were prepared dealing with the above-named factors and these were forwarded with a personal letter from the chairman of the commission to the signatory on such maternal death certificates. A return envelope was enclosed to encourage a better response.

Obstetric hemorrhages have maintained a relatively constant level of incidence as the cause of maternal deaths despite the ever improving availability of blood and plasma for transfusions as well as the more recent use of oxytocics. Cesarean section has been noted as a factor in many maternal deaths, either as a contributing or as the prime factor. Sixty-five obstetric deaths from hemorrhage or cesarean section were reported on the new short study forms during 1948. The response to the new form and the personal letter was an improvement over previous years.

In 1947, 20 per cent of maternal deaths were due to obstetric hemorrhages, and in 13 per cent of all maternal deaths cesarean section was part of the picture. It was these tragic figures that led the commission to study such deaths in greater detail.

The causes of the 24 cesarean section deaths in 1948 as gathered from the answered inquiries follow: three anesthetic deaths, one due to aspiration of vomitus and two attributed to cyclopropane; one postoperative death was from diabetic acidosis; only one death purely due to peritonitis was reported, although there were five from emboli and one from paralytic ileus; two were from operative shock; two from postoperative hemorrhage; four from so-called cardiac failure; three from renal failure in toxemic patients; and two from postoperative cerebral hemorrhage, one of these being from a ruptured congenital aneurysm found at autopsy.

Of the 24 cesarean section deaths studied, 16 (66.6 per cent) of the patients were operated upon by general surgeons, who performed 14 purely classical sections, one classical section plus hysterectomy, and only one low cervical cesarean section. Five sections were planned and eleven were emergency sections. The indications for operation and cause of death (in parentheses) for these sixteen are listed as follows: prolonged labor, 3 cases (paralytic ileus); chronic nephritis (cardiac failure); fetal distress (cerebral hemorrhage); sterilization (embolus); placenta praevia (cardiac failure); case with membranes ruptured 66 hours—forceps used and version attempted plus Dührssen's incision (? embolus); disproportion, 4 cases (cyclopropane, embolus, peritonitis, ileus with cardiac failure); eclampsia (embolus); abruptio placentae (renal failure); diabetes (diabetic acidosis); and one for cardiac failure (cardiac failure).

A summary of these 16 cesarean section deaths shows eight for disproportion and/or prolonged labor, one for fetal distress, one for cardiac failure, one for the sole purpose of sterilization, and one glaring last-resort section. These twelve deaths very probably should not have occurred if the type and timing of the sections had been carefully evaluated and adequate antepartum care

given. There is no place for cesarean section for sterilization purposes only, and practically there should be no place for delayed classical sections as an emergency procedure. Eight cases of disproportion and/or prolonged labor terminating in emergency classical section clearly show a lack of proper evaluation of the conditions and the indications for section as well as the contraindications.

Postpartum hemorrhage, a constant threat, still carries with it a high mortality rate. Of the 65 cases studied, postpartum hemorrhage was the cause of death in thirteen (20.3 per cent). These do not include abruptio placentae nor placenta praevia as the hemorrhage factor, but are strictly postpartum hemorrhages.

The salient factors in these 13 deaths from hemorrhage, derived from careful study of each case, justify our emphasizing the fact that such hemorrhages are constantly a threat and that treatment must be promptly instituted with a sufficient quantity of compatible blood. It is interesting to note that in two of these hemorrhage cases the patients were Rh-negative. They were valiantly treated with all the suitable blood that was available. The fatal result probably was due entirely to the blood factor and the fact that an insufficient supply of compatible blood was available for transfusion.

The commission again urges all hospitals throughout the State to rigidly enforce the requirement of early competent consultation in all obstetric difficulties and to continually emphasize adequate antepartum care. Competent intrapartum care combined with alertness after the second stage of labor is also essential. Cesarean section deaths and hemorrhage deaths must be reduced before we will attain a satisfactory level of maternal mortality. Many such deaths are preventable. Deaths for which the profession is responsible must be reduced, and at the same time we must continue to instruct the public on the need for adequate maternal care.

Respectfully submitted,

CLAYTON BEECHAM
JOSEPH H. CARROLL
RAYMEN G. EMERY
JOSEPH J. KOCYAN
LAIRD F. KROH
WALTER J. LARKIN

HARRY E. LYONS
ROY E. NICODEMUS
JOHN B. NUTT
FREDERICK J. PEARSON
HOWARD A. POWER
JAMES S. TAYLOR, *Chairman*



STATE HEALING ARTS ADVISORY COMMITTEE

To the President and House of Delegates:

The State Healing Arts Advisory Committee has held no meetings this year.

The Department of Public Assistance is holding regional meetings throughout the State in order to inform the school medical examiners, school nurses, and superintendents of schools regarding the procedures necessary to correct defects found in school children.

On January 27 there was a meeting of the Committee on Conservation of Vision in Harrisburg. At that meeting there was quite a comprehensive discussion regarding the question of fees for the correction of eye conditions established under Act 522 which provides for the correction of defects discovered by medical and dental examination of school children.

The Committee on Conservation of Vision recommended a fee of \$7.00 for examination and refraction with mydriatic and \$4.00 for refraction and examination

MEDICAL EXPENDITURES BY TYPE OF PRACTITIONERS
January, 1948 to December, 1948
(Total medical expenditures estimated to be \$2,853,000)

Month	Total	Physicians	Clinics	Dentists	Nurses	Pharmacists
1948						
January	\$212,239	\$100,366	\$12,458	\$29,690	\$9,159	\$60,566
February	209,333	100,002	12,867	27,955	9,040	59,469
March	229,203	107,800	11,872	33,908	10,074	65,549
April	236,217	102,033	18,076	37,939	10,327	67,842
May	234,620	105,244	15,941	36,855	9,902	66,678
June	229,684	96,846	15,227	40,789	10,796	66,026
July	230,212	100,588	13,882	39,606	9,555	66,990
August	225,250	97,088	13,545	38,960	9,905	65,843
September	232,698	100,588	14,719	39,173	9,592	68,626
October*	250,000	112,000	15,000	40,000	10,000	73,000
November*	275,000	132,000	16,000	40,000	11,000	76,000
December*	288,000	140,000	16,000	42,000	12,000	78,000

* Partially estimated.

without mydriatic. The remainder of the fee schedule was satisfactory to the committee.

At a meeting on February 3, the Department adopted this fee schedule with one exception; instead of the \$7.00 fee they suggested \$6.00.

It was difficult to explain to the representatives of the Department of Public Assistance the difference between the \$7.00 and the \$4.00 fee, although your representative informed them that with a mydriatic several examinations were required and that there was considerably more responsibility in correcting the refractive error; however, the Department of Public Assistance adopted a fee of \$6.00 with mydriatic and \$4.00 without.

The Department of Public Assistance has distributed a new medical manual, the changes in which are minor and of very little importance. Copies have been sent to the county medical society subadvisory committee chairmen.

Tabulations indicating expenditures and the great number of physicians serving under the medical assist-

ance program which have been received from the Department of Public Assistance are appended to this report.

Respectfully submitted,

C. L. PALMER, *Chairman*

NUMBER OF PHYSICIANS PARTICIPATING IN MEDICAL PROGRAM

January, 1948 to December, 1948

Month	Number	Month	Number
1948			
January	2758	July	2712
February	2744	August	2744
March	2789	September	2753
April	2815	October	2770
May	2820	November	2780
June	2685	December	2780

PER CENT DISTRIBUTION OF MEDICAL EXPENDITURES BY TYPE OF PRACTITIONER

January, 1948 to December, 1948

Month	Total	Physicians	Clinics	Dentists	Nurses	Pharmacists
1948						
January	100.0%	47.3%	5.9%	14.0%	4.3%	28.5%
February	100.0	47.8	6.1	13.4	4.3	28.4
March	100.0	47.0	5.2	14.8	4.4	28.6
April	100.0	43.2	7.6	16.1	4.4	28.7
May	100.0	44.9	6.8	15.7	4.2	28.4
June	100.0	42.2	6.6	17.8	4.7	28.7
July	100.0	43.5	6.0	17.2	4.2	29.1
August	100.0	43.1	6.0	17.3	4.4	29.2
September	100.0	43.2	6.3	16.9	4.1	29.5
October	100.0	44.8	6.0	16.0	4.0	29.2
November	100.0	48.0	5.8	14.6	4.0	27.6
December	100.0	48.6	5.5	14.6	4.2	27.1

COMMISSION ON LABORATORIES

To the President and House of Delegates:

At the suggestion of our commission the State Medical Society printed and circulated widely to those interested in Pennsylvania hospitals—administrators, chiefs of staff, boards of directors, and pathologists—a booklet entitled "The Basic Requirements of a Department of Clinical Pathology in a Modern Hospital." This pamphlet had previously been prepared by the commission with the assistance of a number of Pennsylvania pathologists.

A preliminary report of a survey of the efficiency with which Pennsylvania laboratories carry out bacteriologic diagnoses was made in the last yearly report. Since this report an analysis of the results showed this type of laboratory study to be highly unsatisfactory. This survey emphasizes, as did the previous chemical survey, the imperative need for better laboratory facilities to meet the demands of present-day laboratory practices.

Respectfully submitted,

JAMES F. FORRESTER

HENRY F. HUNT

GEORGE R. LACY

FRANK B. LYNCH

THOMAS W. MCCREARY

WILLIAM P. BELK, *Chairman*



COMMISSION ON MENTAL HYGIENE

To the President and House of Delegates:

The commission held an organization meeting on December 12, at which the following objectives for the year were agreed upon:

1. To urge the Department of Welfare to use all means possible to provide for the prompt admission of urgent mentally ill cases to mental hospitals and to remove insofar as possible the jail as a way station for the admission of mentally ill patients to hospitals.

2. To emphasize to county medical societies the importance of promoting facilities in general hospitals for the temporary care of cases with acute mental disturbances under qualified supervision, and to request that the county societies publicize their local needs in this matter to the end that all general hospitals will be prepared to fulfill their duties to their respective communities.

3. To urge that each county medical society have as one of its standing committees a Committee on Mental Hygiene, whose duty it shall be to increase public interest in the problems of mental hygiene with particular support of the mental hospitals in their districts. It was further agreed that the county societies should disseminate information regarding mental hygiene to the lay public in their communities, and that they should emulate the fine examples set by the Philadelphia and Allegheny County Medical Societies in this regard.

4. To recommend to the Committee on Public Health Legislation of The Medical Society of the State of Pennsylvania that it support legislation tending to provide budgets for the care of the mentally ill, which take into account the increased costs of maintenance and salaries, to the end that care of the mentally ill in Pennsylvania will at least equal that furnished in the pre-war period, and with the eventual aim of conforming to the standards for the care of the mentally ill as recommended by the American Psychiatric Association.

5. To recommend to the Committee on Public Health Legislation that it support legislation which will per-

mit a building program in the institutions for the mentally ill of Pennsylvania at the maximum level consistent with the present administrative facilities, and that this building program continue until the objectives outlined by Governor Martin's Committee on Mental Hospitals are attained.

6. To impress upon the State Board of Medical Education and Licensure the importance of psychiatric training during internship, and to impress upon the superintendents of state mental hospitals that they should qualify their hospitals for approved intern training.

7. To urge that medical staff positions in Pennsylvania state mental hospitals be made more attractive and stable so that a permanent staff of trained psychiatrists will be available in the Pennsylvania state system.

8. To urge that salaries paid by the state mental hospitals be made adequate to permit employees to serve in hospitals and have sufficient funds to maintain themselves in the community.

9. To recommend that any contemplated change in the over-all care of the mentally ill in Pennsylvania be approved only so far as such changes provide for a medical head either of the department having over-all supervision or of the bureau having direct charge of the mentally ill; and to approve in principle a Bureau of Mental Hygiene as a division in the Department of Health.

10. To recommend that legislation be supported which will permit mental health clinics in Pennsylvania to receive their share of federal monies now earmarked for such clinics.

11. To protest the increasing tendency of boards of trustees of certain of the state mental hospitals to insist upon political qualifications for their employees.

12. To recommend that consideration be given to increasing the use of county infirmaries for the care of the aged and infirm, since much of the overcrowding in state mental hospitals is due to the great influx of such patients.

13. To disapprove the licensing of clinical psychologists unless provisions for medical supervision are included in the bill.

14. To reaffirm the recommendations for constructing an Eastern Pennsylvania Psychiatric Institute and Hospital similar in type to the Western Pennsylvania Psychiatric Institute and Hospital.

These objectives were communicated to the Board of Trustees and to the Committee on Public Health Legislation, and during the legislative session the members of the commission were very active in opposing bills which would permit Christian Scientists to operate mental institutions without medical supervision.

We supported a bill for the transfer of the Bureau of Mental Hygiene to a strengthened Health Department, but dropped our support when there was no evidence of strengthening the Department of Health.

Members of the commission attended various legislative hearings and opposed granting osteopaths the permission to certify mentally ill patients.

During the year the members of the commission also met in joint session with members of the Public Charities Association, and a special meeting of the commission was held on February 13, in Harrisburg, at which we opposed the transfer of the Bureau of Mental Health to the Department of Health unless boards of trustees for mental hospitals were retained. This bill was never introduced.

Members of the commission have been prompt to respond to calls for assistance, and we note that many

of the county societies are showing an increasing interest in mental hygiene.

Respectfully submitted,

JOSEPH A. CAMMARATA	PETER O. KWITEROVICH
JOHN N. FREDERICK	ROBERT A. MATTHEWS
SAMUEL B. HADDEN	ARTHUR P. NOYES
JAMES M. HENNINGER	J. FRANKLIN ROBINSON

HAMBLIN C. EATON, *Chairman*

CONFERENCE OF PROFESSIONAL LICENSEES

To the President and House of Delegates:

No meetings were held by the Conference of Professional Licensees this year.

There was considerable individual activity on the part of the conference with the Legislature to obtain an appropriation large enough to carry out the provisions of the various practice acts.

There was a slight increase in the appropriation for enforcement. The total budget for the 1947-49 biennium was \$720,940, of which amount \$170,343 was allocated for law enforcement, while the General Appropriation Bill for the 1949-51 biennium includes \$800,000 for professional examining boards, of which amount the estimated allotment for law enforcement is approximately \$210,000.

Respectfully submitted,

C. L. PALMER

COMMISSION ON PHYSICAL MEDICINE

To the President and House of Delegates:

The commission held three meetings in the State Medical Society Building in Harrisburg on November 20, January 30, and May 22. A majority of the members of the commission were in attendance at each meeting. The following is a résumé of the work of this commission:

1. Physical medicine is now included in the program of the Graduate Education Institute with a half-day session devoted to the subject in each center.
2. A program of coordinated physical medicine and rehabilitation has been initiated with the interested agencies in all county medical societies.
3. Arrangements have been made for a scientific exhibit on physical medicine and rehabilitation at the convention of The Medical Society of the State of Pennsylvania in Pittsburgh.
4. A change in terminology from "physical therapy technicians" to "physical therapists" has been requested for use in the transactions of this commission.
5. All county medical societies which do not have committees on physical medicine and rehabilitation are to be contacted regarding the appointment of such committees and the planning of programs on physical medicine and rehabilitation with the help of this commission.
6. Teams of specialists are being organized to present programs before county medical societies on physical medicine and rehabilitation in their respective fields, such as cerebral palsy, poliomyelitis, and arthritis.

Respectfully submitted,

GEORGE FARRAR	WILTON D. ROBINSON
JESSIE WRIGHT	GEORGE M. PIERSOL
TEMPLE FAY	ULRICH D. RUMBAUGH
GUY L. MCKINSTRY	WILLIAM H. SCHMIDT

ALBERT A. MARTUCCI, *Chairman*

COMMISSION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE

To the President and House of Delegates:

Our commission held four meetings during the year—October 7, December 16, February 24, and April 28. The transactions follow:

1. Approved a program of immunization for the State, as suggested by Dr. Hubley R. Owen, medical director of the Board of Education of Philadelphia.
2. Recommended to the Committee on Public Health Legislation that a bill be introduced providing subsidies to general hospitals for tuberculous patients.
3. Recommended to the Committee on Public Health Legislation that a bill be introduced amending the present State Nurses Act to provide for practical nurses. This bill was sponsored by the Pennsylvania State Nurses Association.
4. Purchased and distributed 1000 copies of the article entitled "The Significance of the Pennsylvania Practical Nurse Bill."
5. Sent a representative of the commission to Crawford County to attend a meeting concerning an outbreak of Bang's disease in that area.
6. Suggested to MSAP an expansion of their services to include postnatal care and cancer prevention.
7. Approved a suggestion that articles be prepared by members of the commission dealing with the results of the Public Health Survey to be published in THE PENNSYLVANIA MEDICAL JOURNAL.
8. Agreed to assist in the distribution of copies of the Public Health Survey, if approved by the Board of Trustees.*
9. Accepted an invitation to prepare a program on public health and preventive medicine for the Commission on Graduate Education for the year 1949-50.
10. Appointed a subcommittee to study the matter of revising communicable disease regulations in the State of Pennsylvania.
11. Recommended legislation for approval of a sanitary code for cities of the first and second class.
12. Sent a questionnaire to other state medical societies to determine if there was a similar committee in each state. The replies showed that no other state society had a committee by the same name but that 19 states had committees with similar functions. These states are California, Colorado, Connecticut, District of Columbia, Georgia, Idaho, Illinois, Michigan, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, South Dakota, Tennessee, Utah, Vermont, Wisconsin, and Wyoming.

Respectfully submitted,

I. HOPE ALEXANDER	WILLIAM S. McELROY
J. MOORE CAMPBELL	WILLIAM HARVEY PERKINS
VINCENT T. CURTIN	RUFUS S. REEVES
GEORGE R. GOOD	RUTH HARTLEY WEAVER
GEORGE S. KLUMP	JOHN D. YEAGLEY

PASCAL F. LUCCHESI, *Chairman*

ADVISORY COMMITTEE TO PENNSYLVANIA BOARD FOR VOCATIONAL REHABILITATION

To the President and House of Delegates:

Mr. Floyd L. Kefford, acting chief of physical restoration in the State Bureau of Rehabilitation, indicates

* SECRETARY'S NOTE: The Board of Trustees approved, and Chairman Lucchesi was named as a member of the committee to list those entitled to receive the small number of copies allotted to the State Society.

that they have received a \$300,000 deficiency appropriation and a \$1,800,000 appropriation for the next biennium; therefore, they will no doubt be calling on this advisory committee to put in force the plans previously discussed.

Continuation of this advisory committee is requested.

Respectfully submitted,

EARL D. BOND
FREDERICK A. BOTHE
JOSIAH F. BUZZARD
ALLEN W. COWLEY

T. LYLE HAZLETT
DOUGLAS MACFARLAN
ALBERT A. MARTUCCI
WILTON H. ROBINSON
C. L. PALMER, *Chairman*

COMMISSION TO STUDY CONTROL OF RHEUMATIC FEVER

To the President and House of Delegates:

The commission has held three stated meetings in addition to several by various subcommittees.

The chief activity of the commission has been the inauguration of a state-wide survey of active and inactive rheumatic fever patients under 21 years of age. Responses by physicians have been excellent. Several modifications in the forms are planned to aid in the accumulation of additional data. It is necessary to publicize this registration continuously to get doctors into the habit of reporting cases.

In addition to inaugurating the registration program, our state commission has secured the appointment of a rheumatic fever committee in every one of the sixty county medical societies. The chairmen of these committees are requested to encourage the registration of cases, to arrange yearly symposia on rheumatic fever or rheumatic heart disease for county society meetings, and to assist lay groups (such as parent-teacher associations) in arranging their programs.

A meeting will be held Wednesday, September 28, during the 1949 convention in Pittsburgh, for these county chairmen. Various members of the commission will speak. The commission will present an exhibit at the convention covering the prophylaxis and treatment of rheumatic fever with data on the value of sulfonamides.

During the past year, additional physician interest in this commission's work was stimulated by the presentation of a paper on rheumatic fever before the State Society's Conference of Secretaries and Editors in Harrisburg.

This commission was selected for national recognition by the American Medical Association group sponsoring the radio series "Doctors Work Together," a program designed to make the public aware of the efforts of organized medicine in disease control. In April an outline of our commission's activities was broadcast over the National Broadcasting Company network.

The members wish to thank the many Pennsylvania physicians who are cooperating in the rheumatic fever survey.

Respectfully submitted,

ALLEN W. COWLEY
CONSTANTINE P. FALLER
FRANK J. GREGG
PAUL B. KREITZ

J. RODERICK KITCHELL
THOMAS P. TREDWAY
JOHN M. MITCHELL

RALPH L. SHANNO, *Co-chairman*
ANDREW B. FULLER, *Chairman*

COMMISSION ON THE CONTROL OF SYPHILIS AND VENEREAL DISEASES

To the President and House of Delegates:

The commission is pleased to report that its primary effort during the past year has been to complete and mail to the membership of The Medical Society of the State of Pennsylvania an up-to-date article on "*The Control of Syphilis by Means of Penicillin*." Inasmuch as this project was initiated by the 1947-48 commission and completed by the 1948-49 commission, appropriate notice has been made of that fact in the final publication, which was distributed May 25, 1949.

It is hoped that, as further advances are made in the treatment of syphilis by means of penicillin, the commission will have supplementary articles published in THE PENNSYLVANIA MEDICAL JOURNAL, in order that they might be added as extra pages in the booklet and thus be retained as a complete and up-to-date reference.

We have noted that the Commission on Graduate Education has included in its 1949-50 program one hour to be devoted to the subject of "Modern Treatment of Syphilis." The adviser for that program expects to use copies of our publication as a study and reference guide for those who will be attending the course. We believe that this effort in the realm of professional education will aid greatly in developing interest in the treatment of syphilis by means of penicillin.

At the last meeting of the commission on March 27, 1949, it was the consensus that we should consider a survey of the number of cases of syphilis in Pennsylvania. The details of such a survey will be considered at the commission's next meeting, which is to be held during the annual session of The Medical Society of the State of Pennsylvania this fall.

For the ensuing year, one of the most extensive efforts of the Commission will be to consider that portion of the recently completed Public Health Survey Report which deals with the venereal disease control program in the State of Pennsylvania. We shall review and analyze the suggestions contained therein for the purpose of making appropriate recommendations to the Board of Trustees in the interim between sessions.

Respectfully submitted,

PAUL M. CORMAN
LEO P. GIBBONS
ROBERT C. HIBBS
NORMAN R. INGRAHAM, JR.

CLARENCE S. LIVINGOOD
DANIEL P. RAY
RAYMOND RICKLOFF
HAROLD R. VOGEL

SAMUEL L. GROSSMAN, *Chairman*

COMMISSION ON TUBERCULOSIS

To the President and House of Delegates:

The commission does not have a formal report to present this year. Mainly because of other pressures, your chairman has not called a meeting of the group as a whole. Activities have consisted for the most part of advisory services in the various districts by members of the commission.

In spite of the commission's inactivity, there is a real need for a dynamic educational program, particularly in connection with the physician's responsibility in the follow-up of patients found in the various chest x-ray surveys. Also a program of close cooperation with the State Health Department is essential to assist in the department's effort to strengthen its tuberculosis control work.

In view of the foregoing, it is the chairman's feeling

that the Commission on Tuberculosis should be continued under the leadership of someone who can devote sufficient time to organizing and correlating its activities.

Respectfully submitted,

RUSSELL S. ANDERSON	ELMER HIGHBERGER, JR.
JOHN H. BISBING	VICTOR M. LEFFINGWELL
KATHARINE R. BOUCOT	ROYAL H. MCCUTCHEON
HAROLD T. BROWN	CHARLES H. MINER
W. EDWARD CHAMBERLAIN	JOHN S. PACKARD
ROSS K. CHILDREHOSE	FRANK A. PUGLIESE
DAVID A. COOPER	DALE C. STAHLER
ESTEN L. HAZLETT	MARTIN J. SOKOLOFF
CHARLES A. HEIKEN	MICHELE VIGLIONE

C. HOWARD MARCY, *Chairman*

DELEGATES TO AMERICAN MEDICAL ASSOCIATION

To the President and House of Delegates:

The Third Interim Session of the House of Delegates was held at St. Louis, November 30 to December 3, 1948, and was attended at each session by the full complement of ten delegates from The Medical Society of the State of Pennsylvania.

The outstanding action was unanimous approval of the development of a National Educational Campaign under the supervision of a "Coordinating Committee for the Protection of the People's Health," which campaign is now well under way in all states. A widely debated proposal for a national insurance company combining Blue Shield and Blue Cross was voted down.

The delegates from Pennsylvania took an active part in the deliberations of the House under the supervision of the Speaker of the House, Dr. Francis F. Borzell. The following members held positions on reference committees of the House:

Dr. Wm. Bates, Committee on Medical Education; Dr. James Z. Appel, chairman of Committee on Reports of Officers; Dr. James L. Whitehill, chairman of Sergeants at Arms; Dr. William L. Estes, Jr., Committee on Medical Service and Prepayment Insurance Plans. Near the close of the session the delegates rose to their feet in honor of Dr. Walter F. Donaldson leaving the House of Delegates after twenty-six years of continuous service, and at a breakfast held in his honor by his fellow delegates from Pennsylvania, several albums of classical records were presented to him.

The annual session of the House of Delegates was held in Atlantic City, June 6-10, 1949, and again all delegates (11) from Pennsylvania were present, the personnel consisting of Drs. William L. Estes, Jr., James L. Whitehill, George S. Klump, Elmer Hess, James

Z. Appel, E. Roger Samuel, William Bates, Francis F. Borzell, Harold B. Gardner, Charles L. Shafer, and Howard K. Petry, also Henry S. Ruth, delegate from the A.M.A. Section on Anesthesiology, who was appointed chairman of the Reference Committee on Sections and Section Work. It is worthy of note that Pennsylvania was the only one of the larger state delegations having everyone on the floor at both roll calls in the House.

At the opening session of the House, Speaker Francis F. Borzell announced the appointment of the following Pennsylvania delegates on reference committees: Dr. E. Roger Samuel, Committee on Rules and Order of Business; Dr. Charles L. Shafer, Committee on Medical Education; Dr. William Bates, chairman of Committee on Legislation and Public Relations; Dr. William L. Estes, Jr., chairman of Committee on Industrial Health; Dr. Howard K. Petry, Committee for Executive Session, and Dr. George S. Klump on a special Committee for Veterans Affairs.

Some of the outstanding features of this House of Delegates were announcement plans by the Board of Trustees for the retirement of Dr. Morris Fishbein who has served brilliantly as editor of the *A.M.A. Journal*; approval of a national enrollment plan for voluntary insurance by Associated Medical Care plans; unanimous approval of the revised "Principles of Medical Ethics" as presented by the Judicial Council; approval of a set of principles by which local county societies may approve voluntary health insurance plans sponsored by lay organizations (this has never been much of a problem in Pennsylvania, but has been in many states); reference to the Board of Trustees for further study and report back to the House of a controversial resolution in regard to veterans with non-service-connected disabilities being treated in governmental hospitals at the expense of the taxpayers.

At the close of the session, after Dr. Elmer Henderon was elected president-elect of the American Medical Association, the Pennsylvania delegation had the pleasure of seeing Dr. Elmer Hess re-elected to the Council on Medical Service by an overwhelming majority.

The Board of Trustees announced the following places of meeting:

<i>Interim Sessions</i>	<i>Annual Sessions</i>
1949 Washington, D.C.	1950 San Francisco, Calif.
1950 Denver, Colorado	1951 Atlantic City, N.J.
1951 Houston, Texas	1952 Chicago, Ill.

Respectfully submitted,

JAMES L. WHITEHILL, *Secretary*
JAMES Z. APPEL, *Chairman*



OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*

8104 Jenkins Arcade

Pittsburgh 22, Pa.

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

PRACTICING PENNSYLVANIA PHYSICIANS AND UNITED MINE WORKERS WELFARE AND RETIREMENT FUND

The generalized recommendations of the State Medical Society's Commission on Industrial Health and Hygiene and its Committee on Medical Economics, referred to in the report of the latter committee to the 1949 House of Delegates (see page 1255, this issue), are herewith printed as they appeared in their combined March, 1947 report to the Board of Trustees of The Medical Society of the State of Pennsylvania:

The following suggestions might be considered as a framework for future contacts by the unions desiring to offer health services and for the physicians rendering such services. These are simply suggestions, not definite recommendations, as far as the Committee on Medical Economics is concerned. They are created chiefly by the Commission on Industrial Health and Hygiene.

- A. Hospital medical and surgical services for union members might be arranged by contract between MSAP and the union health fund.
- B. Home and office medical and surgical services shall be rendered to union health program beneficiaries by the physician of the patient's choice, provided
 1. The physician wishes to participate.
 2. The schedule of remunerations shall be the average for that medical area.
 3. A combined union and medical committee, with a physician majority, shall deal with grievances concerning treatment or payment. The medical members shall be appointed by the county medical society.
 4. The attending physician shall have full freedom to request and obtain specialist consultation.

SPECIAL COURSE IN ELECTRO- CARDIOGRAPHY

The Commission on Graduate Education is well aware of the increasing demand for and utilization of the electrocardiographic method of study. It is also cognizant of the fact that electrocardiographic interpretation requires very

specialized knowledge, and that serious errors can result from utilization of the method by those improperly trained.

With this in mind, the commission is offering an intensive course in electrocardiographic interpretation which will include a thorough consideration of the all-important basic principles as well as many exercises in the actual reading of a wide variety of tracings.

A special program will be presented in Harrisburg on Thursday, November 10 and 17, December 1, 8, 15, 22 and 29, 1949. The lecture hall will be the nurses' auditorium of the Harrisburg Hospital, Front and Mulberry Streets, Harrisburg. For the seven full days of instruction, the fee will be \$35. Privileges under the G. I. Bill of Rights may be secured by veterans of World War II. The number of registrations will be limited, and if you care to register, we suggest that you do so at your earliest convenience.

A detailed outline of the course is given in the 1949-50 brochure of the Graduate Education Institute, a copy of which was mailed to you on August 1, 1949. For further information address the Commission on Graduate Education, 230 State St., Harrisburg, Pa.

REPORT OF A.M.A. COMMITTEE ON HOS- PITALS AND THE PRACTICE OF MEDICINE *

As condensed, amended, and revised by a reference committee of the 1949 A.M.A. House of Delegates

(See also report of chairman of our Board of Trustees and Councilors to 1949 Pennsylvania House of Delegates, page 1243, this issue.)

"The corporate practice of medicine is distinctly illegal in all of the states in the Union with some exceptions. There has been statutory legislation in several states permitting certain modifications in these general laws.

* Dr. Elmer Hess, Erie, Pa., chairman. Revision of the A.M.A. Principles of Medical Ethics, as adopted by the 1949 House of Delegates after this report had been prepared by Dr. Hess' committee, brought about changes in Chapter III dealing with arbitration, contract practice, and purveyal of medical service.

COMPARISON OF STATUTES DEALING WITH PSYCHOPATHIC SEXUAL OFFENDERS *

	Wisconsin	California	District of Columbia
	Chapter 459, Laws of 1947	Chapter 447, 1939, as amended	Public Law 615-80th Congress
I. Designation of condition	Sexual psychopath	Sexual psychopath	Sexual psychopath
II. Elements of definition	Irresponsible for sexual conduct and thereby dangerous to himself and others because of: 1. Emotional instability; or 2. Impulsiveness of behavior; or 3. Lack of customary standards of good judgment, or 4. Failure to appreciate consequence of acts, or 5. Combination of above	Affected with: 1. Mental disease or disorder, or 2. Psychopathic personality, or 3. Marked departures from normal mentality, in a form predisposing to commission of sexual offenses and in a degree constituting a menace to the health and safety of others.	1. Not insane 2. Repeated misconduct in sexual matters 3. Lack of power to control—danger to others (all three elements required)
III. Basis of jurisdiction	No crime or charge thereof is necessary	Criminal charge	No crime or charge thereof is necessary
IV. Discretion in initiating proceedings	District attorney	Apparently on affidavit of any person	1. U. S. attorney for district (discretionary) 2. Court (discretionary)
V. Tribunal and proceedings	1. Court of record (juvenile court if under 13) 2. Jury on demand 3. Private hearing in court's discretion 4. Time within which hearing must be held	1. Court of record 2. Persons found to be sexual psychopaths may demand jury trial; commitment only on finding by three-fourths of jury 3. No provision for private hearing 4. Trial in not less than five days nor more than ten days from jury demand	1. Court of record 2. Jury on demand 3. No provision for private hearing
VI. Medical examination—qualifications of examiners	Two duly licensed physicians (two years' general experience, or one year's experience as a physician in a hospital for the insane)	1. Two or three psychiatrists, one from state or county hospital (holders of physician's and surgeon's certificate whose practice has been directed primarily to diagnosis and treatment of mental and nervous disorders not less than five years) 2. By decision, held: Court not bound by psychiatrists' findings	Two qualified psychiatrists
VII. Effect of commitment on criminal proceedings	No defense	Proceedings suspended	No defense—stayed until release
VIII. Procedure for release	1. Parole by court upon recommendation of superintendent of institution 2. Proceedings initiated by committed person, relative, or friend	Superintendent of hospital certifies to committing court that person is no longer a menace to health and safety of others	Release by superintendent of hospital
IX. Nature of release—whether complete or subject to supervision	1. Complete release 2. Parole	If within thirty days of certification the court does not order return for criminal proceedings, superintendent of hospital may parole as in case of insane, for not less than five years	Complete except when criminal charge is pending—in such case to court
X. Cases upholding or interpreting statute		Constitutionality not in issue, but see <i>People v. Haley</i> , 46, Calif. App. (2d) 386, 67 p (2) 111.	No check on cases

* These comparisons were referred to in the report of the Committee on Psychiatric Services to Criminal Courts which appears on page 1265.

"In order to support this statement the Principles of Medical Ethics of the American Medical Association are quoted as follows:

- "Chapter I, Section 3
- Chapter III, Article V, Section 1
- Chapter III, Article VI, Section 2
- Chapter III, Article VI, Section 3
- Chapter III, Article VI, Section 6

"After consideration of these Principles, it must be concluded that the over-all policy of the American Medical Association shall be that it is illegal, with the exceptions noted, and unethical for any lay corporation to practice medicine and to furnish medical services for a professional fee which shall be so divided as to produce profit for a lay employer, either individual or institutional, including hospitals and medical schools.

"The ethical principles governing all groups and clinics are exactly the same as those governing the individual.

"In insurance programs, hospital service plans shall provide payment for hospital services only. Medical service plans should supply payment for all of the medical services, including pathologic, roentgenologic, anesthesiologic, and physical therapeutic services. The licensed physician is the only person legally qualified at the present time to render any individual medical service.

"This being so, then the medical profession should be dominant in the physician-hospital relationship in all circumstances, but since the physician and the hospital are interdependent, it is incumbent on both to be completely interested in all phases of their scientific and financial relationships. This means that the professional staff of the hospital has very definite responsibilities toward not only other members of the professional staff, whether active or courtesy, but also toward hospital management. The finances of an institution in which a physician does his professional work are definitely of importance to him and to the professional staff, and the proper consideration must be given to these finances if the hospital is to work efficiently and remain the workshop of the physician.

"The recommendations of the staff are usually accepted by the management of the hospital through its boards of managers or trustees. It must also be remembered that to be approved for residencies in specialties by the American Medical Association and the American College of Surgeons, certain requirements are mandatory to the institution, namely, adequate pathologic and radiologic coverage. As a rule, the staff of a hospital elects an executive committee or works under an appointed executive committee to advise the lay officers of the institution on purely professional matters, and recommends who may or may not use the institution for their professional work. Unfortunately, in many instances, the financial matters of the lay hospital management have been no affair of the staff or of its professional executive committee. This is wrong and probably the cause of most of the differences of opinion. Every professional man on the appointed staff should have a voice in the professional management of the institution. The pathologist, roentgenologist, anesthesiologist, and physiatrist, as well as the other professional staff members, should have equal standing as active members of the staff, and the executive committee or physicians of the active staff should be empowered to recommend the physicians heading these departments in any hospital where they exist. That the finances of

the hospital are of grave importance to the staff goes without saying. Without proper facilities the services rendered to the public are in jeopardy and these public services are the all-important function of both hospital and staff.

"It is therefore the opinion of the committee that most controversies between management and the professional staff, either individually or collectively, should be settled on local levels in accordance with clearly established national policy. To implement the settlement of such controversies, the House of Delegates recommends to each of its constituent state and territorial societies that it appoint a committee on hospital and professional relations. This committee shall be available to receive complaints from any physician, hospital, medical organization, or any other interested person or group with reference to professional or economic relations existing between doctors of medicine and hospitals or medical schools. On receipt of such complaint by such committee, the matter shall be investigated and acted on in such manner as that committee may decide and in accordance with regular and existing modes of procedure.

"There can be no exploitation of the doctor or of the hospital if everyone concerned in both management and on the professional staff will work together to supply the greatest possible good quality medical and hospital services to the public.

"Most of these matters could be settled at the hospital or county level. Therefore, it is recommended that after all efforts at the local and state levels have been exhausted, the charges of unethical conduct by either members of the professional staff or by hospital management should be brought to the Judicial Council for examination. If the Judicial Council, working with similar committees of hospital agencies, cannot adjudicate the specific matter and finds ethical and legal compromise impossible, then suitable action should be taken against the physician or institution found guilty. The authority for this is found in the Constitution and By-Laws of the American Medical Association as follows: Division One, Chapter III, relating to Disciplinary Action, and Division Three, Chapter X, Section 4, relating to Standing Committees.

"If a hospital or other lay group is found guilty and will not cooperate within ethical and legal limits, it is recommended that the Judicial Council shall order the withdrawal of the Association's approval of that institution.

"This committee can find no better recommendations to establish principles governing proper relations between physicians and hospitals than those adopted by the Massachusetts Medical Society, which read as follows:

"1. That the medical costs of hospital care be separated from the non-medical costs, as can be done by existing and accepted methods of cost accounting, and that they appear thus separated on the statement submitted to the patient.

"2. That a basic principle in the establishment of charges should be that each department be self-supporting. This principle should be so applied that neither the hospital nor the physician rendering the service shall exploit the patient or each other.

"3. That fees for medical services which are collected by the hospital be established by joint action of a representative committee of the staff, to include the head of the department and the administrator and the governing body of the hospital.

"4. That the basis of financial arrangement between hospital and physician may be salary, commission, fees or such other method as will best meet the local situation, with due regard to the needs of the patient, the community, the hospital, and the physician.

"5. That bills for all medical services be rendered in the name of the physician or physicians performing the service."

"It is the opinion of your committee that acceptance and practice of these principles will effect the separation

of hospital services and medical care rendered in hospitals, as well as the responsibility for the payment of medical services and non-medical hospital services as defined above, including prepayment and other insurance plans, and should become the basis of policy to be followed in all activities of the headquarters staff."

EXCERPTS FROM A.M.A. SECRETARY'S LETTER

The A.M.A. Bureau of Medical Economic Research has prepared a denial to the claims of several nationally vocal advocates of compulsory sickness insurance that the American Medical Association stated in 1939 that families with incomes of \$3,000 or less could not afford the costs of "serious illness."

In an effort to uncover the source of the claims, which have been given wide circulation, the bureau consulted the advocates of compulsory sickness insurance themselves. So far as the bureau has been able to determine, their statements represent a false interpretation of a chart and a few lines of text appearing on pages 90 and 91 of "Factual Data on Medical Economics," published in 1939 and revised in 1940 by the bureau, which was then known as the Bureau of Medical Economics.

The chart does not show that families with incomes under \$3,000 cannot meet their medical expenses. The chart indicates only that some families in this income group present a problem for public aid and some do not. These families with incomes of \$3,000 or less could, for the most part, pay the costs of their major and minor illness expenses. Help, however, was more often needed in meeting chronic illness expenses.

Set Dates for Annual Public Relations Conference. The second annual A.M.A. Public Relations Conference will be held in Chicago on November 5 and 6, immediately following the Secretaries and Editors Conference, November 3 and 4.

Invited to the conference, which was authorized by the A.M.A. Board of Trustees, will be public relations committee chairmen, executive secretaries, and public relations directors of state medical societies and of county medical societies which maintain executive offices.

Dr. McVay Re-elected Council Chairman. Dr. James R. McVay, Kansas City, was re-elected chairman of the A.M.A. Council on Medical Service, and Dr. Elmer Hess, Erie, Pa., was re-elected vice-chairman at a one-day meeting of the council in Chicago, July 16. The executive committee for the coming year will be made up of Drs. McVay, Hess, and J. D. McCarthy, Omaha, Neb.

The council renewed the Seal of Acceptance for four voluntary prepayment medical care plans. Three additional plans are to be examined further to determine their eligibility for renewal of the seal. Eligibility is determined every two years.

Plans were discussed for expansion of the council staff in order to develop the positive phases of the National Education Campaign, principally the nationwide promotion of the voluntary health insurance campaign on all fronts.

Doctors Depart on Alaskan Medical Mission. Under sponsorship of the U. S. Department of Interior and the American Medical Association, five physicians left July 16 for Anchorage, Alaska, for a two-week session of conferences and clinics. This was the third time in

five years that medical teams have visited Alaska under Department of Interior-A.M.A. sponsorship.

The conference will be conducted by five specialists to provide Interior Department medical officers now serving in remote areas in Alaska with an intensive series of seminars, demonstrations, clinics, and consultations based on late techniques and developments in the fields of internal medicine, general surgery, obstetrics and gynecology, tuberculosis, and ophthalmology.

At the same time eight other physicians volunteered to go to Alaska to replace the Interior Department doctors so they could leave their outlying posts to attend the seminar.

GEORGE F. LULL, M.D.,

A.M.A. Secretary and General Manager

July 25, 1949

RESTRICT INSPECTION OF BIRTH RECORDS

DR. WALTER F. DONALDSON, Secretary,
The Medical Society of the State of
Pennsylvania.

The A.M.A. House of Delegates at its meeting in Atlantic City, June 6 to 10, 1949, adopted the following resolutions on the confidential nature of birth records:

WHEREAS, Physicians attending at births are required by the respective state laws to complete and file a certificate of birth and have an interest in seeing that the confidential nature of the birth certificate is maintained and that none of the data contained therein are used to the detriment or embarrassment of the child and family concerned; therefore be it

Resolved, That the American Medical Association commends the efforts of the American Association of Registration Executives, the Council on Vital Records and Statistics, the Children's Bureau and the National Office of Vital Statistics of the Federal Security Agency to formulate a policy maintaining the confidential nature of birth records which was published in January, 1949 under the title "The Confidential Nature of Birth Records"; and be it further

Resolved, That the American Medical Association urge state legislatures and registration officials to study carefully the recommendations made in this publication and wherever possible to put them into effect by enactment into law or by administrative regulation. It especially urges that the right of inspection of birth records be restricted to the registrant, if of legal age, his parents, guardian or their legal representative, health and official agencies on the approval of the official custodian of vital records or on court order.

Please transmit resolutions to your state legislature and registration officials for their information.

Very truly yours,

ERNEST B. HOWARD, M.D.,

A.M.A. Assistant Secretary.

July 22, 1949

CONTRIBUTIONS TO MEDICAL BENEVOLENCE FUND

The Committee on Medical Benevolence makes grateful acknowledgment of the following contributions to the benevolence fund. These have also been previously acknowledged individually.

Woman's Auxiliary, Bucks County	
A friend, in memory of Mrs. Ralph Worrell	\$10.00
Woman's Auxiliary, Mercer County	150.00
Woman's Auxiliary, Wyoming County	12.00
Woman's Auxiliary, Delaware County	150.00
Woman's Auxiliary, Bradford County	66.00
Woman's Auxiliary, Tioga County	50.00
Woman's Auxiliary, Montgomery County (additional)	403.10
Woman's Auxiliary, Huntingdon County	50.00
Woman's Auxiliary, Schuylkill County	116.35
Woman's Auxiliary, Bucks County	134.00
Woman's Auxiliary, Juniata County	10.00
Woman's Auxiliary, Berks County (additional)	15.00
Woman's Auxiliary, Crawford County	100.00
Woman's Auxiliary, Franklin County	75.00
Woman's Auxiliary, Medical Society of the State of Pennsylvania	500.00
Woman's Auxiliary, Chester County	150.00
Woman's Auxiliary, Venango County	50.00
Previously reported	7,158.88

Total contributions since 1948 report\$9,200.33

A.M.A. SECRETARY'S LETTER OF JUNE 27

DEAR DR. DONALDSON:

State medical societies are becoming more and more conscious of building *better relations between newspapers and the medical profession*.

Several weeks ago the Minnesota State Medical Society invited newspaper editors from all over the state to a Medical Press Conference in Minneapolis. It was a highly successful meeting.

On Thursday, June 16, John L. Bach, director of A.M.A. press relations, attended a dinner meeting of Colorado's Code of Cooperation Committee in Denver. The committee was formed two years ago at the suggestion of Dr. John S. Bouslog, who was then serving as president of the Colorado State Medical Society.

The committee includes the news editors of the six Denver radio stations, the president and secretary of the Colorado Hospital Association, several Denver newspapermen including the managing editors of both dailies, the managing director of the Colorado Press Association, a representative of the Rocky Mountain Radio Council, and about eight representatives of the Colorado State and Denver County Medical Societies.

Since the code was adopted, dinners are held about twice a year to keep, as Executive Secretary Harvey T. Sethman says, "the ball rolling and give us all a chance to dig the bugs out of our cooperative setup."

At the end of two years, the Colorado code is working extremely well. It has paved the way for a better understanding between the doctor and the newspaper and radio people.

Mr. Bach observed that, as a result of the code, the newspaper and radio people today have the same confidence in Mr. Sethman and his field secretary, Evan A. Edwards, as Notre Dame football teams had in Rockne.

On the following day, Friday, June 17, Mr. Bach attended the first Medical-Press-Radio Conference sponsored by the Nebraska State Medical Association at Omaha. More than 160 newspapermen and doctors attended the all-day meeting.

In his opening remarks Executive Secretary M. C. Smith explained that the meeting provided "both doctors and newspapermen an opportunity to unload their gripes and work out a plan of cooperation."

Dr. J. D. McCarthy, Omaha, president of the Nebraska State Medical Association, and Dr. Harold S. Morgan, chairman of the public relations committee of the state association, played an active part in putting on the program.

"Problems now confronting both the doctors and editors in Nebraska are bound to melt away like butter in the sunlight," Mr. Bach said in addressing the group. "When 160 doctors and editors devote a full day to ironing out their troubles around conference tables, only good can come from such a meeting. Problems that loom big at first can, and will, be settled amicably through discussion and understanding."

The Iowa State Medical Society is planning a similar Medical-Press-Radio Conference for September 23.

Two More Added to Coordinating Committee. President-elect Elmer L. Henderson of Louisville and Past President R. L. Sensenich of South Bend have been retained on the Coordinating Committee of the A.M.A. which is charged with the over-all responsibility for the conduct of the National Education Campaign.

Dr. James R. Miller, Hartford, Conn., a member of the A.M.A. Board of Trustees, was named to replace Dr. Louis H. Bauer, of Hempstead, N. Y., who, as chairman of the Board of Trustees, becomes an ex-officio member.

As it now stands, the Coordinating Committee, which serves as the policy-making board of the campaign, is made up of Drs. Hamilton, Gundersen, Martin, and Miller as representatives of the Board of Trustees; Drs. Cline, Bates, and Robins, representing the House of Delegates; Dr. Bauer, chairman of the Board of Trustees; Dr. Irons, president of the A.M.A.; Drs. Henderson and Sensenich, and myself, secretary-general manager, as ex-officio members.

Board to Consider Displaced Physicians' Problem. Two resolutions covering the problem of displaced physicians in Europe were presented to the House of Delegates at the annual session in Atlantic City and referred to the Board of Trustees for appropriate action.

One resolution was presented by Dr. Charles L. Farrell of Pawtucket, R. I. It previously had been adopted by the House of Delegates of the Rhode Island Medical Society. The resolution called for the appointment of a special committee by the president of the A.M.A. "to study the problems of displaced physicians generally and as far as possible to cooperate with the International Refugee Organization and the various state authorities in furthering the resettlement of these individuals in a spirit of friendly cooperation with unfortunate colleagues."

The reference committee report pointed out that the matter involves investigation as to whether the various state boards can cooperate; that immigration authorities must be consulted and that someone must be responsible for the physicians brought to the United States. The Board of Trustees was directed to consider the question.

A resolution presented by Dr. D. M. Vickers of the New York State Medical Society called for the appoint-

ment of a committee by the Board of Trustees to cooperate with other organizations in solving the problem. The reference committee recommended its adoption "if feasible." This matter, likewise, was referred to the Board of Trustees.

Exhibit Shows World Medical Association Setup. A map showing the forty countries represented in the membership of the World Medical Association was displayed in one of the exhibits at the recent A.M.A. meeting in Atlantic City.

The objects of the Association and of the U. S. Committee were shown on placards. Opportunity was given to visitors to become members of the U. S. Committee. A goal has been set of 5000 individual members of the Committee. At present there are only 1000.

The World Medical Association will hold its 1950 General Assembly in the United States, probably in New York City. The date has not yet been set, but it will probably be in September or October. Any member of the U. S. Committee is eligible to attend as an observer.

The next *Bulletin* of the World Medical Association will be out about July 1, and will contain summaries of studies on medical education, cult practice, and medical advertising in the various countries.

A.M.A. Endorses CARE Medical Book Program. The Board of Trustees of the A.M.A., meeting in Atlantic City, voted to endorse the CARE program to send medical books overseas to war-ruined libraries.

The Board also authorized the appointment of a committee of three physicians to study the program and to arrange for the cooperation of the A.M.A. in obtaining medical books, microfilms, and funds. CARE has received many requests for literature to bring European doctors and students up to date.

Contributors of more than \$10 will be permitted to express a preference for the countries and institutions they wish to help. Contributions may be sent to any CARE office in principal cities or to headquarters, 20 Broad street, New York.

Vivisection Transcriptions Available. The Bureau of Health Education of the A.M.A. has available a new series of dramatic recordings dealing with animal experimentation, a subject of great current interest, for use on local radio stations. The 15-minute transcriptions provide forceful arguments in favor of controlled animal experimentation. Scripts were written by trained radio specialists.

An innovation has been the inclusion of brief statements by prominent personages in defense of laboratory studies in which animals play a significant part. Included are: Dr. Louis Mann, rabbi of Sinai Temple, Chicago; Ned Dearborn, president of the National Safety Council, Chicago; Morton Gould, composer and conductor; Anton Rost, president of the National Canine Research Foundation; Harold Stassen, president of the University of Pennsylvania; Dr. George D. Stoddard, president of the University of Illinois; Dr. George D. Curtis, director of surgical research, Ohio State University; and Mrs. Frank J. Lausche, first lady of the State of Ohio. Dr. W. W. Bauer, director of the Bureau of Health Education, who conceived and developed the series, also is a participant.

Important cooperation was provided by the National Society for Medical Research.

The series is titled "The Story Behind the Discovery" and is available without charge to local medical societies. Requests should be sent to the Bureau of Health Education, 535 North Dearborn St., Chicago

10, Ill. Societies in Florida, Louisiana, New Jersey, New Mexico, Oregon, Pennsylvania, Tennessee, Texas, and Washington may obtain platters direct from their state headquarters.

Fleming to Speak on A.M.A. Radio Program. Sir Alexander Fleming, world-famous developer of penicillin, will participate in an A.M.A.-NBC radio program to be aired from Oklahoma City, Okla., on Saturday afternoon, July 2.

Dr. Fleming, who is making a special trip from England to Oklahoma City to assist in the dedication of a multi-million dollar medical research center, will be a speaker on the half-hour radio program. The dramatized show, which will be built around development of the center, will run from 2:30 to 3 p.m., Central Daylight Saving Time. It will be a special feature in the regular American Medical Association series that is presented each Saturday afternoon.

The new Oklahoma Medical Research Foundation represents the culmination of concerted activity on the part of participants from every walk of life. According to Mr. Hugh Payne, general manager, public contributions have ranged from 50 cents to several thousand dollars. Members of the Oklahoma State Medical Association donated \$500,000, the state dental organization \$225,000, the nurses' association \$50,000, and drug organizations \$300,000. Contracts have been let for initial construction on a two-acre tract provided by the state legislature. The foundation will operate in close cooperation with the University of Oklahoma Medical School. Basic approach in research will be on the problems of geriatrics (care of the aged).

Dr. Fleming will be the principal speaker at cornerstone-laying exercises preceding the radio show.

GEORGE F. LULL, M.D.,
Secretary and General Manager of A.M.A.

CHANGES IN MEMBERSHIP OF COUNTY SOCIETIES

New (37) and Reinstated (24) Members

ALLEGHENY COUNTY: B. Irene Armstrong, Edwin R. Fisher, Arnold J. Friedhoff, Thomas Parran, James J. Reilly, Frank N. Tetlow, and James S. Wyland, Pittsburgh; Michael F. Dimun, Carnegie; Thompson A. Ferrier, Coraopolis; George W. W. Little, Homestead. (Reinstated) George Evashwick, Albuquerque, N. M.; Homer G. McClintock, Ann Arbor, Mich.; Harold S. D. Mock, Cheswick; Frank B. Patterson and Edward W. Provost, Pittsburgh.

CHESTER COUNTY: (R) James S. Dean and Joseph G. Ross, Spring City; Theodore Linton Mercer, Avondale; Romeo R. D'Onofrio, Kennett Square.

FAYETTE COUNTY: Robert W. Guie, Connellsville.

HUNTINGDON COUNTY: (R) George Katz, Mount Union.

LACKAWANNA COUNTY: (R) John E. Murphy and Seraphin C. Wandolowski, Scranton.

LANCASTER COUNTY: Robert R. Dugan, Lancaster.

LUZERNE COUNTY: (R) Francis A. Blaum, White Haven.

LYCOMING COUNTY: Russell G. Lindauer and Charles J. Rodgers, Williamsport.

MERCER COUNTY: Ira W. Flannery, Sharpsville; Howard A. Steiner, Sharon.

MONTGOMERY COUNTY: Rosalie J. Ging, Saratoga; William H. Ramsey, II, Bryn Mawr.

PHILADELPHIA COUNTY: Charles W. Day, Daniel F. Downing, Victor E. Gambone, George B. Hobach, John P. Hobach, S. Richard Kaplan, Robert Leman, Martin M. Mandel, Lester Mann, Robert S. Mutch, Matthew Francis Reilly, Joseph Rudolph, Karl Salus, Louis H. Schindfeld, Jacob Specter, and Laurence B. Weiss, Philadelphia; Alfred S. Froese, Drexel Hill; William T. O'Brien, Jr., Paramount, Calif.; Rowland Ricketts, Merchantville, N. J. (R) Orlando M. Carrozzino, Leonard I. Lapinsohn, Harrie B. Lochhead, Luther L. McCallion, George M. Mandelbaum, William Harvey Perkins, Jacob Clarence Rosen, Mary Ruisi, Griffin A. Saunders, John T. Schofield, Jr., Daniel M. Shewbrooks, Daniel Simkins, George Erban Thomas, Daniel M. Rosman, and Joseph A. Smith, Philadelphia; Philip L. DeLong, Havertown.

SCHUYLKILL COUNTY: Richard E. Miller, Tamaqua.

VENANGO COUNTY: (R) Kelse M. Hoffman, Franklin.

WESTMORELAND COUNTY: (R) Joseph F. Lipinski, New Kensington.

Transfers (11), Resignations (5), Deaths (7)

ALLEGHENY: *Deaths*—Charles T. Osterloh, Sr., Pittsburgh (Univ. Pgh. '01), recently, aged 73; Granville H. Walker, Bellevue (Jeff. Med. Coll. '02), June 25, aged 73.

BERKS: *Deaths*—Homer J. Rhode, Reading (Univ. Pa. '01), June 3, aged 72; Charles F. Smith, Topton (Univ. Pa. '11), June 4, aged 61.

CAMBRIA: *Death*—George F. Wright, Johnstown (Hahn. Med. Coll. '21), June 9, aged 57.

CRAWFORD: *Transfers*—Clifford Cooper and Harry Kanhofer, Titusville, to Venango County Society.

MERCER: *Transfer*—S. Victor King, Sharon, to Armstrong County Society.

MIFFLIN: *Transfer*—Frank J. Zukoski, Lewistown, from Lehigh County Society.

MONTGOMERY: *Transfer*—Lovett Dewees, Glen Mills, to Delaware County Society. *Death*—Arthur J. Denman, Narberth (N. Y. Univ. Med. School '13), June 24, aged 61.

NORTHUMBERLAND: *Transfer*—R. R. Scicchitano, Ashland, to Schuylkill County Society.

PHILADELPHIA: *Transfers*—David S. Marshall and Helen L. Marshall, Pottsville, to Schuylkill County Society; John J. Buckley, Pottsville, to Schuylkill County Society. *Resignations*—John F. Cadden, Front Royal, Va.; Jefferson N. Richardson, Atlantic City, N. J.; Leonard Averett, Los Angeles, Calif.; Rubin M. Lewis, Seattle, Wash.; Philip Getson, Philadelphia. *Death*—Charles James Cole, Philadelphia (Univ. Pa. '14), June 22, aged 62.

SCHUYLKILL: *Transfers*—T. Lamar Williams, Mt. Carmel, to Northumberland County Society; Hugh Heim, Nanticoke, to Luzerne County Society.

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since May 31. Figures in first column indicate county society numbers; second column, State Society numbers.

June 1	Westmoreland	207-209	10468-10470	\$45.00
	Luzerne	364	10471	15.00
	Cambria	168	10472	15.00
2	Montour	38	10473	15.00
7	Lancaster	232	10474	15.00
13	Schuylkill	148, 156-163	10475-10483	135.00
14	Lackawanna	281-282	10484-10485	30.00
	Montgomery	340-341	10486-10487	30.00
	Chester	110-112,		
		116	10488-10491	60.00
16	Westmoreland	210	10492	15.00
20	Huntingdon	29	10493	15.00
	Lackawanna	283	10494	15.00
	Franklin	77	10495	15.00
22	Luzerne	365	10496	15.00
24	Crawford	56	10497	15.00
27	Jefferson	57-58	10498-10499	30.00
29	Mercer	94-95	10500-10501	15.00

ARE YOU USING THE PACKAGE LIBRARY SERVICE?

Are you taking advantage of the facilities offered by the package library service of The Medical Society of the State of Pennsylvania? There are, at the present time, over 101,000 reprints and tear sheets from current periodicals filed in the library for your use.

Prior to 1944 the average yearly number of requests was approximately 350. However, from 1944 to 1948 inclusive, there has been a continuous increase in borrowers. A total of 1192 requests were received during 1948, an increase of 293 requests over the total for 1947.

A package of reprints will be sent immediately for a loan period of two weeks to any member of the State Society. There is a charge of 25 cents for each subject requested to cover postage and part of the expense of collecting the material. Send requests to the Librarian, 230 State St., Harrisburg, Pa.

Requests filled during the month of June were:

Hodgkin's disease
Medical history
Reiter's disease
Sex hygiene
Myasthenia gravis
Rickets
Tuberculosis of cervix
Nephropexy
Lumbar sympathectomy
Treatment of leg ulcers
Kahn test
Paraplegia
Aphasia

Pharmacy
Heart disease (4)
Vitamin E
Angina pectoris
Convalescent care
Hygiene of pregnancy
Rheumatic fever
Liver function tests
Toxicity of alcohol
Impetigo
Medical service
Treatment of leukemia
Electrocardiography

Mesenteric thrombosis	Undulant fever	Erythroblastosis foetalis
Endometriosis	Peroneal palsy	Hemiatrophy of the face
Vitamin A	Para-aminobenzoic acid	Amputation in diabetes and arteriosclerosis
Vitamin B ₂ deficiency	Diabetes	Industrial ocular injuries
Sedimentation rate	Hypertension	Public health in Pennsylvania
Decortication of lung	Plastic surgery	Psychiatric examinations
Hemophilia	Registered hospitals	Reticulo-endothelial granuloma
Cosmetics	Psychiatry	Mortality of gallbladder surgery
Arteriosclerosis	Rehabilitation	Injurious effects of tobacco
Rh factor	Health	Postoperative thrombo-embolism
Decubitus ulcers	Hamsters	Approved medical schools
Nausea and vomiting in pregnancy		Manipulation of the spine
Effect of glutamic acid upon mental functioning		Effects of nicotine on sterility
Clubbed fingers in congenital heart disease		Ambulatory treatment of hypertension
Diverticula of intestines		Veterans Administration
Carcinoma of uterus and ovaries		Cardiac diseases in children
Perforated peptic ulcer		Convalescent homes in Pennsylvania
Anatomy and physiology of sympathetic nervous system		Veterans Administration medical service fee schedule

DEFINING THE GENERAL PRACTITIONER

From surveys it has been estimated that but 15 per cent of illnesses require experts and hospitalization, and that the remaining 85 per cent may be handled satisfactorily by the general practitioner in his office or at the home of the patient. It is through a very long experience that the function of the practitioner of general medicine has become established. The development of the specialist as an adjunct to such function became a necessity relatively recently through the rapidly accumulating knowledge in special fields of medicine. When such special professional care is needed is best determined by the general practitioner who is in charge of the patient. Dr. C. D. Leake (*Southern Medical Journal*, March, 1949), in defining the position of the general practitioner, has recently said: "The patient needs the general practitioner to observe and advise him, to guard his interests at all times, to promote his health and welfare, to examine him regularly, to manage his illnesses, to recommend special care for him when necessary, to obtain consultation and specialty service when indicated, to prevent his illness, and to preserve his good health." These responsibilities of the general practitioner are heavy ones. They demand that he should keep abreast of medical progress and have a critical sense of his own limitations in medical fields in which he has not had suitable training and proper experience.

Because of this important place which is occupied by the general practitioner, the demand is great upon medical educators and those responsible for training programs in hospitals to see that their educational programs are directed primarily toward supplying the public with men who are adequately trained to practice general medicine. Dr. Leake goes so far as to recommend, in order to help the status of general practice, that teaching hospitals should agree to admit to residency training in approved specialties only such doctors as have spent five years in general practice. This would no doubt have beneficial effects on medical practice and also on the future specialist, but it is hardly likely that such agreement is possible. There are signs, however, that educational opportunities in some

medical schools and teaching hospitals are being expanded for young men desiring to enter general medical practice. Such changes cannot come too soon, and all medical and all hospital training centers must further realize their definite responsibility to a public which still looks to the general practitioner for medical care and health guidance.

It often has been said that the general practitioner cannot be defined. It is an idle task to try to do so, for he needs no defining. His important place in medicine is well recognized, not only by the public but by the general practitioner himself. Such a recognition of responsibility is best seen in the program of the American Academy of General Practice, which aims at systematic self-appraisal on the part of the physician and the maintenance of his professional efficiency. The result of such a forward-looking program will be reflected in the attitude of the public toward medicine as a whole. Any schemes for socialization which would tend to place medicine in the category of a commodity to be bought and sold will not be tolerated when the public and the profession alike become truly aware of the importance of the practitioner of general medicine and will give him the support he so richly deserves.—Editorial, *Connecticut State Medical Journal*.

Scientific Exhibit

The Scientific Exhibit will be located in the Fort Duquesne and Allegheny Rooms of the Hotel William Penn. It will be open Monday from 1:00 p.m., to 5:00 p.m., Tuesday and Wednesday from 9:00 a.m. to 5:30 p.m., and Thursday from 9:00 a.m. to 3:00 p.m.

This exhibit is worthy of the attention of every registrant. The exhibitors have spent much time, research, and effort in order to present to the Society and its guests those phases of medicine which are new, important, and of interest to the practicing physician. The Committee on Scientific Exhibits requests that you visit the exhibit often during the convention.

Medical Service Association of Pennsylvania

Cases Paid in 1948 By Type of Service

<u>Service</u>	<u>Number of Cases</u>	<u>Amount Paid</u>
Obstetrical		
Delivery	3,042	\$181,935.00
Cesarean section	134	13,400.00
Surgical		
Tonsillectomy	4,725	\$135,106.00
Appendectomy	1,526	153,511.50
Circumcision	920	11,352.00
Hysterectomy	838	105,392.50
Dilatation and curettage	652	25,995.00
Herniotomy	609	49,358.00
Hemorrhoidectomy	545	29,336.50
Laparotomy	493	49,192.50
Cystoscopy	439	13,529.50
Cholecystectomy	409	51,752.50
Traumatic wounds	362	3,755.00
Perineorrhaphy	274	13,525.00
Ligation of saphenous vein	200	13,951.00
Uterine flexions	178	18,832.50
Benign breast tumor	164	6,079.50
Oophorectomy	121	12,450.00
Thyroidectomy	115	13,655.00
Submucous resection	112	5,857.50
Prostatectomy	95	11,505.00
Fracture of radius and ulna	88	4,188.00
Chalazion	83	870.00
Strabismus	81	7,927.50
Fistulectomy	71	3,072.50
Mastectomy (radical)	59	5,952.50
Salpingectomy	54	5,460.00
Nephrectomy	51	7,250.00
Gastrectomy	40	5,875.00
Cystocele	31	2,512.50
All other surgery	5,876	294,738.00
Total surgical and obstetrical	<u>22,525</u>	<u>\$1,257,317.50</u>
Medical Cases	<u>3,147</u>	<u>\$103,474.50</u>
Grand total	<u><u>25,672</u></u>	<u><u>\$1,360,792.00</u></u>

TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the co-operation of the Pennsylvania Tuberculosis Society
and The Medical Society of the State of Pennsylvania

THERE has been little research directed at testing the efficiency of mechanical barriers to the air-borne passage of tubercle bacilli. Yet the importance of this type of study scarcely needs to be pointed out to the physician and the nurse whose duties bring them in close contact with cases of active tuberculosis.

THE EFFICIENCY OF GAUZE MASKS

Although there is no certain knowledge as to the size of the infectious particles concerned in the origin of human inhalation tuberculosis, there is considerable evidence to suggest that these are much smaller than the limits of ordinary visibility. Primary pulmonary tuberculosis in man takes root not in the upper respiratory passages but deep in the lung parenchyma, usually beneath the pleura. The effective pathogenic units must be assumed, therefore, to be smaller than the lumina of the terminal bronchioles. That the tubercle bacilli-containing particles responsible for naturally acquired air-borne pulmonary tuberculosis in rabbits are of microscopic dimensions is indicated by the fact that ultraviolet irradiation of the air of a room contaminated by tubercle bacilli protected rabbits from an air-borne contagion that caused progressive tuberculosis in 73 per cent of animals of the same genetic resistance similarly exposed in an unirradiated room. The ventilation of the irradiated room was such that some of the droplet nuclei of tubercle bacilli floating in the air were exposed to irradiation for only one second before inhalation by the exposed rabbits.

Therefore, it was not certain whether gauze masks with pores of relatively large magnitude, such as may be worn by individuals exposed to air-borne contagion of human tuberculosis, would filter out the dangerous invisible droplet nuclei of tubercle bacilli. There is evidence that six-layer gauze masks, especially after repeated washing, will remove bacteria floating in the air without interfering with respiration.

Miss Esta H. McNett, of the Veterans Administration, designed a six-layered gauze mask

to be worn by nurses engaged in the care of tuberculous patients. The efficiency of these masks was studied in an apparatus for quantitative air-borne infection modeled after the one described by Wells. The protective action of the gauze masks developed by Miss McNett was tested against the quantitative inhalation of droplet nuclei of tubercle bacilli which regularly induce pulmonary tuberculosis in rabbits.

The essential feature of the instrument was a nebulizer which generated droplet nuclei of tubercle bacilli. Most of these nuclei contained isolated bacilli; only occasionally were minute clumps, not larger in diameter than a red blood cell, liberated into the air. This infected air was drawn into an exposure chamber, into which the heads of the rabbits to be exposed protruded through a close-fitting collar. The infected air circulated past the noses of the rabbits and was removed through an exhaust pipe.

Three and six-layer gauze masks, 40 by 44 threads to the square inch, were sewn to fit the contour of the rabbit's head, neck, and ears. The gauze in front of the rabbit's nose and mouth had no seams.

Rabbits without masks and rabbits wearing masks were exposed simultaneously to the inhalation of air containing droplet nuclei of virulent bovine tubercle bacilli of the Ravenel strain.

It was found that, if all the air respired by rabbits exposed to the inhalation of droplet nuclei of virulent bovine tubercle bacilli passes through three or six-layer gauze masks, there is a 90 to 95 per cent reduction in the incidence of primary pulmonary tuberculous foci which developed

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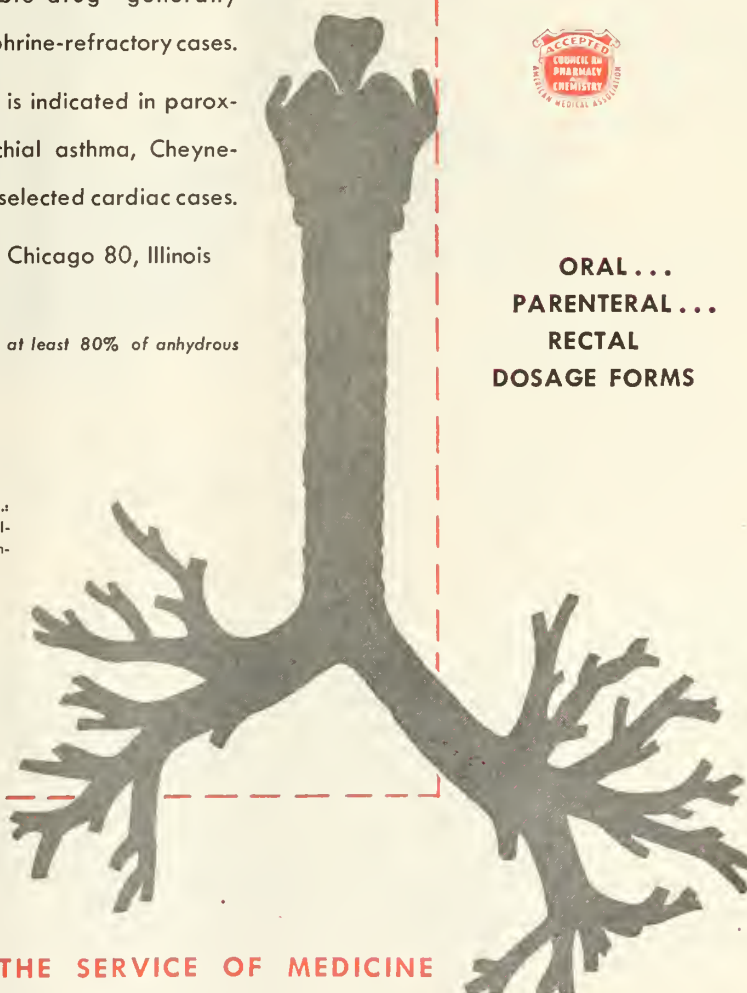
G. D. Searle & Co., Chicago 80, Illinois

*Searle Aminophyllin contains at least 80% of anhydrous theophylline.

1. Rackemann, F. M., in Cecil, R. L.: Textbook of Medicine, ed. 7, Philadelphia, W. B. Saunders Company, 1948, p. 539.



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RESEARCH IN THE SERVICE OF MEDICINE

within five weeks. It would follow that, if the respired air contains but a few bacilli, the masked animal will usually be protected from an otherwise fatal infection. Twelve of 20 masked animals were completely protected against air-borne contagion of such intensity that from 29 to 1027 tubercle bacilli units were deposited in the lungs of simultaneously exposed unmasked rabbits.

Measurements of the thread diameters and interthread spaces of these masks by H. Shapiro showed that the superimposition of three to six layers of this material would occlude practically all of the spaces and in this way explain the results of the experiments.

One must be extremely guarded in applying these data to the protection of human beings. With the rabbits all of the respired air passed through the masks. To be equally effective for human beings exposed to air-borne infection of tuberculosis, masks must be worn in an equally effective manner. The masks protected rabbits from air populated with droplet nuclei of tuber-

cle bacilli to a degree that would rarely, if ever, be found in the air respired by human beings. Human primary tuberculosis usually originates as a single pulmonary focus, whereas the unmasked rabbits in these experiments developed an average of 51 primary tubercles. Nevertheless, it seems reasonable to advise persons wearing masks to refrain from deep inspiration which may diminish the filtering efficiency of the masks.

Conversely, masks worn by coughing patients can hardly be expected to retain the invisible droplet nuclei containing tubercle bacilli propelled through them during fits of coughing.

Summary—Under the conditions of these experiments, from 90 to 95 per cent of pathogenic droplet nuclei of virulent bovine tubercle bacilli in the respired air can be removed by gauze masks properly worn by rabbits during quiet breathing of heavily infected air.

The Efficiency of Gauze Masks, Max B. Lurie, M.D., and Samuel Abramson, V.M.D., American Review of Tuberculosis, January, 1949.

THE FACE MASK IN TUBERCULOSIS

The major obstacle to the rapid expansion of better care for tuberculous patients and to the education of student nurses in tuberculosis nursing seems to be the recognized danger of contagion. The only known methods of protection for nurses against tuberculosis are: BCG (Bacillus Calmette Guérin) vaccine, available only to tuberculin-negative nurses, and communicable disease technique, based upon the use of mechan-

ical agents—cap, mask, gown, and hand-washing. None of these agents except the mask protects nurses and auxiliary workers from infection by inhalation, which modern medical opinion regards as one of the most important mechanisms in the transmission of tuberculosis.

The Face Mask in Tuberculosis, Esta H. McNett, R.N., American Journal of Nursing, January, 1949.

State Dinner

The annual State Dinner will be held in the Pittsburgh Room of the Hotel William Penn at 7 p. m., Monday, September 26. The Honorable Clarence J. Brown, Representative in Congress from the Seventh Ohio District, will be the principal speaker. Congressman Brown, now serving his sixth consecutive term, is a member of the powerful House Rules Committee and served as a member of the Hoover Commission. Music will be furnished by Homer Ochsenhirt's popular orchestra and the Westinghouse Quartet will sing. Formal dress for the State Dinner is optional. Tickets for this dinner are now available at \$5.00 each. Tables for ten may be reserved in advance. All reservations should be received by September 15. Use the reservation form on page 1232 to order your tickets.



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PROGRESS IN STREAM POLLUTION CONTROL

Published Through the Cooperation of the Pennsylvania
Department of Health and The Medical Society
of the State of Pennsylvania

The greatest emphasis is being placed today upon the state-wide stream pollution control program so ably and forcibly advocated by Governor Duff, both as Attorney General and subsequently as Governor of the State. In 1944 a plan was adopted by the State Sanitary Water Board for a more intensive effort to protect the streams of the Commonwealth. The program then undertaken has since been followed with growing force.

First, there was an appraisal made of the streams of the State, and they were classified on the basis of the degree of pollution. Next the polluting agencies were notified to prepare plans for treatment works. Some 1200 notices were issued by the Sanitary Water Board to municipalities and industries, said plans to provide for works for the treatment of sewage or industrial waste to the degree designated by the Board, comprising at least primary treatment and whatever higher degree the individual case might require. Those plans have been and are being received, studied by the Bureau of Sanitary Engineering, reported upon, and permits are issued.

Because of the high cost and difficulties of construction, the Board has refrained from issuing wholesale orders for the building of treatment plants, but just lately it has proceeded to adopt a policy for two important drainage basins in the State including the issuance of orders for actual construction of these plants. These basins are the main Delaware River and its principal tributary, the Schuylkill River. The general policy contemplates the building of these plants within a period of two years from the time of notification, with the thought that the work will proceed over the entire watershed area and result in the cleanup of a large river basin.

This project is particularly significant in the Schuylkill River basin because of the comprehensive program in that area for desilting the Schuylkill River of the culm deposited there over perhaps 100 years. The culm originates in the breakers and washeries at the anthracite coal mines at the headwaters. Here the Department's principal function was to prevent the discharge of additional coal silt into state waters. Under the Department's orders, desilting systems have been installed at all of the 47 collieries in that area, resulting in the retention daily of thousands of tons of fine-size coal and other materials formerly dumped into the streams. This is the greatest cleanup job of its kind ever accomplished anywhere, and it is particularly important because of the great use made of the Schuylkill River for public and industrial water supplies, and

for many other purposes. Coincidentally, under the State Department of Forests and Waters, in conjunction with the Federal Government, the silt now in the river will be removed, and this stream will be brought to a usable condition and a far more attractive appearance than at present.

Attention is also being given to the matter of acid mine drainage, for which at present a practical means of treatment is unknown. Research studies on this problem have been underway for three years at the Mellon Institute, Pittsburgh.

Other research projects now underway include: (1) the study of practical methods of treating wastes from small slaughter houses; (2) a biologic study of Conestoga Creek in Lancaster County to determine the effect of pollutants upon stream life; (3) a study of the Clarion River, heavily polluted with industrial wastes and municipal sewage, with a view to determining the needs of this case and means for procuring abatement.

One of the outstanding projects in the entire country is proceeding in the city of Philadelphia where it is expected that some \$60 million will be expended within the next few years in the collection and treatment of the city's sewage. When put in operation, the treatment thus afforded will do much to relieve the Delaware and Schuylkill Rivers of the almost intolerable burden of pollution now imposed on these streams. An important factor in this situation is the requirement of the New Jersey Department of Health upon the city of Camden and other communities in the Philadelphia area to provide treatment of an equivalent degree to that of Philadelphia. Downstream from Philadelphia, a group of some thirty municipalities are making progress in providing for the collection and treatment of the sewage of that entire area.

In the city of Pittsburgh-Allegheny County area a tremendous project is well underway. More than 100 separate municipalities are located there with virtually no sewage treatment in the entire district. To solve this problem the Allegheny County Sanitary Authority was organized, and over the course of two years has studied the problem of collection and treatment of sewage and industrial wastes for all communities involved. This project is estimated to cost \$82 million, and will of course require several years for its completion. When finished and put into operation, its effect on state waters will be most beneficial.

H. E. MOSES, Chief Engineer,
Bureau of Sanitary Engineering,
Commonwealth of Pennsylvania.



Building stones

Tissue repair is the keystone of the recovery process. It makes little difference if the infection is halted, the fracture reduced, or the metabolic imbalance adjusted—it is the patient's own cells that must complete the cure.

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PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division, American Cancer Society, in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

Is Public Response Needed?

DURING the past several years the American Cancer Society has raised and spent many millions of dollars on research, service, and education. Positive accomplishments of its work may be found in all parts of the country. At the same time doctors, hospitals, federal, state, and local government units, and individuals have accomplished much in this field.

This spring the Pennsylvania Division of the American Cancer Society had a record public response to its annual fund campaign, indicating that more and more persons are becoming interested in the organization's three-pronged program of research, education, and service. In view of the tremendous efforts of the doctors, the government, and other organizations and individuals, is this public response needed?

The answer is "yes." Dr. John H. Harris, president of the Pennsylvania Division, American Cancer Society, points out that the organization is the best possible catalyst to stimulate and pull together the efforts of the entire public and all interested groups. The society is set up so that it is a true partnership of doctors and the people in this common effort.

The society's research program already has effected the treatment of many kinds of cancer. Its devoted workers have alleviated thousands of desperate social situations by making modern treatment available. Its educational program has brought the word cancer out into the public eye and brought more and more curable patients early to the doctors' offices.

From the standpoint of the physician, Dr. Harris pointed out, the society's program helps to correct the type of situation that leads unthinking people to clamor for government medicine. If for no other reason than his interest in humanity as a whole, the thoughtful doctor will support this society by working with the organization. He will show the people that he appreciates what they are doing by giving his support to the society in an effort to help promote the cancer control program in Pennsylvania.

New Educational Films

In an effort to have more persons consult their physicians at a time when a possible malignant growth may be cured, the society is expanding its educational program, the latest step of which is to provide professional educational films showing various types of cancer. The series of six films is designed also to be of vital importance to nurses.

The first film, just recently completed, is titled "Cancer, The Problem of Early Diagnosis." The second one, on breast cancer, is being produced now and will be ready for distribution in October. Remaining films will deal with gastro-intestinal, oral, uterine, and lung cancer.

Also being planned is a public educational film designed to teach women how to examine their own breasts for cancer. Two additional motion pictures will be distributed this fall for use in high schools. The one will deal with the biology of cancer and the other is a cartoon-animation film for recruiting volunteer workers. The latter will show scores of jobs that volunteers can fill in helping to spread knowledge concerning cancer.



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1. Rohr, J.H., and Colwell, A.R.: Arch. Int.
Med. 82:54, 1948.

2. ibid Proc. Am. Diabetes Assn. 8:37, 1948.



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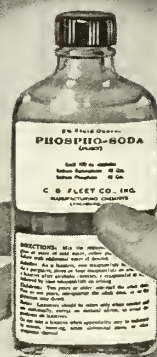
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ACCEPTED FOR ADVERTISING BY THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

547 Water Street

Indiana, Pa.

THE INCOMING PRESIDENT



Mrs. Hinton

After a most successful year as president-elect, Mrs. Drury Hinton will be installed as the president of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania at the twenty-fifth annual convention. Her training and capability for the position are unquestionably high, and her record of performance in lesser Auxiliary offices augurs a wise, efficient, and progressive administration.

Born Elizabeth MacIlroy, daughter of John and Grace (Ward) MacIlroy, she was educated in the McKeesport public schools and was a student of piano at the Pittsburgh Conservatory of Music. Her teachers were Frances Nelson Ferguson and Beveridge Webster, director of the Conservatory. She later studied voice and organ under private instructors. She is a graduate of the University of Pennsylvania Nurses' Training School. For a year preceding her marriage, she was head nurse in Dr. Charles H. Frazier's brain surgery clinic at the University Hospital.

Mrs. Hinton is active in the Episcopal Church of the Holy Comforter of Drexel Hill. She has been secretary of the church school for the past eight years, has directed the junior choir of the church, and is a member of the senior choir and of the woman's auxiliary of the church.

Her husband, Dr. Drury Hinton, a surgeon, practices in Philadelphia and Drexel Hill. They have a daughter, Joyce, aged twelve, who is the proud owner of a beautiful three-gaited chestnut saddle mare which she rides in horse shows. "Joy" attends Friends' Central School and studies music, both piano and violin. Her mother is a member of the P.T.A. and the Nurses' Alumni of the University of Pennsylvania Hospital.

Mrs. Hinton, our president-elect, has long been an active leader in Auxiliary groups, having served as president of the Delaware County Auxiliary in 1942 and 1943 and as councilor of the Second District from 1943 to 1947. Great zeal and success in the organization of new county auxiliaries has been the outstanding feature

of a very busy year as president-elect. Five years on the executive board of the State Auxiliary mean familiarity with every phase of the work and cognizance of each worker's difficulties and problems.

Next to the Auxiliary in Mrs. Hinton's interest these days is a new home, for which ground has just been broken, and which will be built even while her presidential year is fulfilling its great promise.

(MRS. RUFUS M.) CLARA RENFER BIERLY.

WE'VE GOT A JOB TO DO— LET'S DO IT WELL!



Mrs. Craig

This is the assignment given to us by our Medical Society—to assist in carrying out the plans of the National Education Campaign of the American Medical Association. We are all—every doctor and every doctor's wife—asked to distribute material to twenty people, to ask their support in publicizing the dangers of compulsory sickness insurance and the advantages of voluntary insurance. During the summer months we can make our influence felt by getting the story to the people.

In one county auxiliary the first list of twenty names to be turned in to the chairman was from a member who seldom gets to meetings, but who knows the importance of this kind of activity. Her comment, written on the list, was: "These people have already written to their Congressmen." Would that every member was on the job as promptly!

Explain to those with whom you talk the basic effect of compulsory sickness insurance on their personal welfare. Get their active interest in discussing the issue with their families and friends, and in writing to their Congressmen.

To make letter-writing easier, supply them with the names and addresses of Pennsylvania Congressmen, and tell them to write in their own words such things as these: Compulsory

Belle Vista Sanatorium

Chestnut Hill, Philadelphia, Pa.

† † †

State licensed, Belle Vista offers complete sanatorium care for convalescents, senile cases, nervous and mild mental patients. The most advanced ideas in treatment, including hydrotherapy, electroshock therapy, and metrazol are available. Ambulatory cases accepted. Physicians are invited to retain charge of their patients. Reasonable rates.

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Established 1910

Booklet on request

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The ELWYN TRAINING SCHOOL

FOUNDED 1852

Provides practical training for mentally retarded children between the ages of seven and fifteen.

Academic, manual, physical, and musical training by specially trained personnel.

Faculty of twenty teachers and resident staff of three physicians.



For further information, catalog, or rates address:

E. A. WHITNEY, M.D.

Elwyn, Pa.

sickness insurance is political medicine and will be paid for by a *payroll tax*. It is a fatal step toward complete government control of private lives. Ask them to state that they will favor legislation making possible the extension, without government control, of voluntary, prepayment sickness insurance.

For your use, every doctor has supplies of the two pamphlets WB1 and WB2—one with an eagle on the cover called "The Voluntary Way Is the American Way"; the other with a picture of "The Doctor" on the cover called "Your Medical Program—Voluntary or Compulsory." You may also have the Auxiliary pamphlet "Your Family's Future Health." Pamphlet material is available from the Committee on Public Relations, The Medical Society of the State of Pennsylvania, 230 State St., Harrisburg.

Your friends should be told to discuss the issue of health insurance with their friends in the insurance business. These men know that the voluntary way is the American way and are eager to help inform the public and to assist in solving the problem of medical care costs.

Don't rush out and attack the first twenty people you meet. But as the occasion arises, at clubs and parties, and as you talk with salespeople, your baker and the milkman, talk about government medicine. You will be surprised to learn how many know more about the problem than you do and are glad to be asked to participate. Keep a list of those who agree to help.

We have heard it said, "This is not our job." If it is not ours, whose is it? Who cares about the future health of America if not the doctor and the doctor's wife? Who cares if our children are to be saddled with a "scheme whereby those close to the grave fasten themselves on the paychecks of those closer to the cradle and ride piggyback toward the grave" if not the mothers of this country?

Let us tell the story with a sense of civic responsibility, conscientiously and with discretion, as a community service, to protect our country from the political planners who would turn America into a welfare state from which our children cannot escape. This is no year for "social business as usual." It is a year for women to carry the banners, to tell the story. Ask people to decide for themselves. Help them to feel the urgency of the issue and they will thank you for opening their eyes.

As a personal service to your husband, will you see that the poster "The Doctor" is prominently displayed in his office? (It looks well framed.) Be sure that his waiting room table

has, at all times, a good supply of pamphlets. Order the poster and the pamphlets from the State Society.

If you are willing to go further, discuss with the officers of clubs and church groups to which you belong the possibility of having their organization pass a resolution Against the Compulsory Way—For the Voluntary Way. Sample resolutions have been sent to every Auxiliary president and can be obtained from the Harrisburg office.

It is urgent that we get people "on the record" with their opinion on this issue which has been called the great moral issue of our time by no less a person than Lord Horder, eminent physician of England, who should know whereof he speaks.

Auxiliary participation in this program has the approval of the State Medical Society. It is a job which can be effective only if each of us does her part. It is the most important thing we have been asked to do in our twenty-five years as an organization. We can do it at home, on vacation, through the summer, and on into the future, until we are sure that this threat to our children's world is overcome. We've got a job to do—let's do it well!

(MRS. PAUL C.) CATHARINE PALMER CRAIG,
President.

TWENTY-FIFTH ANNUAL CONVENTION

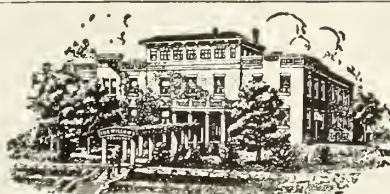
The Silver Anniversary Convention of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania promises to be an outstanding event which alert doctors' wives will not want to miss. The program offers much that is fine for all doctors' wives, as may be seen in the following outline of events arranged by our convention chairman, Mrs. Jay G. Linn, and her vice-chairmen, Mrs. Walter F. Donaldson and Mrs. Howard A. Power.

Of particular notice is the new time of meetings; morning sessions will open at nine o'clock (with the exception of Monday's executive board meeting) and luncheons are scheduled for 12:15.

To insure an interesting convention, panel discussions have been added to the program, with group participation. County and state officers' reports will be mimeographed and distributed for your reading during and after the convention.

A tea will be held Wednesday afternoon honoring our past state presidents.

(Turn to page 1301.)



The Willows Maternity Sanitarium, Inc.

Est. 1905

Superior services for expectant unmarried mothers. Patients accepted any time. Early entrance advised. All adoptions arranged through the Juvenile Court. Rates reasonable and adapted to patient's needs.

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WEST CHESTER, PENNSYLVANIA

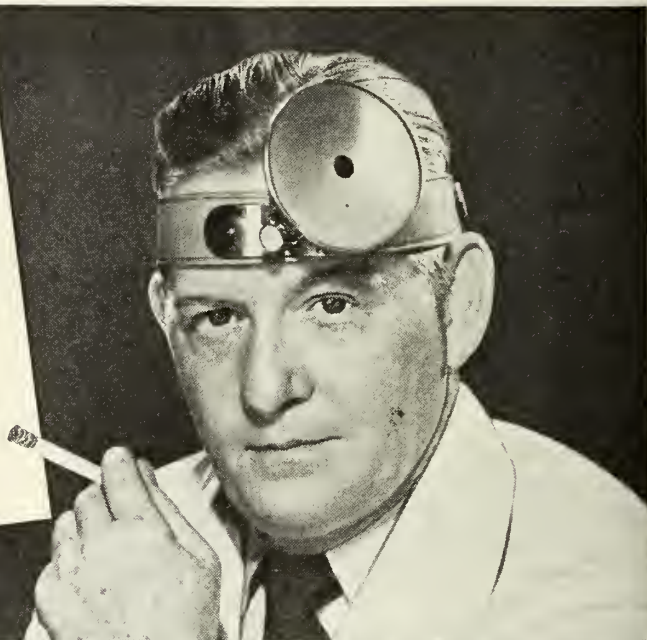
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DOCTORS REPORT

In a recent test of hundreds of people who smoked only Camels for 30 days, noted throat specialists, making weekly examinations, reported

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SMOKERS REPORT

"I MADE THE CAMEL 30-DAY TEST AND I **KNOW!** CAMELS ARE THE MILDEST CIGARETTE I'VE EVER SMOKED—AND SO GOOD TASTING, TOO!"

Rita Edwards
TELEPHONE OPERATOR



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More Doctors Smoke Camels

than any other cigarette

Doctors smoke for pleasure, too! And when three leading independent research organizations asked 113,597 doctors what cigarette they smoked, the brand named most was Camel!

WOMAN'S AUXILIARY—Continued.

YOU will not want to miss this Silver Anniversary Convention. Other surprises await you. Make your hotel reservations NOW! We'll see YOU in Pittsburgh, September 25-28!

PROGRAM

Twenty-fifth Annual Meeting of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania

September 25 to 28, 1949

Headquarters: Roosevelt Hotel, 607 Penn Avenue, Pittsburgh.

Convention chairman—Mrs. Jay G. Linn, 36 Altadena Drive, Pittsburgh 16.

Vice-chairmen—Mrs. Walter F. Donaldson and Mrs. Howard A. Power.

Treasurer—Mrs. Hubert J. Goodrich.

Timekeeper—Mrs. Edgar S. Buyers.

Sunday, September 25

3:45 p.m.

Religious Hour—Stephen C. Foster Memorial Auditorium, University of Pittsburgh.

5:00 p.m.

Tea—Faculty Club, Seventeenth floor, Cathedral of Learning, University of Pittsburgh.

Subscription \$1.00 per person

(Mail reservations for Tea, with check, to The Medical Society of the State of Pennsylvania, 230 State St., Harrisburg, Pa.)

Monday, September 26

Registration—Roosevelt Hotel, 9 a.m. to 12 noon and 2 to 5 p.m.

9:30 a.m.

Pre-convention Executive Board meeting.

Mrs. Paul C. Craig, presiding.

(1948-49 county presidents and presidents-elect, and past presidents of the State Auxiliary are invited to attend this meeting.)

Invocation—Mrs. Charles G. Eicher.

Official business.

12:15 p.m.

Luncheon—in honor of Mrs. David B. Allman, president of the Woman's Auxiliary to the American Medical Association, and Mrs. Paul C. Craig, president of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania.

Mrs. David W. Thomas, presiding.

Chairman—Mrs. William B. Guy.

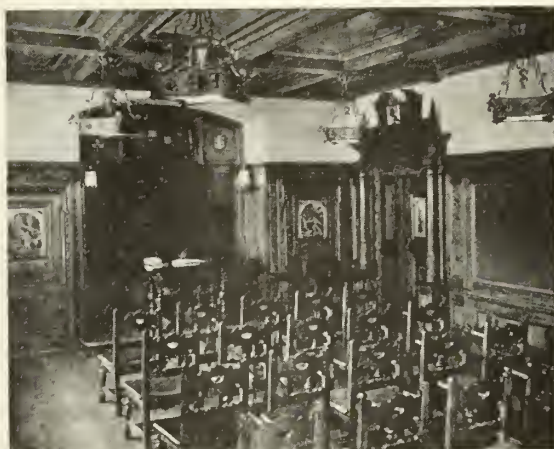
Vice-chairman—Mrs. C. Russell Schaefer.

Invocation—Mrs. J. Newton Hunsberger.

Introduction of 1948-49 county presidents—Mrs. Paul C. Craig.

Address—"The Auxiliary's Place in the Sun"—Mrs. David B. Allman.

(Reservations for Monday luncheon should be sent to Mrs. Edmund C. Boots, 6855 Penn Ave., Pittsburgh 8, chairman of reservations.)



Another room of the Nationality group in the Cathedral of Learning, which will be open to visitors on Sunday afternoon—two to four o'clock.

2:00 to 4:00 p.m.

Panel Discussions:

1. Poster Contest.
2. Health Meetings.
3. Nurse Recruitment and Scholarships.

7:00 p.m.

State dinner—Pittsburgh Room, Hotel William Penn.

Subscription \$5.00 per person

(Mail reservations for State Dinner, with check, to The Medical Society of the State of Pennsylvania, 230 State St., Harrisburg, Pa.)

Tuesday, September 27

9:00 a.m.

Formal opening of convention.

General session.

Invocation—Mrs. James I. Johnston.

Pledge of loyalty—Mrs. Charles C. Crouse.

Address of welcome—Paul G. Bovard, M.D., president of the Allegheny County Medical Society.

Greetings—Mrs. Lester L. Bartlett, president of the Woman's Auxiliary to the Allegheny County Medical Society.

Response—Mrs. Charles H. Smith.

"In Memoriam"—Mrs. Harry B. Jones, Sr.

Solo, "The Lord's Prayer."

Roll call of counties—Mrs. Frank P. Dwyer.

Announcement of the nominating committee—Mrs. Rufus M. Bierly.

Report of registration—Mrs. Robert C. Hibbs.

Reports of officers:

President, Mrs. Paul C. Craig.

President-elect, Mrs. Drury Hinton.

Recording secretary, Mrs. Frank P. Dwyer.

Corresponding secretary, Mrs. John C. Stolz.

Treasurer, Mrs. Edmund C. Boots.

Auditor's report—Mrs. S. Dale Spotts.

Speaker—Pauline Beery Mack, Ph.D., Director, Ella H. Richards Institute, Pennsylvania State College.

Subject, "Eating and Health."

Panel Discussions:

1. How Study Groups Function.
2. Our Part in Legislation.

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Extract of capsicum in an acetone and isopropyl base.

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COOK COUNTY GRADUATE SCHOOL OF MEDICINE

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technique, two weeks, starting August 22, September 26, October 24. Surgical Technique, Surgical Anatomy and Clinical Surgery, four weeks, starting September 12, October 10. Surgical Anatomy and Clinical Surgery, two weeks, starting September 26, October 24. Surgery of Colon and Rectum, one week, starting September 12, October 10. Esophageal Surgery, one week, starting October 10. Thoracic Surgery, one week, starting October 3. Breast and Thyroid Surgery, one week, starting October 10. Fractures and Traumatic Surgery, two weeks, starting October 3.

GYNECOLOGY—Intensive Course, two weeks, starting September 26, October 24. Vaginal Approach to Pelvic Surgery, one week, starting September 19, November 7.

OBSTETRICS—Intensive Course, two weeks, starting September 12, November 7.

MEDICINE—Intensive General Course, two weeks, starting October 3. Gastroenterology, two weeks, starting October 24. Gastroscopy, two weeks, starting September 26, October 24. Electrocardiography and Heart Disease, four weeks, starting September 7.

DERMATOLOGY—Formal Course, two weeks, starting October 24. Informal Clinical Course every two weeks.

ROENTGENOLOGY—Diagnostic and Lecture Course first Monday of every month. Clinical Course third Monday of every month. X-ray Therapy every two weeks.

UROLOGY—Intensive Course, two weeks, starting September 26. Ten-day Practical Course in Cystoscopy every two weeks.

General, Intensive and Special Courses in all Branches of Medicine, Surgery and the Specialties

**TEACHING FACULTY—ATTENDING STAFF
OF COOK COUNTY HOSPITAL**

Address: Registrar, 427 South Honore Street,
Chicago 12, Illinois

12: 15 p.m.

Luncheon.

Mrs. John H. Doane, presiding.

Chairman—Mrs. Alfred W. Crozier, Jr.

Vice-chairman—Mrs. Oliver E. Turner.

Invocation—Mrs. Wellington D. Griesemer.

Guests—Drs. Gilson Colby Engel, E. Roger Samuel, Howard K. Petry, Louis W. Jones, Adolphus Koenig, Walter F. Donaldson, James L. Whitehill, Paul C. Craig, Drury Hinton, Paul G. Bovard, Jay G. Linn, John H. Doane, Miss Ida Little, Mr. Lester H. Perry, Mr. Leo E. Brown, and Miss Suzanne Treadwell.

Speaker—John S. DeTar, M.D., Michigan's foremost family physician for 1948. Subject, "The Country Doctor Views the Changing Scene."

Subscription.

3: 00 p.m.

General session.

Unfinished business.

New business.

Election of delegates to 1950 national convention.

Report of finance chairman—Mrs. S. Dale Spotts.

Report of registration and convention announcements.

8: 15 p.m.

General meeting of The Medical Society of the State of Pennsylvania to be held at the Carnegie Music Hall. Inaugural address by E. Roger Samuel, M.D., president.

Music by Pittsburgh "Little Symphony Orchestra" under the direction of Victor Saudek. Soloists: Mary Martha Briney, soprano, and Bob Carter, tenor.

Wednesday, September 28

8: 00 a.m.

Breakfast—councilors and county presidents for 1949-50.

9: 00 a.m.

General session.

Invocation—Mrs. Laurie Dodd Sargent.

Unfinished business.

Panel discussion—Public Relations and Publicity.

New business.

Report of the resolutions committee—Mrs. Maxwell Lick.

Report of registration—Mrs. Robert C. Hibbs.

Report of nominating committee—Mrs. Rufus M. Bierly.



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MEDICAL DIRECTOR

RATES:

\$50 WEEKLY AND UPWARDS

Election of officers.

Installation of newly elected officers—Mrs. Rufus M. Bierly.

Presentation of gavel to Mrs. Drury Hinton by Mrs. Paul C. Craig.

Address—Mrs. Drury Hinton, president of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania, 1949-50.

Presentation of the past president's pin—Mrs. Charles J. Swalm.

Convention announcements—Mrs. Jay G. Linn.

Adjournment.

12: 15 p.m.

Luncheon.

Mrs. Edward Lyon, presiding.

Chairman—Mrs. Joseph A. Hepp.

Vice-chairman—Mrs. Harold M. Cohen.

Guests—presidents and presidents-elect from our neighboring states—New York, New Jersey, Ohio, Delaware, West Virginia, District of Columbia, and Maryland.

Invocation—Mrs. Leon C. Darrah.

Speaker—Frank G. Dickinson, Ph.D., director of the Bureau of Medical Economic Research, A.M.A. Subject, "Man's Greatest Half Century."

Fashion show.

3: 00 p.m.

Auxiliary tea in honor of past state presidents.

Chairman—Mrs. Linfred L. Cooper.

Vice-chairman—Mrs. Norman A. Hartman.

Program—Mrs. Walter E. Starz.

9: 00 p.m.

President's Reception—Pittsburgh Room, Hotel William Penn. In honor of E. Roger Samuel, M.D., president of The Medical Society of the State of Pennsylvania.

Dancing to Baron Elliot's WCAE Orchestra.

Thursday, September 29

9: 00 a.m.

Breakfast.

Post-convention Executive Board meeting, Mrs. Drury Hinton, presiding. (All members of the Executive Board are urged to be present.)

Chairman—Mrs. Joseph A. Soffel.

Vice-chairman—Mrs. Alfonso Aiello.

Announcement of committee appointments.

Presentation of program for 1949-50.

Plans for work of standing committee chairmen.

Election of Executive Board delegates to 1950 national convention.

Adjournment.

"In a few words, the executive branch of the government is now back to the basic principle of the New Deal—the policy accurately described as "tax and tax, spend and spend, elect and elect." This is the trademark of a Socialist-Labor government, such as that which is steadily reducing the British people to universal poverty."—*Farm Journal*.

SPECIFIC DESENSITIZATION is the aim in Ragweed Pollinosis..

The antihistaminic drugs "do not replace the more lasting benefit obtainable by successful specific . . . desensitization."

Feinberg, S. M.: *Postgrad. Med.* 3: 92 (1948).

"Apparently, desensitization treatment is still the method of choice, and the antihistaminic drugs cannot be considered as substitutes."

Levin, L.; Kelly, J. F., and Schwartz, E.: *New York State J. Med.* 48: 1474 (1948).

The antihistaminic drugs "are valuable additions to our armamentarium, but do not . . . supplant the specific desensitizing injections."

Brown, G. T.: *M. Ann. District of Columbia* 16:675 (1947).

Pollen desensitization "still remains the treatment of choice in hay fever."

Rosen, F. L.: *J. M. Soc. New Jersey* 45: 390 (1948).

DIAGNOSTIC AND TREATMENT SETS

State Pollen Diagnostic Sets (\$7.50): Dry pollen allergens selected according to state; 1 viol house-dust allergen. Material for 30 tests in each viol.

Stock Treatment Sets (\$7.50): Each consisting of a series of dilutions of pollen extracts for hypo-sensitization, with accompanying dosage schedule. Single pollens or a choice of 21 different mixtures. Five 3-cc. viols in each set—1:10,000, 1:5,000, 1:1,000, 1:500, and 1:100 concentrations.

Special Mixture Treatment Sets (\$10.00)

Mixtures of pollen extracts specially prepared according to the patient's individual sensitivities. Ten days' processing time required.

Arlington offers a full line of potent, carefully prepared, and properly preserved allergenic extracts for diagnosis and treatment—pollens, foods, epidermals, fungi, and incidentals.

Literature to physicians on request.

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2 Hanger Legs — Independent Living

A double amputee, Harvey A. Mocy, says: "The pair of Hip Control AK Hanger Limbs are as near perfect as I believe an artificial leg can be. I am satisfied with them in every detail—looks, comfort, and performance. I drive my car with only one added feature, a special hand throttle." Hanger Artificial Limbs here have made possible the important thing for every amputee—returning to self-reliant daily life. Careful fitting and manufacture have done the same for thousands of Hanger Wearers for 88 years.

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Baltimore 1, Maryland
Pittsburgh 30, Penna.
Wilkes-Barre, Penna.

ENGLISH DOCTOR APPEALS TO AMERICAN DOCTORS

(Notes on an address presented by LAWRENCE ABEL, Chief Surgeon, Gordon Hospital, London, England, before the American Proctological Society, Columbus, Ohio, June 1, 1949.)

Subject: "The Present Status of Socialized Medicine in England."

"In order to provide for better medical care for the low income groups, the panel system was inaugurated fifteen years ago. This proved to be inadequate, so that when the present government came into power, it expanded this system to cover everything and everybody." The following facts resulted:

1. The minister of health has become sole arbitrator of medical care.
2. The cost of hospital beds has risen from \$40 to \$80 per week.
3. Eight thousand million dollars worth of private property, hospitals, and endowments have been confiscated by the labor government.
4. Only 10 per cent of religious hospitals remain intact.
5. Of \$1.00 taken from every person for Social Security each week, 14 cents goes for health and 1½ cents goes for the family doctor.
6. Private practice is gone because hospital beds are not available and, if a bed is found, full costs are charged plus 25 per cent in order to discourage private practice.
7. Each specialist is allowed 200 consultations per year—all others must be free.

THE NEW YORK POLYCLINIC

MEDICAL SCHOOL AND HOSPITAL (Organized 1881)

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PROCTOLOGY and GASTRO-ENTEROLOGY

A combined course comprising attendance at clinics and lectures; instruction in examination, diagnosis and treatment; witnessing operations; ward rounds; demonstration of cases; pathology; radiology; anatomy; operative proctology on the cadaver.

For the GENERAL PRACTITIONER

Intensive full-time instruction in those subjects which are of particular interest to the physician in general practice, consisting of clinics, lectures and demonstrations in the following departments—medicine, pediatrics, cardiology, arthritis, chest diseases, gastro-enterology, diabetes, allergy, dermatology, neurology, minor surgery, clinical gynecology, proctology, peripheral vascular diseases, fractures, urology, otolaryngology, pathology, radiology. The class is expected to attend departmental and general conferences.

For Information Address: MEDICAL EXECUTIVE OFFICER, 345 West 50th St., New York 19, N. Y.

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FOR Mild Nervous and Mental Disorders. Located at Mercer, Pa., midway between Pittsburgh and Erie. All private rooms. Electroshock, Hydrotherapy, Occupational Therapy. Licensed by State of Pennsylvania.

Address

J. A. McKAY, M.D., Medical Director



Effect of Services on the Public

The scramble for needed and unnecessary service exceeds all expectations, involving every class of people and demonstrating thoughtlessness and greed. Apparent benefits do not exist. Early diagnosis and proper care are impossible. Thereby medicine is degraded.

The public has neither the prudence nor the control to run the scheme properly.

If America arrives at a cost of any plan, double it, then triple it and still this would not be sufficient. New Zealand is fast beggaring herself with a similar plan.

Effect on the Family Doctor

Seeing sixty to one hundred patients each evening converts the physician's office into a sorting station.

Paper work robs the patient of time which should go to him.

Clinics are neglected.

Patients are dissatisfied and demand multiple consultations, preventing the truly ill from receiving needed attention.

Young doctors have great difficulty getting started. They fill out endless forms and queue up to be sent to areas designated by the government. Too often untrained men are assigned locum tenens. Specialists must make application to lay boards.

Preceptorships have ceased.

Physicians whose sons have followed the medical profession cannot turn their practices over to them.

The practice of medicine, like labor, must be directed by the government.

Quality of Medical Care

This intricate part of the medical profession becomes diluted because of restrictions of freedom, endless directives, and numbers of people seen.

A sense of frustration prevails among all doctors.

Hard-earned skills and reputation now count for nothing.

Effects on Hospitals

These institutions are in the monopoly of the state.

The cost of bed care is doubled.

Specialty private practice is NIL.

Hospital expenses are increasing at an alarming rate.

More and still more administrative employees are added to get the same work done.

Cut-backs have been ordered and some hospitals greatly needed have been closed to save money.

Charity revenue is absent. People have no money to give or leave to charity.

Recently, 10 per cent of hospital beds have been ordered set aside for chronically ill cases, while a great shortage of beds exists which should be provided for the acutely ill. This is a far-reaching waste.

The specialist is now the paid servant of the hospitals and the state.

There is a down-grading of medical men to save money.

In the flood of bureaucracy and detail, research is suffering.

Effect on Doctors

There is no right to arbitration. Doctors have become schemers and there is a constant sense of hopelessness and degradation.

Face the Facts

Keep your freedom, independence, and individuality. When the government gives—it later takes away. In control, it gets thirstier and thirstier. Sometimes it will listen, but advice is never taken.

for Fifty Years

PROFESSIONAL PROTECTION EXCLUSIVELY

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

PHILADELPHIA: E. N. Williams, E. L. Edwards and Richard A. Smith, Representatives,
406 Medical Arts Bldg., Tel. Rittenhouse 6-9223

PITTSBURGH: S. A. Deardorff and B. J. Gallagher, Representatives, 239 Fourth Ave., Tel. Court 5282

Today economic pressure is brought against the profession and blackmail is practiced to force acquiescence and conformance.

Insurance is the only way. A man must know for what he is paying.

America must learn from the sad mistakes of England. Develop something good of your own and teach us, the Old World, the truth of Lincoln's words, "Nothing endures half slave, half free."—Jackson County (Mo.) Medical Society Weekly Bulletin.

BUREAUCRATS' BONANZA—SOCIALIZED MEDICINE

When in 1933 Harry Hopkins had worn himself to a nubbin spending the taxpayers' money and the treasury was growing anemic, President Roosevelt, fearing that he might sacrifice a good confederate and jeopardize his spending spree, takes more money out of the taxpayers' purse and sends Harry on a health-building sea voyage with instructions to look over "social insurance schemes in England, Germany, Austria, and Italy because I think you might pick up some ideas useful to us in developing our own American plan for security." Can any kind of security come out of Europe? These two obsessive, compulsive spendthrifts were looking over the field where already so-called security was wrecking national honor and integrity, in order to enlarge their own plans for riotous spending on the road to ruin.

In spite of personal contact with the Nazi régime and his observation of the blood purge, the decline of the Reichstag, the death of Hindenburg, the murder of Dollfuss, and Hitler's swift rise to total power, Harry returned with a flaming torch from the Bismarckian social security plan already responsible for the European conflagration. This torch set the social security fire ablaze for the New Deal. Thus millions of American citizens have lost their liberty and their self-respect while being placed under obligation to the government that enslaves them.

Strange to say, the man who ignored the European social security debacle made bold to say in his speech of acceptance, when appointed secretary of commerce: "We find ourselves in a world which seems to have gone almost crazy in a welter of hates and fears, and in which a new and competitive philosophy has suddenly emerged; a world in which dictatorships, both red and black, have swept aside with ruthless decision almost all of the liberties and freedoms that have made life beautiful and wholesome." Considering his acknowledged power of perception and his opportunity to see all this in Germany, one wonders about his sincerity.

After having channeled billions upon billions of the taxpayers' dollars through thousands upon thousands of hatched-up projects, we now come to the bureaucrats' bonanza—socialized medicine.

The present plan under the guise of the Ten Year Prescription is to enslave all the people as soon as possible. Ostensibly the prescription is written for ten years, but the chains accompanying this generous gesture are forged for life. Socialized medicine is the soul of dissembling and destruction.—*Journal of the Oklahoma State Medical Association*, February, 1949.



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MEDICAL NEWS

Births

TO DR. AND MRS. LINCOLN GODFREY, JR., of Rosemont, a daughter, Margaret Rawle Godfrey, July 9.

TO DR. AND MRS. FRANCIS G. HARRISON, JR., of Rosemont, a son, Francis Grillet Harrison, 3d, July 11.

Engagements

MRS. ELAINE F. KAUFMAN to Philip Rosenberg, M.D., both of Philadelphia.

MISS LOIS ATKINSON to Roy Deck, Jr., M.D., son of Dr. and Mrs. Roy Deck, all of Lancaster.

MISS FRANCES TABOR McDONALD, of St. Davids, to Mr. Jay C. Sands, son of Dr. and Mrs. Joseph E. Sands, 2d, of Rosemont.

MRS. CHARLES HENRY WIGHT, of Wayne, to Mr. William George Gerhard, son of Arthur H. Gerhard, M.D., of Philadelphia, and the late Mrs. Gerhard.

MISS AUDREY G. SMITH, daughter of Dr. and Mrs. J. Hunter Smith, 2d, of Drexel Hill, to Mr. James Lee Harrison, a student at Hahnemann Medical College.

Marriages

MISS MARY ELIZABETH DUCK to Harry H. Haddon, Jr., M.D., both of Philadelphia, July 23.

MRS. SYLVIA FALK of Hagerstown, Md., to Jack W. Cutler, M.D., of Philadelphia, July 16.

MISS MARJORIE BARBARA KNAPP to Mr. Rufus Wielder Miller, 2d, son of Dr. and Mrs. Hugh McCauley Miller, all of Wyncote, June 24.

MISS MARY DEHAVEN STICK, daughter of Dr. and Mrs. Edward W. Stick, of Hanover, to Mr. Wiley T. Jones, II, of Memphis, Tenn., July 18.

MISS JANE ARMSTRONG SPONSER, daughter of Marshall B. Sponsler, M.D., of Drexel Hill, to Mr. Robert Joseph Garland, of Philadelphia, July 30.

MISS JULIA URSULA SINKLER, daughter of Dr. and Mrs. Francis W. Sinkler, of Bryn Mawr, to Mr. H. Gordon Fraser, Jr., of Providence, R. I., July 2.

MISS ELOISE ELIZABETH HUNT, daughter of Dr. and Mrs. Henry F. Hunt, of Danville, to Mr. James Howe Comerford, of Ardsley-on-Hudson, New York, July 2.

MISS NANCY MILLER MCKINNEY, daughter of Dr. and Mrs. Walter B. McKinney, of Broadaxe, to Mr. Harold Farquhar Jones, son of Dr. and Mrs. Harold W. Jones, of Wynnewood, June 28.

Deaths

○ Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

○ John S. McCafferty, Freeport; University of Pittsburgh School of Medicine, 1933; aged 40; died suddenly in a restaurant in Montreal, Canada, July 3, 1949. A specialist in heart diseases, Dr. McCafferty was a member of the medical staff of Allegheny Valley Hospital. He was a major in the U. S. Army Medical Corps during World War II. Serving as a transport surgeon, he made many trips to overseas ports. He is survived by his widow, his mother, two sisters, and a brother. A year ago a brother was killed in a plane crash in Leesburg, Va., and about fifteen years ago another brother died in an automobile accident.

○ Harry A. D. Baer, Allentown; Jefferson Medical College of Philadelphia, 1917; aged 61; died July 14, 1949, of a cerebral hemorrhage. Dr. Baer founded the ten-bed Baer Hospital which he operated for twenty-six years. When he closed it two years ago, he said: "I've enjoyed every minute of my time in medicine and I intend to continue private practice until my death." He was a minister for two years before studying medicine. During World War I, he was a flight surgeon of the 29th Aero Service Squadron of the U. S. Army at Camp Knox, Ky. His mother and a sister survive.

○ Virginia M. Alexander, Philadelphia; Woman's Medical College of Pennsylvania, 1925; aged 49; died July 24, 1949, after a short illness. In 1937 Dr. Alexander entered the field of public health after completing graduate studies at the Yale University School of Medicine. She was medical adviser to the student body at Howard University, Washington, D. C., and served with the U. S. Public Health Service. She was a staff member of the Woman's Medical College Hospital and Mercy-Douglass Hospital. Surviving are her father, a sister, and two brothers.

○ William J. Carey, Philadelphia; Hahnemann Medical College and Hospital of Philadelphia, 1936; aged 38; was killed in an automobile accident July 1, 1949. Dr. Carey was a captain in the U. S. Army Medical Corps during World War II. Prior to the war, he practiced in Girardville. He is survived by his widow, who is a nurse at Memorial Hospital, Roxborough, a son, a daughter, his mother, a brother, and three sisters.

○ Charles K. Shanor, Sewickley; University of Pittsburgh School of Medicine, 1909; aged 66; died July 19, 1949. Dr. Shanor retired in 1946 after practicing for thirty-seven years. He was a staff surgeon and x-ray specialist at Sewickley Valley Hospital. During World War I, he served in the U. S. Army Medical Corps. Surviving are his widow, a son, a brother, and three sisters.

○ Charles A. Blayney, Penfield; Jefferson Medical College of Philadelphia, 1900; aged 80; died July 11, 1949, after a long illness. For thirty-five years, Dr. Blayney was medical adviser to Gimbel Brothers, Philadelphia. He retired five years ago. Surviving are his widow, a brother, a sister, and a grandson.

○ Hagop G. Barsumian, Lancaster; Jefferson Medical College of Philadelphia, 1904; aged 74; died June 27, 1949, following a long illness. Dr. Barsumian was born in Aintab, Turkey, and came to the United States in 1897. He is survived by his widow.

William Udell, Philadelphia; Medico-Chirurgical College of Philadelphia, 1909; aged 71; died July 29, 1949. He was retired. Three sisters and a brother survive.

○ Jacob G. Silewski, Nanticoke; Friedrich-Wilhelms-Universität Medizinische Fakultät, Berlin, Germany, 1923; aged 53; died suddenly July 21, 1949, in New York City.

○ George F. Wright, Johnstown; Hahnemann Medical College and Hospital of Philadelphia, 1921; aged 57; died June 9, 1949.

○ Arthur J. Denman, Narberth; New York University College of Medicine, 1913; aged 61; died June 24, 1949.

Miscellaneous

CLARENCE E. MOORE, M.D., of Harrisburg, won the 1949 championship of the American Medical Golfers' Association during the recent Atlantic City session of the A.M.A. In competition against 211 physicians, Dr. Moore scored 148 (71-77) for 36 holes.

THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, 1015 Highland Bldg., Pittsburgh 6, Pa., reports having recently certified 236 candidates and announces that application (part I) may be had upon request made before Nov. 5, 1949.

THE INTERNATIONAL COLLEGE OF SURGEONS, United States Chapter, will hold its fourteenth annual assembly and convocation in Atlantic City, N. J., Nov. 7 to 12, 1949, according to David B. Allman, M.D., Atlantic City, chairman of the assembly.

A GROUP OF GENERAL PRACTITIONERS from Cumberland, Dauphin, Perry, York, Lancaster, Adams, Franklin, and Lebanon counties met on July 10 for the purpose of organizing a local chapter of the Pennsylvania Academy of General Practice. The following officers were elected for the coming year: Creedin S. Fickel, Carlisle, president; Josiah A. Hunt, Delta, vice-president; and William H. Gelnett, Millerstown, secretary.

RALPH S. METHENY, M.D., chief of professional services at the Veterans Administration Hospital in Louisville, Ky., has been appointed manager of the 200-bed hospital under construction in Altoona, Pa. The new manager will supervise the activation of the hospital, construction of which is scheduled for completion in November of this year. A graduate of the University of Nebraska College of Medicine in 1930, Dr. Metheny was in private practice from 1931 to 1933.

THE FIFTY-FOURTH ANNUAL CONVENTION of the National Medical Association, representing the Negro medical profession in the United States, met in Detroit August 8 to 12. After the general opening meeting, the scientific assembly broke up into various sectional meetings, which were held in five of the large hospitals of the city. One entire day was spent by the medical and surgical sections at the University of Michigan Hospital in Ann Arbor.

HILDING A. BENGS, M.D., was appointed State Commissioner of Mental Health in July at an annual salary of \$11,000. A native of Smethport, the appointee to the newly created post spent twelve years on the War-

ren State Hospital staff before going to Harrisburg in 1944 as assistant director of the Bureau of Mental Health in the State Welfare Department. He has been director of the bureau the last three years. Governor Duff appointed Dr. Bengs to provide "over-all professional coordination of the commonwealth activities in the mental health field."

CHEVALIER JACKSON, M.D., honorary professor of broncho-esophagology at Temple University School of Medicine, Philadelphia, has received an honorary fellowship from the Royal College of Surgeons in Edinburgh, Scotland. He was one of two American delegates to the International Congress of Otolaryngology in Edinburgh honored by the Royal College. The other was Kurth Hermann Thoma, M.D., professor of oral surgery at Harvard University. Dr. Jackson, who is now nearly 84 years old and has been in retirement for thirteen years, celebrated his fiftieth wedding anniversary with Mrs. Jackson on July 9.

ON JULY 14 THE COLLEGE OF PHYSICIANS of Philadelphia awarded the Alvarenga Prize for 1949 to Owen Harding Wangenstein, M.D., Ph.D., professor of surgery at the University of Minnesota, for his important contributions to the etiology and therapy of gastric and duodenal ulcer. Dr. Wangenstein will deliver the Alvarenga Lecture on this subject at the College of Physicians of Philadelphia on Nov. 2, 1949.

The Alvarenga Prize was established by the will of Pedro Francisco da Costa Alvarenga of Lisbon, Portugal, an associate fellow of the College of Physicians of Philadelphia, to be awarded annually by the College of Physicians on the anniversary of the death of the testator, July 14, 1883.

THE *New England Journal of Medicine* reports that Harvard University has again hewn to the line in its recognition of academic merit by the appointment of Dr. William A. Hinton as clinical professor of bacteriology and immunology at the Harvard Medical School. Dr. Hinton thus becomes the first Negro to hold a professorship in Harvard University.

Dr. Hinton was graduated from Harvard College in 1905 and from Harvard Medical School in 1912; he joined the staff of the Harvard Medical School in 1923 and has remained on it consistently ever since.

An authority on rabies, Dr. Hinton, is best known for his research in syphilology and for the development of the Hinton and the Davies-Hinton tests for syphilis.

MELLON INSTITUTE WILL AGAIN JOIN WITH THE University of Pittsburgh's School of Medicine in holding the second annual Symposium on Orthopedic Appliances at the Institute during the week of Sept. 19, 1949. The first symposium, which was fully successful in every

POSTGRADUATE COURSE AT HAHNEMANN MEDICAL COLLEGE AND HOSPITAL

Another postgraduate course in Cardiology will be given during the coming winter. Starting in October, on Thursday afternoons from 3:00 to 5:00, thirty sessions will be held. Modern diagnosis and treatment of various forms of heart disease will be covered. Registration is limited and individual instruction will be emphasized.

Detailed information will be forwarded upon request to DR. GEORGE D. GECKELER, Hahnemann Hospital, Philadelphia 2. Early registration is suggested.



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respect, has been cited as a "dynamic example of cooperation among scientists, physicians, engineers, and technicians."

The second symposium, also sponsored by the Sarah Mellon Scaife Foundation through its Multiple Fellowship on Orthopedic Appliances in the Institute, will be open to invited orthopedic physicians and surgeons as well as to selected orthopedic technologists skilled in brace design, fitting, and construction. The symposium's lecture staff will include a number of nationally recognized authorities in orthopedics as well as scientists of Mellon Institute. They will give detailed attention to bracing problems in cerebral palsy, paraplegia, and hemiplegia resulting from poliomyelitis and other disabling diseases, to scoliosis and related spinal conditions, and to other specialized orthopedic problems.

This year, arrangements have been made to have all registrants as well as our non-resident lecture staff housed in the Schenley and Webster Hall Hotels, immediately adjacent to the University campus and to Mellon Institute. Hotel reservations will be placed for all persons finally accepted for attendance through the Orthopedic Appliances Fellowship at the Institute.

The fee for attendance at the Symposium will be ten dollars, payable at the time of registration, Monday morning, September 19.

CLASSIFIED ADVERTISEMENTS

Classified advertisements are payable in advance. To avoid delay in publishing, remit with order.

RATES: 1 insertion, 10c per word; 3 insertions, 9c; 6 insertions, 8c; 12 insertions, 7c. Minimum rate for any number of words, \$3.00. A fee of 25c is charged advertisers for answers sent in care of the JOURNAL.

For Rent.—Offices of retiring general practitioner. Location established for 35 years. Write CHARLES A. FITZGERALD, M.D., Clarion, Pa.

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Wanted.—House physician with Pennsylvania license for 185-bed general hospital 18 miles from Pittsburgh. Adequate salary. New Hospital addition planned. Good location for later private practice. Apply to DIRECTOR, Citizens General Hospital, New Kensington, Pa.

For Rent.—Offices, used for 40 years by eye, ear, nose and throat specialist, now deceased. Excellent location. Center of business district. Ground floor. Living quarters available if desired. Write W. CULLEN GOURLEY, 108 S. Findley St., Punxsutawney, Pa.

Position Wanted.—Physician who has just completed two-year rotating internship desires assistantship or locum tenens in or near Philadelphia. Class A medical school graduate. Pennsylvania license. Write Dept. 169, PENNSYLVANIA MEDICAL JOURNAL.

For Rent.—Office rooms in desirable location. Office furniture for sale at reasonable price. Growing population of 23,000 in vicinity. Great need for general practitioner. Hospital facilities near. Vacancy left by death of doctor who had been established for 30 years. Write P. O. Box 387, Carmichaels, Greene County Pa.

Wanted.—General practitioner to locate in Marion Center, Indiana County. Good farming and coal mining section on Buffalo to Pittsburgh highway. Fine schools and churches. Two hospitals within 15 miles. For further details write MR. CHARLES P. NIGHTINGALE, Marion Center Lions Club, Marion Center, Pa.

For Sale.—Ideal property for convalescent home located at Blue Bell, Montgomery County, one mile from Pennlyn Station, Reading Railroad. Well-built house, 150 feet from road with large lawn and trees, three baths, nine bedrooms, and five porches. Two acres of ground. Asking \$21,500. Write or phone HARRY Z. MAXWELL, Blue Bell, Pa. Telephone Ambler 0941.

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BOOK REVIEWS

ORAL AND DENTAL DIAGNOSIS. With suggestions for treatment. By KURT H. THOMA, D.M.D., F.D.S.R.C.S. Eng., Professor of Oral Surgery, Emeritus, and Brackett Professor of Oral Pathology, Harvard University; Lecturer on Oral Surgery, Graduate School of Medicine, University of Pennsylvania. With contributions by Henry Goldman, D.M.D., Head of the Dental Department, Beth Israel Hospital, Boston, and Fred Trevor, D.M.D., formerly Instructor in Oral Pathology, Harvard Dental School. Third edition with 776 illustrations, 60 in color. Philadelphia: W. B. Saunders Company, 1949. Price, \$9.50.

This is the third edition of one of Thoma's several texts. It is well outlined, easy to read, and rich in illustrations, as are most of Thoma's works. The style is characteristic of Thoma with an extensive bibliography being used.

The book is divided into two parts, the first dealing with methods of examination and diagnosis, and the second with diagnosis and treatment of dental and oral diseases. The outline form in which it is written serves as a reference for a quick review and aids in making a rapid diagnosis. Local and systemic diseases affecting the mouth and its related parts are covered, including the less common conditions. Treatment is included and is brought up to date in this edition.

This book is of value to the student, dentist, dental specialist, and any physician interested in or confronted by problems of the mouth.

NUTRITION AND DIET IN HEALTH AND DISEASE. By JAMES S. McLESTER, M.D., Professor of Medicine, University of Alabama, Birmingham. Fifth edition. 800 pages. Philadelphia: W. B. Saunders Company, 1949. Price, \$9.00.

With the publication of this new edition, Dr. McLester has endeavored to bring our knowledge of nutrition and diet up to date. For the most part he has succeeded admirably. The sections on protein, folic acid, and para-aminobenzoic acid have been considerably amplified. The low sodium diet in congestive heart failure, the role of diet in essential hypertension, and the newer nutritional concepts in pernicious anemia, peptic ulcer, and liver disorders are adequately discussed. The chapters on Nutrition in Surgery by Lund and Feeding of Infants by Jeans are of special merit. Food tables and daily dietary allowances have been revised.

Unfortunately, the consideration of fat metabolism in arteriosclerosis and "alimentary obesity" are inadequate. With regard to the last-mentioned syndrome, the author appears to be somewhat nebulous, as illustrated by the following sentence: "If, however, such a person has the strength of character for a time to deny himself and to change his dietary habits, it is surprising how readily his appetite will readjust itself and permit him to remain comfortable upon a more appropriate regimen." Such a statement needs considerable elaboration for the clinician, in order that he may help the patient, via individual selective procedures, to diminish his excess need for oral gratification.

Also absent from the text is detailed information on dietary histories, food habits, and nutritional behavior, with particular reference to the fundamentals of hunger and appetite, which seems necessary for the application of all nutritional programs. However, the fact that this book is now in its fifth edition attests to its continued practical value to all physicians.

POLIOMYELITIS. Papers and discussions presented at the First International Poliomyelitis Conference. Compiled and edited for the International Poliomyelitis Congress. Philadelphia: J. B. Lippincott Company, 1949. Price, \$5.00.

This is a truly remarkable compilation, the objective being the coordination and evaluation of the progress made by medical science in the study of infantile paralysis during the past decade. International and worldwide views are brought together in this particularly interesting book and it offers a postgraduate course to all who are interested in the fight against poliomyelitis.

The contents are divided into ten sessions as follows:

Session One—The Importance of Poliomyelitis as a World Problem

- a. Epidemiologic Patterns in Different Parts of the World
- b. Economic Aspects of Management
- Discussion

Session Two—Poliomyelitis; Pathogenesis of the Early Stage

- a. Evolution of Signs and Symptoms
- b. Pathologic Anatomy
- c. Some Aspects of the Pathologic Physiology

Session Three—The Management of Poliomyelitis in the Early Stage

- a. Diagnosis and Treatment
- Discussion

Session Four—Poliomyelitis; the Convalescent Stage

- a. Progressive Pathology
- b. Progressive Disabilities
- c. Progressive Deformities
- Discussion

Session Five—The Management of Poliomyelitis in the Convalescent Stage

- Discussion

Session Six—Problems of Rehabilitation

- a. Management of Poliomyelitis in the Late Stage
- Discussion

Session Seven—Bulbar Poliomyelitis

- a. Pathologic Aspects
- b. Neurologic Signs
- c. Outline of Essential Treatment
- Discussion

Session Eight—Immunology and Chemotherapy in Poliomyelitis

- a. Mechanisms of Immunity
- b. Immunologic Types of Viruses
- c. Experimental Chemotherapy
- Discussion

Session Nine—Public Health Aspects of Epidemic Poliomyelitis

- a. Public Health Measures
- b. Hospitalization of the Poliomyelitis Patient
- c. Families of Children with Poliomyelitis
- Discussion

Session Ten—Poliomyelitis Throughout the World

- a. Official Delegates from Foreign Countries
- Index

The statistical data are well illustrated and easily understood. The illustrations of pathologic anatomy are clear and concise, and those on the management of poliomyelitis are also exceptionally good.

This book is the work of twenty-two outstanding authorities with both laboratory and clinical experience in poliomyelitis. There is an extensive bibliography and index. Certainly this book can be considered a milestone in the field of medical literature. It can be used both as a textbook and as a reference. The publishers should be commended for the clarity of their print and illustrations.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

PAPERS ON PSYCHO-ANALYSIS. By ERNEST JONES, M.D., F.R.C.P. (Lond.), President of the International Psycho-Analytical Association; Honorary President of the British Psycho-Analytical Society; Founder of the International Journal of Psycho-Analysis; Consulting Physician to the London Clinic of Psycho-Analysis; Honorary Fellow of the British Psychological Society. Fifth edition. Baltimore: The Williams & Wilkins Company, 1949.

TRENDS IN MEDICAL EDUCATION—The New York Academy of Medicine Institute on Medical Education, 1947. Edited by MAHLON ASHFORD, M.D. New York: The Commonwealth Fund, 1949. Price, \$3.00.

AESCULAPIUS COMES TO THE COLONIES.

The Story of the Early Days of Medicine in the Thirteen Original Colonies. By MAURICE BEAR GORDON, M.D. Ventnor, N. J.: Ventnor Publishers, Inc., 1949. Price, \$10.00.

THE SKIN PROBLEM FACING YOUNG MEN AND WOMEN.

By HERBERT LAWRENCE, M.D., Diplomate of American Board of Dermatology. San Francisco: Timely Publications, 1949.

MEDICINE OF THE YEAR, 1949. Editorial direction, JOHN B. YOUMANS, M.D., Dean, College of Medicine, University of Illinois. Internal Medicine, HUGH J. MORGAN, M.D., Professor of Medicine, Vanderbilt University; Obstetrics, FRANK WHITACRE, M.D., Professor of Obstetrics and Gynecology, University of Tennessee; Pediatrics, HENRY G. PONCHER, M.D., Professor of Pediatrics, University of Illinois; Surgery, WARREN H. COLE, M.D., Professor of Surgery, University of Illinois. Philadelphia: J. B. Lippincott Company, 1949. Price, \$5.00.

REGIONAL ILEITIS. By BURRILL B. CROHN, M.D., Consulting Gastro-entecrologist, Mount Sinai Hospital, New York. New York: Grune & Stratton, 1949. Price, \$5.00.

MEDICAL ETYMOLOGY. The History and Derivation of Medical Terms for Students of Medicine, Dentistry, and Nursing. By O. H. PERRY PEPPER, M.D., Professor of Medicine, University of Pennsylvania. Philadelphia: W. B. Saunders Company, 1949. Price, \$5.50.

OPERATIVE TECHNIC IN GENERAL SURGERY. Edited by WARREN H. COLE, M.D., F.A.C.S., Professor and Head of the Department of Surgery, University of Illinois College of Medicine; Director



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of Surgical Service, Illinois Research and Educational Hospitals, Chicago. Introduction by Frank H. Lahey, M.D., F.A.C.S. New York: Appleton-Century-Crofts, Inc., 1949. Price, \$16.00.

CARDIOVASCULAR DISEASE. Fundamentals, Differential Diagnosis, Prognosis and Treatment. By LOUIS H. SIGLER, M.D., F.A.C.P., Attending Cardiologist and Chief of Cardiac Clinic, Coney Island Hospital; Consulting Cardiologist, Rockaway Beach Hospital; Consulting Cardiologist, Memorah Home and Hospital for the Aged. New York: Grune & Stratton, 1949. Price, \$10.00.

MANUAL OF MEDICAL EMERGENCIES. By STUART C. CULLEN, M.D., Professor of Surgery; Chairman, Division of Anesthesiology, State University of Iowa College of Medicine, and E. G. GROSS, M.D., Professor and Head of Department of Pharmacology, State University of Iowa College of Medicine. Chicago: The Year Book Publishers, 1949. Price, \$3.75.

SUNBURN AND CHIGGER REMEDIES MAKE SUMMER MORE COMFORTABLE

The simplest and most effective treatment for mild sunburn is the application of cold compresses of strong tea, says Sigmund S. Greenbaum, M.D., professor of dermatology and syphilology at Jefferson Medical College, Philadelphia.

"The tannic acid in the tea often relieves the pain at once and within twenty-four hours may convert the

sunburn into a gratifying tan," he writes in the July issue of *Hygeia*.

The compresses can be made by dipping any clean white cloth into the tea, which has been allowed to cool, and wringing out the excess moisture.

Cold compresses of milk or carron oil are also beneficial for mild sunburn, according to Dr. Greenbaum.

"In recent years, numerous remedies have appeared on the market, either to prevent sunburn or to help the user to achieve a uniform tan," he points out. "There is a variety of widely advertised greases containing local anesthetics which relieve the pain of mild sunburn, but they are of little value if blistering has occurred. Such anesthetics may interfere with healing and, of course, are harmful to those sensitive to them."

Sunburn prevention and sun tan preparations are of three general varieties, Dr. Greenbaum explains: opaque substances, such as phenyl salicylate or salol, zinc oxide ointment, some types of red vaseline, cold cream, or oil; fluorescent substances such as quinine sulfate; and tanning substances, such as tannic acid.

The first two types of preparations are the best for preventing sunburn, he advises, although all offer some protection. Too much should not be expected of any sunburn preparation, however; common sense is still the best preventive.

For chiggers which accompany sun tan acquired on grass, a hot soapy bath as soon as possible after exposure may help by washing them off before they have a chance to dig in, says another article in the same issue of the magazine. Dusting sulfur in shoes and socks is a helpful precaution before hiking in weeds and grass.



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An Editorial



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* Cecil, R. A.: A Textbook of Medicine. Philadelphia, W. B. Saunders Co., 1947, p. 376.

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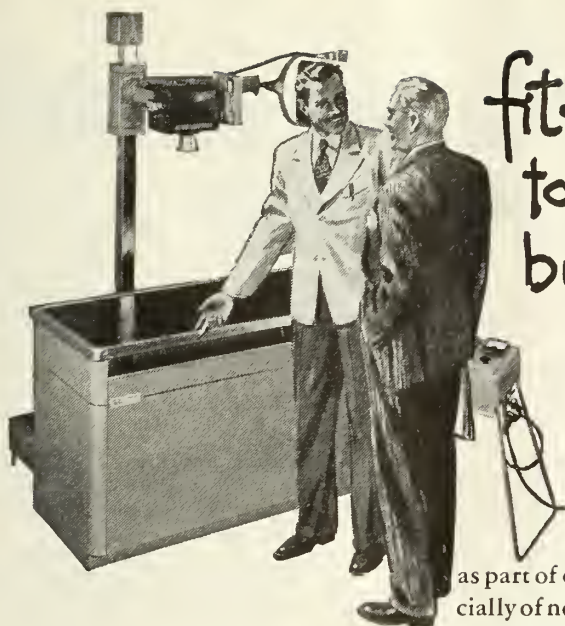
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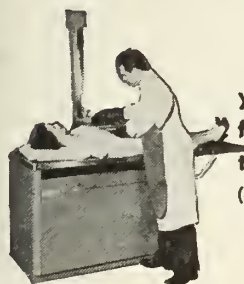


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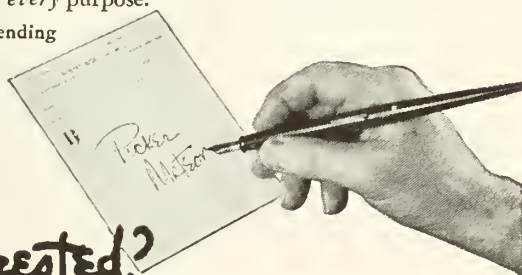
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delayed diagnosis

is enemy number one of

DIABETICS

A million or more diabetics are undetected and untreated.† But only about 55,000 new cases are being discovered each year in the course of insurance examinations and routine checkups. Early diagnosis and prompt treatment give the physician his best opportunity to ameliorate the disease and to avert or delay its complications.

An urgent problem

How shall the unknown diabetic be detected and directed to the doctor's office for diagnosis and proper treatment?

An important answer

AMES Selftester*

a quick home screening test that brings those with glycosuria to you for diagnosis

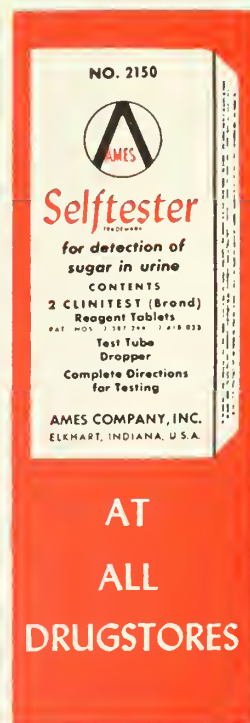
The Ames Selftester for detection of sugar in urine is approved by the Council of the American Diabetes Association. It is a simple, reliable screening test to establish the presence or absence of urine-sugar and "refer" those with glycosuria to you for diagnosis.

The directions state:

1. The Selftester does not diagnose diabetes or any other disease. Its sole function is the detection of sugar (glucose) or sugar-like substances.
2. If reaction is positive, see your doctor at once. Sugar in your urine does not necessarily mean you have diabetes (nor does a negative result definitely exclude the presence of disease). But only your doctor, by medical examination and by additional laboratory tests, can tell you why you show sugar.

† Wilkerson, H. L. C. and Krall, L. P. Diabetes in a New England Town, Journal of the American Medical Association, 135:209 (Sept. 27) 1947.

* Ames Selftester —TRADE MARK



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LIST OF COUNTY MEDICAL SOCIETIES OF PENNSYLVANIA

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS
Adams	John J. Knox, Gettysburg	Raymond M. Hale, Arendtsville	Monthly
Allegheny	Paul G. Bovard, Pittsburgh	William F. Brennan, Pittsburgh	Monthly†
Armstrong	F. O'Neil Robertson, Jr., Cadogan	Cyrus B. Slease, Kittanning	Monthly*
Beaver	George R. Boyd, Beaver Falls	J. Willard Smith, Beaver Falls	Monthly
Bedford	John A. Topper, Hyndman	Joseph A. Eyler, Bedford	Monthly
Berks	Archibald R. Judd, Hamburg	Clair G. Spangler, Reading	Monthly
Blair	Robert M. Keagy, Altoona	George R. Good, Altoona	Monthly*
Bradford	George E. Boyer, Troy	Stanley D. Conklin, Sayre	Monthly
Bucks	Clifford Laudenslager, Doylestown	Walter J. Hendricks, Perkasie	6 a year
Butler	Charles B. Turnblacer, Butler	Joseph Van S. Donaldson, Butler	Monthly*
Cambria	Francis T. Carney, Johnstown	Warren F. White, Johnstown	Monthly
Carbon	Marvin Evans, Lansford	John L. Bond, Lehighton	Bimonthly
Centre	William L. Welch, State College	Hiram T. Dale, State College	Monthly
Chester	Alfred L. Chicote, Phoenixville	Francis Jacobs, West Chester	Monthly
Clarion	George P. Deacy, Rimersburg	James M. Hess, Tylersburg	Quarterly
Clearfield	Maximo J. Tornatore, Clearfield	George C. Covalla, Clearfield	Monthly
Clinton	William C. Long, Jr., Lock Haven	David W. Thomas, Lock Haven	Monthly
Columbia	G. Paul Moser, Bloomsburg	Jesse G. Fear, Berwick	Monthly
Crawford	John P. Hobson, Cambridge Springs	Robert G. Pett, Meadville	Monthly
Cumberland ...	E. Blaine Hays, Carlisle	Richard R. Spahr, Mechanicsburg	Bimonthly
Dauphin	A. Harvey Simmons, Harrisburg	Hamblen C. Eaton, Harrisburg	Monthly*
Delaware	Walter E. Wentz, Jr., Media	Walter E. Egbert, Chester	Monthly
Elk	Augustine C. Luhr, St. Marys	Robert J. Dickinson, Ridgway	Monthly*
Erie	James H. Delaney, Erie	Russell B. Roth, Erie	Monthly
Fayette	Harold L. Wilt, Brownsville	Rudolph E. Medlen, Uniontown	Monthly
Franklin	Robert B. Brown, Waynesboro	Earl Glotfelty, Waynesboro	Monthly
Greene	Wayne E. Booher, Waynesburg	C. Leonard O'Connell, Waynesburg	Monthly
Huntingdon ...	Charles L. Schucker, Huntingdon	Robert H. Beck, Huntingdon	Monthly
Indiana	Warren L. Whitten, Indiana	Harry B. Neal, Jr., Indiana	Monthly
Jefferson	Raymond F. O'Connor, Punxsutawney	E. Nicholas Sargent, Falls Creek	Monthly
Juniata	Samuel F. Metz, Thompsontown	Robert P. Banks, Mifflintown	Bimonthly
Lackawanna ..	Michael G. O'Brien, Scranton	Victor J. Margotta, Dunmore	Weekly
Lancaster	Charles W. Ursprung, Lancaster	Charles P. Stahr, Lancaster	Monthly
Lawrence	Charles H. Whalen, New Castle	Wilbur E. Flannery, New Castle	Monthly
Lebanon	Herbert C. McClelland, Lebanon	J. DeWitt Kerr, Lebanon	Monthly*
Lehigh	Rowland W. Bachman, Allentown	J. Frederic Dreyer, Allentown	Monthly
Luzerne	Marvin C. Johnson, Kingston	Joseph W. Ehrhart, Forty Fort	Semimonthly*
Lycoming	James H. Burrows, Williamsport	Raymond A. Davis, Williamsport	Monthly
McKean	Homer A. Wilson, Bradford	Persis Straight Robbins, Bradford	Monthly
Mercer	James W. Emery, Mercer	William A. Reyer, Sharon	Monthly*
Mifflin	Edward E. Reiss, Jr., Lewistown	John R. W. Hunter, Jr., Lewistown	Monthly
Monroe	Evans C. Reese, Stroudsburg	Harold B. Flagler, Stroudsburg	4 a year
Montgomery ..	Joseph L. Hunsberger, Norristown	Alice E. Sheppard, Pottstown	Monthly*
Montour	J. Reed Babcock, Danville	Howard T. Fiedler, Danville	Monthly
Northampton ..	Paul E. Schwarz, Easton	Thomas H. A. Stites, Nazareth	Monthly*
Northumberland	William A. Lustusky, Mt. Carmel	Mark K. Gass, Sunbury	Monthly*
Perry	William H. Gelnett, Millerstown	Amos G. Kunkle, Liverpool	Bimonthly
Philadelphia ..	Richard A. Kern, Philadelphia	John Davis Paul, Philadelphia	Monthly*
Potter	Clarence E. Baxter, Coudersport	George C. Mosch, Coudersport	Bimonthly
Schuylkill	John J. Walsh, Pottsville	Charles V. Hogan, Pottsville	Monthly
Somerset	Harold E. Musser, Somerset	Harold G. Haines, Berlin	Bimonthly
Susquehanna ..	Gordon E. Snyder, New Milford	Park M. Horton, New Milford	4 a year
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Venango	Jane M. Marshall, Oil City	James E. Hadley, Oil City	Monthly
Warren	Jacob F. Crane, North Warren	John C. Urbaitis, Warren	Monthly
Washington ...	Clarence A. Crumrine, Washington	Albert E. Thompson, Washington	Monthly*
Wayne-Pike ..	Clare C. Kenny, Matamoras	Richard A. Porter, Hawley	Bimonthly
Westmoreland .	Russell A. Garman, Jeannette	William E. Marsh, Jeannette	Monthly*
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York	James E. Throne, York	H. Malcolm Read, York	Semimonthly*

* Except July and August.

† Except June, July, and August

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5. CALCIUM—300 mg. per ounce of Cerevim  thus supplying 8 times the calcium in a fluid ounce of milk—plus:
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BIBLIOGRAPHY:

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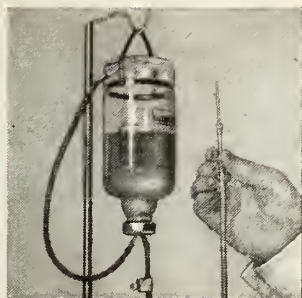
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LETTERS

Veteran's Loan Repaid

GENTLEMEN:

Enclosed please find my check for \$500 in repayment, with many thanks, of my \$500 non-interest-bearing loan from the Veterans Loan Fund "MSSP."

Yours,

Aug. 22, 1949

A.M.A. Membership Assessment

GENTLEMEN:

Within you will find a check for \$10 as my payment of the membership assessment of the A.M.A.

You will note that it is not the amount requested and that it comes after some delay. The payment that I am making results from quite a bit of thought over the turmoil of compulsory health insurance and the attitude of the A.M.A.

As a physician starting practice after many years of training, the full sum of assessment means a great deal more to me than it does to an established practitioner whose stable existence is threatened. Moreover, the attitude of the older physicians and of the hospitals (staffs, courtesy privileges, etc.) is not conducive to the full-hearted cooperation of the struggling new practitioner. Furthermore, many of us are not in full accord with the propaganda ("educational") techniques of the A.M.A. program.

However, I am firmly against government interference with medicine as outlined in the present bills for compulsory health insurance, despite the need for a better health coverage of the country. My years in the Army and in the VA (as a resident physician I saw the constant fight between the new medicine and the old bureaucracy of the VA) have convinced me that the medical world must play a firm hand in guiding its own destinies and not be subject to the whims and

non-cooperation of government officials. Therefore, I compromise and give my contribution to the A.M.A.

Yours truly,

_____, M.D.
Pennsylvania.

Hereditary Predisposition

GENTLEMEN:

Would you publish the following request?

The study of twins is of great value in providing information concerning the respective importance of hereditary predisposition and environmental influences in disease in man. The results of the use of this method have shown a hereditary predisposition to tuberculosis, diabetes, and tumor formation, and a high, medium, or low intelligence quotient.

There is some *a priori* evidence showing a hereditary predisposition for peptic ulcer. Only six cases of the occurrence of peptic ulcer in the one or both of monozygotic or dizygotic twins have been reported in the readily accessible literature. Since twins are born in 1 of 86 births and identical twins in 1 of 344 births and the general incidence of ulcer is from 5 to 10 per cent, there should be plenty of material available.

I should like to ask physicians to cooperate in assembling such material by sending me cases in which (1) one or both twins develop peptic ulcer, (2) the site of the ulcer, (3) the age of onset of ulcer, (4) the type of twins (monovular or diovular), (5) the sex of the twins, (6) the date of birth of the twins, and (7) the number and age of the brothers and sisters and the absence or presence of ulcer in each.

Yours sincerely,

A. C. Ivy, M.D.,
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The above studies should be supplemented, when possible, with courses in mathematics, qualitative analysis, physical chemistry, foreign languages (Spanish, French, or German), and sociology.

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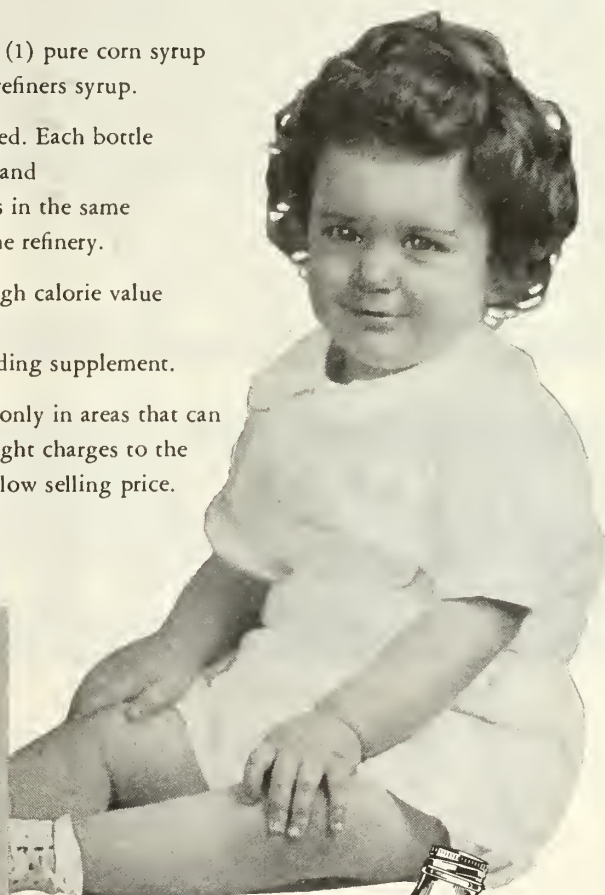
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Sugars, Before Inversion	
As Invert.	33.21
As Dextrose	32.13
Sugars, After Inversion	
As Invert.	39.13
As Dextrose	37.66
Sucrase	4.50
Glucose	66.3
(211°V)	
Total Sugars after Prolonged Acid Inversion (Includes Dextrines)	
As Invert Sugar	68.3
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Dextrins (calc.)	25.4
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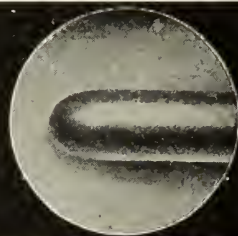
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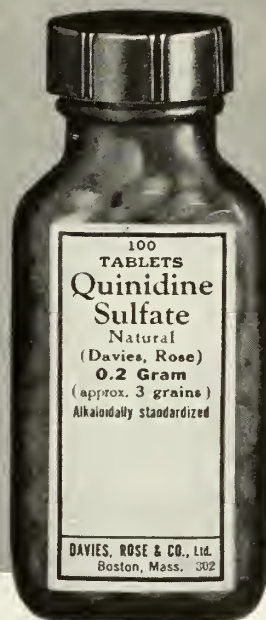


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References: 1. Dodd, K. and Minot, A. S.: *J. Pediat.*, 8:442, 1936.
2. Dodd, K. and Minot, A. S.: *J. Pediat.*, 8:452, 1936.
3. Sahyun, M.: *Am. J. Dig. Dis.*, 13:59, 1946.

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1. Brewster, J. M., U. S. Naval Med. Bull. 49: 1-11, January-February 1949.



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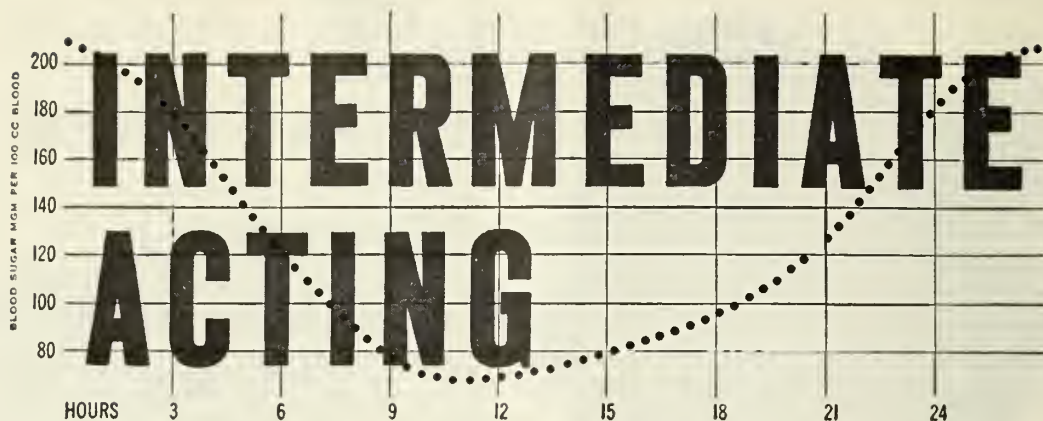
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1. Pohr, J.H., and Colwell, A.R.: Arch. Int.
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2. ibid Proc. Am. Diabetes Assn. 8:37, 1948.



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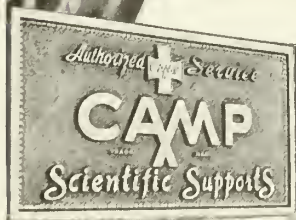
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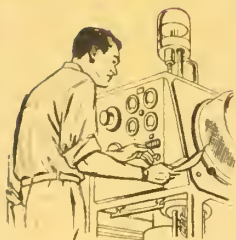


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The Choice of Cases for Uretero-intestinal Anastomosis

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Dr. Beisler

AFTER a survey of the literature one realizes not only the importance of the historical background but also the tremendous handicaps under which our predecessors worked. It is not within the scope of this paper to include a complete historical summary of all the work dealing with uretero-intestinal implantation but to present that bearing on the more important indications for uretero-intestinal anastomosis. This surgical procedure is the direct outgrowth of attempts to remedy the congenital malformation known as exstrophy of the bladder. It was in the latter half of the nineteenth century, following the advent of anesthesia, that surgeons turned to what they termed a "radical cure" of this condition.

The first case on record of this procedure was performed in England in the year 1851 by John Simon on a 13-year-old boy suffering from exstrophy of the bladder. Simon succeeded in establishing a fistula between both ureters and the rectum by the simple method of using a necrosing suture. The patient died a year later of bilateral pyelonephrosis, calculus formation, and renal insufficiency.

Over a quarter of a century passed before another attempt was made to anastomose the ureter

with the intestine. In 1878 an Englishman, later to be known as Sir Thomas Smith, performed a bilateral uretero-colonic anastomosis in two stages by an extraperitoneal method in a case of exstrophy of the bladder. In the next fifteen years many cases of ureteral anastomosis are reported in the literature. These anastomoses were performed without preservation of the ureterovesical sphincter and disclosed a mortality of 33 per cent or greater.

Experimental observations led Tuffier in France, as early as 1890, to the conclusion that ascending infection after uretero-intestinal anastomosis could be prevented only by the preservation of the ureterovesical sphincter. With this conclusion in mind, Maydl, in Germany in 1894, devised a technique, later to be known as the Maydl ureterotrigono-intestinal anastomosis. This was the first great forward step in this field of surgery, and in 36 cases in which this method was used only a 14 per cent mortality existed. Why this operation was abandoned entirely is not explained and it appears worthy of further investigation.

The Maydl technique of transplanting the ureters with their orifices and surrounding bladder mucosa was the operation of choice until the work of Coffey in the United States was published in 1911. Coffey, after much experimentation, evolved the submucous tunnel technique of ureteral anastomosis, producing a so-called valve principle to prevent hydro-ureter and hydro-nephrosis from back pressure from the intestine.

Read before the Section on Urology at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 5, 1948.

Dr. Beisler is chief urologist at the Roosevelt Hospital, New York City.

Mayo was the first to use the Coffey technique, and between 1912 and 1921 operated upon 35 cases with varying results.

Although the Coffey technique overcame to some extent resultant hydro-ureter and hydro-nephrosis experienced by the earlier techniques, peritonitis, periureteritis, and abscess formation at the site of the submucous tunnel were still frequent complications. A disadvantage of this technique was the necessity of transplanting only a single ureter at the first operation, the second ureter being transplanted at a later date, as the edema in the bowel following operation caused ureteral obstruction at the site of the anastomosis for 24 to 48 hours postoperatively.

In 1925 Coffey presented a technique which he believed would overcome the afore-mentioned problems. The procedure consisted of a cleansed and packed intestine, the insertion of catheters in both ureters, and the submucous tunnel technique of anastomosis. The catheters were removed 48 hours postoperatively after the intestinal edema had subsided. He concluded his paper with the statement that he now felt that uretero-intestinal anastomosis in the hands of a competent surgeon could be safely recommended as treatment for any condition in which the bladder was no longer considered suitable to collect and expel urine. Coffey's third technique, in which a cutting retention suture was employed, soon followed. By 1935 more than one thousand cases of uretero-intestinal anastomosis had been reported in the literature and over 70 surgical procedures described. It should be mentioned that the vast majority of the procedures were variations of the Coffey technique, or utilized some phase of his operation. Coffey's untimely death was a great loss.

The past twenty years have added many new advances to the subject of ureteral anastomosis. Although Coffey's original principles were still employed, procedures of transplantation into varying portions of isolated or semi-isolated bowel or anastomosis of the ureter intact with second-stage formation of the uretero-intestinal opening have been performed. In 1933 Nesbit published a technique in which the first stage was a colostomy, followed later by rectal transplants. Jewett reported, in 1940, a procedure in which the ureters were first anastomosed to the sigmoid by the use of the submucous tunnel and then, at a later date, the intestinal opening was made with a special cutting cautery, with final inversion of the ureteral stump. Davalo, in 1945, described the use of a transverse incision in place of the conventional longitudinal incision.

In the past ten years, with the advent of sul-

fonamides, penicillin, and streptomycin, the frequent and serious complications of peritonitis, abscess formation at the anastomotic site, periureteritis, and secondary urinary tract infections have occurred less frequently and are more within the control of the surgeon in postoperative care. While chemotherapeutic agents have been of great aid in the success of this procedure, pre- and postoperative care and sound basic surgical principles are still important phases in the success of this operation. These points have been well expressed by Hinman, who believes that careful preoperative bowel preparation, surgery preserving as much as possible of the normal anatomic position of the ureters, and postoperative control of intestinal function are still the most important steps in the success of this operation. Where once uretero-intestinal anastomosis was considered radical, dangerous, and a last resort, with high operative and postoperative mortality, it has today become an accepted surgical procedure with an ever increasing number of reported cures and improvements.

A review of the literature reveals that the majority of these operations up to the year 1925 were for exstrophy. Today it is generally accepted that uretero-intestinal transplants are indicated in exstrophy of the bladder, most surgeons recommending the operation in the first years of life. The last decade of the nineteenth century is full of reports of this surgical procedure being used in a number of cases in which exstrophy was not the disease entity. In Germany, in 1891, Kuster reported transplantation of the ureters into the bowel following perineal removal of the bladder and prostate for carcinoma. Chaput of France, in 1892, in a case of ureterovaginal fistula following vaginal hysterectomy, united the right ureter to the rectum and reported an uneventful recovery, stating that the patient was well after eight years. Chaput also, in 1892, reported a case of double uretero-colonic anastomosis in two stages for "tubercular" cystitis. Trendelenburg, in 1895, reported a case in which the left ureter, including the orifice with a small amount of surrounding bladder mucosa, was transplanted into the sigmoid following removal of the right kidney and bladder for tuberculosis. He stated that functionally the operation was a success, despite the patient's subsequent death from tuberculous extension to other organs.

The following outline is submitted as a list of those conditions in which bilateral or unilateral uretero-intestinal anastomosis may be indicated or in which it should be seriously considered. It was formulated on a basis of personal experience,

cases reported in the literature, and a knowledge of work being done by others. No other outline was found in the literature and it is realized that this one will cause some controversy. With the increased use of the operation this one will serve its purpose for the present.

AN OUTLINE OF CASES FOR URETERO-INTESTINAL ANASTOMOSIS

- I. Congenital anomalies.
 - A. Exstrophy of the bladder and epispadias.
- II. Carcinoma.
 - A. Bladder
 1. Bladder neck lesions initially extensive and those not responding to the usually accepted more conservative means.
 2. The extensive or multiple intramural lesions.
 3. The multiple and frequently recurring lesions not responding to accepted conservative therapy.
 4. The cases with obstruction or involvement of one or both ureters not lending themselves to segmental resection or reimplantation of the ureters into the bladder.
 5. The obviously hopeless case from the standpoint of cure with marked bladder symptoms that might be more comfortable with diversion of the urinary stream.
 - B. Prostate

Cases with subtrigonal involvement or direct extension into the bladder with or without ureteral obstruction.
 - C. Urethra

Primary recurrent lesions, primary extensive involvement, and cases of secondary involvement.
 - D. Ureter

In selected cases of primary neoplasm or metastatic involvement.
 - E. Sigmoid }
 - F. Rectum }
 - G. Vulva }
 - H. Vagina }
 - I. Cervix }
 - J. Uterus }
 - K. Ovaries }

In cases in which, with or without extension from the primary site of the malignancy, removal of the pelvic structures is considered, including cystectomy.
- III. Fistula group.
 - A. Vesicovaginal
 - B. Vesicorectal
 - C. Ureterovaginal
 - D. Accidental division of ureter
- IV. Contracted bladder.
 - A. Radiation cystitis
 - B. Tuberculous cystitis
 - C. Chronic cystitis due to specific or non-specific infection including interstitial cystitis.
- V. Cutaneous ureteral transplants (for cosmetic, hygienic, or psychologic reasons).
- VI. Trauma to pelvis with complete destruction of either the urethra or bladder or both.

Urologists are in agreement as far as exstrophy of the bladder and epispadias are concerned, differing only as to the appropriate age for the operation. In the last two decades there has been an increasing trend to uretero-intestinal

anastomosis with or without total cystectomy, prostatectomy, seminal vesiculectomy, and urethrectomy for certain cases of carcinoma of the urinary bladder. Subgroupings 1 to 4 under "Carcinoma" cover the cases which for possible cure require this radical operation followed by cystectomy, and it is inferred that there is no definite evidence of extravesical extension. They are as follows: bladder neck lesions which are initially extensive and those failing to respond to more conservative procedures; the extensive or multiple intramural lesions; the multiple and frequently recurring lesions which do not respond to more conservative methods; those with obstruction to or involvement of one or both ureters, not lending themselves to segmental resection and reimplantation of the ureters into the bladder; and last the extensively involved hopeless cases, with extension of the malignancy outside the bladder and marked bladder irritability, whose remaining days might be made more comfortable by diversion of the urinary stream by uretero-intestinal anastomosis.

In the field of malignancy there is the occasional case of carcinoma of the prostate gland with subtrigonal involvement with or without ureteral blockage and those in which there is direct extension of the malignancy of the prostate into the bladder and in which uretero-intestinal anastomosis followed by cystectomy and a radical prostatectomy might be considered. There are certain cases of malignancy, such as extensive or recurrent primary or secondary carcinoma of the urethra, in which for either hope of a so-called cure or for relief of unbearable symptoms this operation would be indicated with or without urethrectomy and cystectomy.

To complete the field of malignancy in the genito-urinary tract, one must include the cases in which one or both of the lower ureters become partially or completely obstructed due to compression by metastatic lesions, as well as the occasional case with a metastatic lesion in the lymphoid tissue within the ureteral wall. While in the past the accepted procedure has been ureteronephrectomy, uretero-intestinal anastomosis might be considered in those cases of involvement of the lower portion of the ureter if one were certain of the absence of renal lesions, or where the other kidney is either absent or of questionable or poor function. Then there is the field in malignancy that does not primarily involve us as urologists which was opened by Brunschwig and followed by many of the gynecologists. Similarly, some of our surgical colleagues are doing more radical procedures in lower large bowel surgery. In these latter two

fields, cystectomy, uretero-intestinal anastomosis, and colostomy are frequently necessary. Further time must elapse to evaluate the results in these cases and therefore the advisability of continuing or discontinuing this work.

In Group III, which includes vesicovaginal, vesicorectal, and ureterovaginal fistulas and surgical division of the ureter, uretero-intestinal anastomosis is not indicated until adequate repeated attempts for correction by proper plastic surgery have failed and in the vesicorectal group until colostomy has been employed prior to plastic repair. Early recognition of the ureterovaginal fistula group followed by a prompt extraperitoneal approach, freeing of the ureter, with establishment of external drainage and the judicious use of an indwelling ureteral catheter, will frequently result in a cure. In late cases either nephrectomy or uretero-intestinal anastomosis is frequently necessary. In the cases of accidental surgical division of the ureter, immediate suture of the divided ends over an indwelling catheter is the accepted procedure. Where, however, the ends cannot be approximated, either ligation of the proximal stump or more preferably uretero-intestinal anastomosis is indicated.

In Group IV under the title of Contracted Bladder are listed severe radiation cystitis, tuberculous cystitis, chronic cystitis of specific or non-specific origin, and interstitial cystitis. In our limited experience we have never had to employ uretero-intestinal anastomosis in these cases, although its use has been reported in the literature. In the radium cystitis cases, gravity dilatation under anesthesia sufficed and with time satisfactory progress was maintained. In severe tuberculous cystitis, we have resorted to presacral and lateral sacral section along with occasional gravity dilatation of the bladder with gratifying results even though the remaining kidney was tuberculous. The more troublesome contracted bladders due to chronic cystitis responded well to the presacral and lateral sacral nerve section, some not requiring gravity dilatation.

In the past three years three cases have been reported in the literature of reimplantation of skin ureterostomies into the bowel. The first of these was reported by Hyman in a case of carcinoma of the urinary bladder with extravesical extension, and a one-stage bilateral skin implantation and cystectomy was performed. The patient would not accept the skin ureterostomies and reimplantation into the intestine was successful. A second quite similar case was reported by one of us. Both of these patients lived one and a half years before dying of their malignancy, maintaining adequate renal function. The third

case was also reported by one of us—a woman who had cerebrospinal meningitis at the age of eighteen followed by complete urinary incontinence. Later an unsuccessful plastic operation was complicated by a large vesicovaginal fistula and complete loss of the urethra. A second plastic operation met with failure. She had large dilated regurgitant ureters and dilated kidney pelvises. She consented to skin ureterostomies only on the promise of having the ureters reimplanted into the bowel provided the ureters improved after skin drainage. The patient succeeded in making life almost unbearable in the intervening time before the ureters were successfully reimplanted into the bowel.

In the last group are the relatively rare cases in civilian practice of severe injuries to the pelvis with complete destruction of either the urethra or bladder or both. These cases were seen mainly in injuries sustained in World War II and necessitated uretero-intestinal anastomosis.

In conclusion, an outline has been presented on the choice of cases for uretero-intestinal anastomosis and this has been discussed in some detail. While this operation is increasingly employed, it is still a formidable procedure and should be used only if every other available more conservative operation is inapplicable or has failed. It is true that with chemotherapy, proper preparation, improved surgical technique, and maintenance of the normal ureteral position the mortality figures have been reduced from over 30 per cent to below 5 per cent, but the morbidity percentage is still too high. The major problem in spite of everything is stricture and resultant obstruction at the site of anastomosis, which does not necessarily occur in the immediate postoperative period but may occur as long as one year after operation. Likewise, symptoms relative to this do not necessarily occur promptly after onset and may not occur until it is too late to correct the condition. Early recognition is important, and therefore frequent study by intravenous pyelography is important during the first postoperative year.

The operation of uretero-intestinal anastomosis is generally accepted in principle, but the choice of cases applicable is controversial. This paper has covered what is believed to be the important steps in the development and establishment of this surgical operation, and has also attempted to outline the more important conditions in which the procedure is considered feasible without any dogmatic conclusions. In the last analysis the choice as to applicability must be left to the judgment of the individual physician, who must make his decision after a careful ap-

praisal of the patient both organically and psychologically.

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ABSTRACT OF DISCUSSION

JOSEPH C. BIRDSALL (Philadelphia): This interesting paper very adequately presents the choice of cases which are most suitable as well as the more important indications to be considered in uretero-intestinal anastomosis. Historically, a surgical procedure was attempted to correct the congenital defect of exstrophy of the bladder and the mortality was extremely high until operative procedures were developed which had as their underlying principle the preservation of the ureterovesical valve. This proved to be successful in the Maydl, Maydl-Moynihan and Bergenheim, Pezza and Peters operations, and the experimental work of Coffey in 1898-1910 convincingly demonstrated that the submucosal uretero-intestinal implantation was the answer to this all-important (64 dollar question) problem.

Previously, exstrophy of the bladder was the principal condition to be corrected, but Dr. Beisler has very ably given us an extensive classification of urinary tract anomalies and conditions in which uretero-intestinal anastomosis should be considered after all conservative procedures have been tried and proved to be inadequate.

Many of us have had cases which have taxed our surgical ingenuity and skill in the correction of a congenital or acquired defect without having to resort to what seemed at first an obvious uretero-intestinal anastomosis. In one case a young man was referred for uretero-intestinal anastomosis who had, as a result of an accident, a fractured pelvis and rupture of the urethra. Suprapubic cystostomy drainage was maintained for three years and all attempts to pass instruments through the urethra met with failure. A successful perineal urethral anastomosis was accomplished after the closed proximal and distal urethral ends were

opened. A second case referred for uretero-intestinal anastomosis was one in which a bilateral ureterovaginal fistula developed following panhysterectomy for uterine carcinoma in which both ureters were severed from the bladder; cystoscopic examination showed an intact bladder, and successful bilateral ureterovesical implantations were accomplished.

A young girl whose urethra was destroyed following an automobile accident in which her pelvis was fractured has had a new urethra constructed and almost perfect vesical sphincter control, while in a similar case with loss of apex of trigone and urethra following a panhysterectomy, all plastic reconstruction repairs met with failure. A uretero-intestinal anastomosis was successfully accomplished.

We like and prefer the Wharton modification of Coffey's No. 1 technique which consists of implanting the ureters with a catheter in situ in its new intestinal bed and, as the last step in the procedure, making an opening through the mucosa of the bowel with the cautery, removing the catheter, anchoring the ureter, and closing the muscle and serosa of the bowel over the opening; a unilateral transplantation is a safer procedure.

Most essential is the preoperative preparation of the patient, including chemotherapeutic sterilization of the bowel. Preoperative intravenous urography will provide a pattern to which you may refer if postoperative studies become necessary. Postoperative streptomycin and sulfa drug therapy should be given early and judiciously.

Where formerly uretero-intestinal anastomosis was regarded as a serious operative undertaking, it is today, with such effective chemotherapeutic agents and improved surgical technique, considered a comparatively safe and approved surgical procedure.

In closing, I would like to hear from Dr. Beisler as to which technique he employed—Coffey's first, second, or third, and what he thinks of the Higgins procedure; also, his experience with and what he thinks of the use of the metallin or catalin tubes advocated by his fellow townsman, Sam Rubin.

PHILIP S. ROSENBLUM (Philadelphia): I would like to ask Dr. Beisler whether dilated ureters are a distinct contraindication to uretero-intestinal anastomosis.

DR. BEISLER (in closing): In answer to Dr. Birdsall's question, I have employed many of the Coffey or Wharton types of technique. I have had no experience with the use of the tubes he mentioned.

As to the remaining question, with regard to the transplantation of the dilated ureter, I think one can successfully transplant a much more dilated ureter than we thought possible some time ago. In the case of the 35-year-old woman, her ureters were really dilated, to about Grade 2, when they were finally transplanted into the bowel, and they gradually became smaller after they were implanted into the bowel.

I have had no experience with Higgins' method.

Surgical Treatment of Hypertension

Present Concepts

MAX M. PEET,* M.D., and ROBERT C. BASSETT, M.D.
Ann Arbor, Mich.

SURGICAL attack upon the constitutional state of arterial hypertension should in no instance be considered a curative measure; however, in our series of well over 2100 cases a significant percentage of the results is gratifying.⁴

Our patients are studied independently by the internists and in most instances are first given the benefit of all present methods of medical management. After evaluation of the cardiovascular-renal status, hereditary and environmental factors, and a subsequent trial of medical therapy and failing to obtain material benefit from such measures, these patients are then considered for surgical treatment on the basis of physiologic fitness for operation.

History and Rationale

As long ago as 1913 workers in France and Italy introduced surgical attack upon the sympathetic nervous system for the relief of hypertension per se, the effect hoped for being the establishment of a vascular pool with diminished peripheral resistance and therefore a lowering of the pressure.

Crile felt that the adrenals were the chief etiologic factor in the production of hypertension and directed his efforts toward interruption of the neurohumoral cycle through denervation of these glands.

Eventually Goldblatt's work demonstrated conclusively the role of renal ischemia in the production of hypertension in dogs.²

It was this work which caused one of us (Dr. Peet) to devise the supradiaphragmatic lower dorsal sympathectomy and splanchnicectomy,³ the basic idea being to relieve relative renal ischemia and thus overcome the "physiologic" Goldblatt clamp.

Criteria for Surgical Treatment

Originally, when the criteria for surgical treatment were set up in our clinic, it was felt that

the procedure would be of no value in individuals over forty because of possible irreversible changes in the arteries—those of the kidney in particular—rendering them unresponsive to sympathectomy. However, as we collected an ever increasing number of cases which did well in spite of a considerable degree of peripheral and retinal arteriosclerosis, this age limit was set aside and not considered arbitrarily in the group of criteria. Individuals were then considered on a physiologic basis with less regard for the chronologic factor.

Rigid criteria which must be met if surgical treatment is to have any degree of possible success are a compensated heart and normal kidney function. The fact that an individual may have had one or more episodes of coronary occlusive disease or be afflicted with coronary insufficiency (angina pectoris) does not mitigate against surgical treatment if the heart is compensated. Morbidity and mortality are, of course, proportionately affected.

Renal function must be within empirical limits of normal as measured by blood nonprotein nitrogen of less than 45 milligrams per 100 cc., blood urea of 16, urea clearance values greater than 65 per cent, and concentrating ability of no less than 1.018. Intravenous pyelography was done originally on all patients; however, the added expense of this procedure caused it to be limited to those cases in which intrinsic renal disease was clinically obvious or suspected.

Patients are classified according to the vascular changes present in the ocular fundi after Wagener and Keith.⁹

Each patient is studied electrocardiographically and the heart size is determined by orthodiagram and teleoroentgenogram.

The fact that an individual has had one or more cerebrovascular accidents, providing they have not been too permanently incapacitating, does not render him ineligible for surgical treatment. Again however, as in the cases having coronary arterial disease, the morbidity and mortality are proportionately increased.

Read before the Section on Surgery at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 5, 1948.

From the Department of Surgery, University of Michigan Medical School and Hospital, Ann Arbor, Mich.

* Deceased March 25, 1949.

Surgical Technique

The Peet sympathectomy for hypertension is the simplest of the techniques in present-day usage. It is a bilateral procedure, both sides being done at the same time in sequence.

Approximately two inches of the eleventh rib is resected and a cleavage plane established between the endothoracic fascia and parietal pleura, which strips away from the former with ease. By use of a lighted retractor the lung and diaphragm are displaced laterally and the ganglionated chain and splanchnic nerves are removed as an intact specimen from D-7 and occasionally higher through D-12. Positive pressure is then applied with the gas machine and the wound closed airtight in layers, after which the pressure is released. An identical procedure is then carried out on the opposite (left) side. The right side is usually done first.

The average operating time for the complete procedure varies from 45 minutes to one hour. Basal avertin, ether, and oxygen are the anesthetics selected.

Operative Mortality

The factors most influencing operative mortality are coronary and cerebrovascular sclerosis. Usually with induction of anesthesia and following completion of the first side there is a marked fall in blood pressure. The fall in blood pressure, if not controlled by sympathomimetic drugs, may and does induce further thrombosis in the circulatory tree already embarrassed by pre-existing arterial disease and may prove fatal.

The operative mortality for 2100 consecutive cases is 3.2 per cent.

Postoperative Morbidity

Postoperative postural hypotension occurring in the more extensive procedures is seen only in an occasional case. When present it is invariably transient, usually disappearing after two to three days of ambulation.

Three distinct types of pain are encountered: incisional pain that is dull and aching in the back, radiating intercostal neuritic pain bilaterally which is characterized by a hypersensitivity to touch, and severe cramping abdominal pain. The pain and cramps may be controlled with codeine, atropine, and hot tub soaks. The back pain and cramping are transient, usually disappearing within five to ten days, whereas the intercostal neuritis may persist for two to three months.

Factors Influencing Selection of Cases

Early in our experience the criteria for surgical treatment were rigidly adhered to, par-

ticularly the age of patient, cardiac status unhampered by evidence of sclerosis or previous failure, freedom from episodes of encephalopathy or strokes, and normal kidney function. However, with the increased volume of cases seen and critically reviewed, it was noted that in many the fulfillment of the aforesaid specifications was borderline or beyond. Therefore, it was concluded that if the procedure was to be of any practical worth an attempt at salvage should be made in all cases, within logical limitations, previously denied the more than probable benefits of surgical treatment.

Malignant Hypertension. This phase of the hypertensive cycle has been and well might be considered pre-terminal hypertension. It is general knowledge that the outlook for individuals in this phase of the hypertensive state is extremely limited. For this reason this phase of the disease is considered by many a contraindication to surgical treatment.

Malignant hypertension is characterized by a fulminating clinical course with marked neuroretinopathy, excessively high diastolic levels, and usually some evidences of constitutional failure (renal, cardiac, or cerebral).

It so happened that the first patient in this clinic treated surgically for hypertension was an individual suffering from the malignant phase of the disorder. Results in this particular case were so outstanding that as time went on the malignant phase was removed from the list of contraindications to surgical treatment, provided that other criteria were fulfilled.

We have recently evaluated 143 such patients followed five to twelve years who had been treated surgically. Results were indeed favorable when compared to a similar series treated medically. In this series 21.6 per cent had survived five years or longer, which compares more than favorably with a medically treated series in this phase.

Even though the operative mortality is naturally higher in a group of this sort (10 per cent), the fact that a 20 per cent chance of salvage exists makes serious consideration of surgical treatment worth while.

Coronary Sclerosis and Cardiac Hypertrophy. More significant in our present-day attitude toward surgical treatment of the hypertensive state is the information gained from patients suffering from coronary insufficiency or with marked cardiac hypertrophy as a result of their hypertension.

In a recent study of approximately 400 cases presenting clinical evidence of heart disease and

operated upon as long ago as five to thirteen years, it was noted in those patients with significant reduction of blood pressure that there was definite improvement in the electrocardiogram and a reduction in heart size. Those who had previously suffered from anginal seizures were for the most part relieved following operation. Eleven patients out of this group had had definite coronary occlusion preoperatively and eight of these still survived nine years following splanchnicectomy.

In those patients responding satisfactorily to surgical treatment as far as blood pressure levels were concerned, 40 per cent who had abnormal preoperative tracings and abnormally large hearts showed definite improvement in the tracings and decrease in heart size towards normal. For this reason previous coronary occlusion, anginal seizures, or cardiac hypertrophy no longer can be considered contraindications to surgical treatment if the requirement for cardiac compensation can be fulfilled, although there is no question that the outlook for these individuals, particularly if they have been in congestive failure or have had gallop rhythm preoperatively, is only about one-third as good as for an individual with no evidence of cardiac involvement.

Cerebrovascular Disease. It is well known that once a cerebrovascular accident has occurred in the individual suffering from hypertension, should he survive the initial attack he will suffer others, with the mortality from each successive incident increasing in a rapidly rising curve. Therefore, again with the thought in mind that there must be a definite percentage of salvage available in this unfortunate group of individuals, we recently reviewed a group of hypertensive patients who had suffered cerebrovascular accidents and had subsequently undergone supradiaphragmatic splanchnicectomy and lower dorsal sympathectomy with a survival of from five to ten years.

Five-year survival for the entire series was 67.3 per cent; the ten-year survival rate was 40.5 per cent. Fifty per cent of the deaths occurring in this group came about as a result of recurrent cerebrovascular accidents, and survival was definitely influenced if there had been other evidences of constitutional involvement such as poor renal function, excessively high diastolic pressures and heart disease, and retinal hemorrhages.

Whether or not the procedure has definitely benefited this series of patients cannot be stated unequivocally since there are no good control data available from the clinical point of view

with which to compare these individuals. However, since we do know that the prognosis is extremely grave with the onset of this complicating feature, and assuming the attitude that all therapeutic efforts possible should be undertaken for the benefit of the patient, we feel that the procedure definitely has influenced the rate of salvage in this more or less hopeless group of patients.

Hypertensive Nephropathy. There is no question that for years hypertensives have become terminal and have demonstrated their terminal phase in renal failure and, since they had probably had no clinical complaints or previous clinical evaluation before this terminal phase was reached, many of these had been labeled as terminal glomerular nephritis. Undoubtedly many of these with episodes of "renal apoplexy" had been labeled hemorrhagic glomerular nephritis, when actually these manifestations are the end result of the weakening of the renal link in the chain of circumstances brought about by the constitutional state of hypertension.

More than any one phase of the constitutional effects of hypertension, the renal status is most important in determining whether or not the patient is a fit candidate for surgical treatment. In attempting to salvage patients from certain hopelessness, we have learned from experience that in no instance when the nonprotein nitrogen has been elevated, even though subsequently lowered with forcing of fluids, has survival exceeded eighteen months to two years following operation. Once renal function has been interfered with to the extent that such a gross test as measurement of the nonprotein nitrogen or blood urea nitrogen shows evidence of renal damage, there is little use in considering possible benefit from surgery.

In an evaluation of 117 postoperative patients followed five to eleven years, 50 had evidence of impaired renal function as measured by lowered concentrating ability below 1.018, impaired urea clearance below 65 per cent of normal, and lowered excretion studies. Of this group, 36 per cent showed significant improvement in concentrating ability, over half of them were unchanged, while a small percentage (11 per cent) were worse.

It is the general experience of individuals in this field that the problem presented by bilateral kidney disease due to pyelonephritis should not be considered hopeless in the presence of accompanying severe hypertension until splanchnicectomy has been tried. Many of these patients can be helped, although no definite criteria for prognosis with operation are at hand.

Pregnancy and Prepregnant Hypertension. A large number of females first experience difficulty with the hypertensive state when entering into their first pregnancy. This is particularly true in those women who have hypertension preceding the onset of their pregnancy. We have studied 28 women who have undergone pregnancy subsequent to splanchnicectomy for hypertension. They were followed an average time of three years. Preoperatively, their blood pressures averaged 200/135. In this group, fifteen had lowering of blood pressure to normal levels as a direct result of the operation, nine of the group had a significant reduction in pressure, and four maintained an average blood pressure greater than 170 systolic.

We have also treated surgically five cases with toxemia superimposed upon prepregnant hypertension. In two cases the results were excellent with the blood pressure returning to normal and pregnancy successfully terminated with living infants. In three cases the course of the toxemia was not influenced by operation; however, in one of these cases, following delivery of the non-viable uterine contents, the blood pressure was significantly diminished compared to prepregnant levels.

It is our impression that if following splanchnicectomy a woman is desirous of entering into a pregnancy, provided that her blood pressure has been significantly influenced by the procedure and the kidney function remains normal, such a

step is permissible provided the course of the pregnancy is carefully followed by the attending physician. It is our further opinion that splanchnicectomy should be seriously considered in the treatment of toxemias in individuals having prepregnant hypertension if other means fail before interruption of the pregnancy is considered if the parties concerned are desirous of carrying the pregnancy to term if at all possible.

Summary

We again emphasize the fact that the surgical treatment of the hypertensive state can in no way be considered a cure; however, because of its influence in a large percentage of cases, it has certainly attained a significant status in accepted therapy.

There can be no rigid rules concerning candidacy of an individual for surgical treatment. Each case must be analyzed on its own merits with a background of logical criteria in mind.

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PUBLIC OPINION ON ANIMAL EXPERIMENTATION

The screams of the antivivisectionists and the Hearst press to the contrary, the great majority of the general population today favors the use of live animals in medical research and teaching. According to a survey conducted by the National Opinion Research Center, 85 per cent of the public is favorable to animal experimentation and the turning over of unclaimed pound animals to medical schools. The results of this survey should prove surprising to those who have been annoyed and hindered by the opposition, for 63 per cent did not even know that groups existed who oppose animal experimentation and, of those who did, only 12 per cent had even heard of the antivivisectionists.

However, only 47 per cent were consistent supporters of animal experimentation without reservations. About a quarter objected to the use of certain

animals, largely domestic, giving as their reasons their usefulness and sentimental relationship to man. And, when the factor of pain was presented, the percentage of those opposing the use of certain animals rose to 40 per cent. The majority withdrew their objection, however, when asked what their opinion would be if these animals were better suited than any other. About a fifth objected to certain uses of the animals.

The problem seems to be largely one of lack of interest and information, which leads to inconsistent and illogical points of view rather than one of conscious opposition to animal experimentation, which appears to be limited to about 3 per cent of the public. While ignorant of the specific contributions that the use of animals has made and the necessity of using particular animals in particular ways, the public recognizes that animal experimentation is an essential technique in medical research and education, and that attempts at human improvement are more valuable than animal life.—*Journal of Iowa State Medical Society*.

Pediatric Education and the Practicing Physician

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THE aim of medical education is to train a group of men and women in such a manner that they are fitted to enter upon the duties and responsibilities of any of the varied fields of medical endeavor. To this end they must be prepared to enter the practice of medicine, to perform research, to assume the role of teachers, and to undertake one of the many assignments in the field of public health.

It is obvious that all of this cannot be accomplished in the four years spent in medical school and one additional year of hospital training. The teacher, the investigator, or the medical specialist is required to spend additional years of preparation to equip him to meet his full duties.

Therefore, almost the sole field open to the physician with but one year of hospital experience after graduation from medical school is that of the general practice of medicine. This amount of training is generally accepted as a satisfactory minimum for that purpose.

The majority of physicians in the United States are engaged in the practice of medicine. Of all physicians in practice, 65 per cent are in general practice in the fullest sense of that term, that is, they do not themselves profess a special interest in any particular field.

In view of these facts, the public and the physician entering general practice are clearly justified in expecting the medical schools and hospitals approved for intern training to provide experience designed to fit their needs as practitioners of medicine. This paper is concerned with the evaluation of the training so provided in the field of pediatrics.

It would seem fair to assume that the amount of training provided to the practitioner in any branch of medicine should bear a close relationship to the importance of the subject in the general scheme of medical practice, and to the proportion of time which will be devoted to it in the practice of medicine. On the basis of information furnished to the Study of Child Health Services of the American Academy of Pediatrics,¹ 35 per cent of all visits made by general

practitioners are for children. In addition, one patient in every seven seen by specialists (pediatricians excepted) is a child. These figures should be borne in mind in the following discussion of the time spent in pediatrics during the undergraduate years and the internship.

Hours in Pediatrics in Medical School

A measure of the increasing importance attached to pediatrics in the medical school curriculum may be obtained from a comparison between the number of hours devoted to that subject in 1947 and those reported to the Third White House Conference on Child Health and Protection held in 1930. In the earlier year no school allotted more than 400 hours, and 39 of the 54 schools included in the report allowed less than 200 hours to pediatrics. In 1947, of the 70 schools in existence, only nine allotted less than 200 hours and six allowed over 400 hours (Table I). The average amount of time allotted in 1947, as indicated by catalogue schedules, was 286 hours. Actually, on account of overtime work, a total of 314 hours was devoted to pediatrics. Twenty medical schools, which were rated as having the best pediatric departments on the basis of detailed analysis of many features considered to affect the value of undergraduate teaching, averaged 384 actual hours.

Since the average number of total catalogue hours in all subjects for the four years is 4800, the hours allocated to pediatrics represent 6 per cent of the total. A more meaningful comparison can be made if pediatrics, which is essentially a clinical subject, is considered as a portion of the last two years of medical school, which are primarily clinical. The proportion of catalogue time devoted to pediatrics during the junior and senior years averages 11 per cent of the total. It is of interest to compare this figure with the 35 per cent of time spent by general practitioners in the medical care and health supervision of children.

Obviously, it must not be assumed that these two figures should necessarily be equalized, or that the hours spent in pediatrics represent all of the instruction given to the student concerning

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TABLE I
STUDENT TIME IN PEDIATRICS DURING FOUR YEARS
IN MEDICAL SCHOOL

Catalogue Hours	Number of Schools	
Comparison in years	1928-29*	1946-47
Less than 200 hours	39	9
200 to 300 hours	13	34
300 to 400 hours	2	21
400 or more hours	0	6
	54	70
Under 140 hours	9	0

* Quoted by VEEDER, B. S., *Journal of Pediatrics*, February, 1948.

the medical care of the child. However, in making allowance for this, it should be recalled that during instruction in pediatrics the student is also learning general medicine in all of its ramifications.

Over the past decade purely didactic methods have been replaced gradually by bedside teaching and actual work with patients. However, progress has not been uniform. While today no school entirely lacks some clinical clerkship experience in pediatrics, there are still two schools in which all students do not get an in-patient clerkship and one school in which they do not get an out-patient clerkship. In nine more schools the clerkship is so arranged that the students do not follow in-patients assigned to them from the time of admission to discharge or throughout the duration of the clerkship. There are 16 schools in which the students get no opportunity to take in-patient histories from the patient or parents and 4 schools in which they do not take out-patient histories. In a number of schools in which students supposedly take histories, no real effort is made to see that the clinical clerk is called to the admitting room or ward at the time of admission in order that he may see the patient and obtain a history at this crucial period before diagnosis.

Almost a third (22) of the schools have no mechanism by which students are on call for admissions after ordinary school hours (9 a.m. to 5 p.m.) or over week-ends. Much valuable material is neglected in this manner.

As previously indicated, there is great variation in the amount of time devoted to pediatrics among the various schools and the variation in the hours spent working directly with patients is even greater. Among the extremes is a school which offers a total of 509 hours in pediatrics, of which 303 hours are spent in work with patients (60 per cent), and one which allots 141 total hours, of which 28 hours are spent in work with patients (20 per cent). In other words, while

the students in the first school spend three and one-half times the number of total hours in pediatrics, they spend eleven times as many hours as those in the second school in personal contact with child patients.

It should be emphasized that the 28 hours cited above does not represent the total amount of clinical instruction in pediatrics received in that school, for it excludes ward rounds, clinical conferences, and amphitheater clinics. It does represent, however, the total opportunity for personal contact between students and pediatric patients throughout the medical school course, that is, time spent in taking and recording histories, performing physical examinations, and carrying out therapeutic procedures.

Intern Training in Hospitals Approved for Pediatric Residency

In any discussion of the adequacy of undergraduate training in the actual handling of patients, the point will doubtless be made that this experience will be gained during the period of hospital intern and residency training. This is entirely correct for the certified pediatrician who must spend three years in intern and residency appointments in approved hospitals. However, it is with the general practitioner that we are especially concerned in this paper, and it therefore becomes pertinent to examine in detail the amount of time spent in hospital training in pediatrics by this group—the physicians who account for 75 per cent of the medical care given to the nation's children.

In 1947 there were 180 hospitals approved for residency training in pediatrics. These institutions included essentially all of the hospitals connected with the departments of pediatrics in the medical schools. The remainder represented

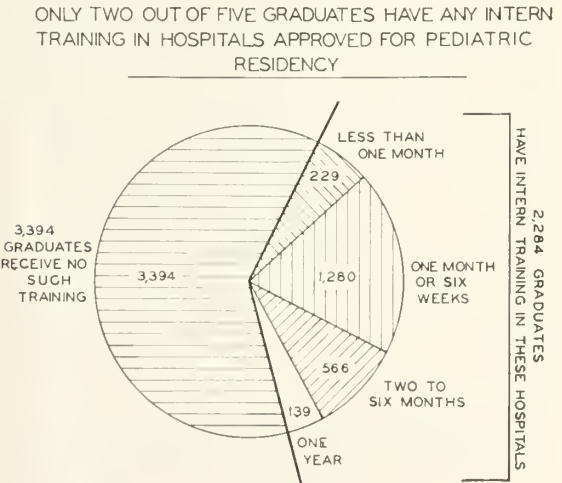


Chart 1

those hospitals whose pediatric services were of sufficient size and organization and whose staffs were of sufficient competence to warrant recognition as training grounds for pediatricians. They were therefore indubitably the best hospitals for training interns in the care of children.

In a detailed study of 158 of these hospitals (90 hospitals associated with medical schools, and 68 other hospitals), the findings are revealing with regard to the amount of training received in these institutions by those physicians who may be entering general practice.

In the 158 hospitals studied, the total resident staff numbered 843 physicians. Of these, 656 physicians were residents and assistant residents, that is, persons who were in their second and third year of hospital training in pediatrics. It is a safe assumption that but a negligible number of these physicians will become general practitioners. The remaining 187 resident staff members were straight interns, that is, interns devoting an entire year to pediatrics. Of these, 139 were in their first year of hospital training. Most of these straight interns would probably become assistant residents the following year and hence were probably planning to enter pediatrics as a specialty.

In addition to the 139 straight interns serving in their first year after graduation, there were 253 rotating interns who served for a period of a few weeks to six months. Hence there are 392 interns serving on pediatrics at a given time. On the basis of the period of time served by these rotating interns, it can be estimated that approximately 2300 physicians receive pediatric intern training annually in hospitals approved for pediatric residency training (Table II and Chart 1).

In 1947 there were 5678 graduates from medical schools in the United States. Therefore, only two out of five graduates receive pediatric intern training in hospitals approved for residency training in that field. Two-thirds of this number serve for six weeks or less even when the appointees for a full year are included. The average duration of training in other hospitals is probably less than that in the approved hospitals. Therefore, in 1947 almost 4000 of the nation's 5678 graduates received six weeks or less of pediatric intern experience during their first year of hospital service. This estimate is supported by the fact that 46 per cent of general practitioners have reported to the Academy Study a total of less than one month of hospital training in pediatrics.

The fact that only 40 per cent of graduates receive pediatric intern training in hospitals approved for residency training in that specialty is

TABLE II
LENGTH OF INTERN SERVICE

	Number of Internships	
	At a Given Time	Estimated Aggregate During Year
Less than one month . . .	23	299
One month or six weeks . .	128	1280
Two to six months	102	566
One year	139	139
Total	392	2284

explained in part by the reluctance of many of the best pediatric training centers to accept rotating interns. There are certain difficulties in accomplishing this in some children's hospitals remote from a general service, but a rotation plan could doubtless be arranged in most of them if they were willing to take the initiative. In general hospitals the arrangement should be made with even less difficulty.

The arguments advanced against the acceptance of rotating interns are varied. The most common statement is that the period of time that the intern spends is too short to be worth while. From the standpoint of the pediatric service this is at best a selfish attitude. From the standpoint of the intern it is scarcely tenable. Few pediatric educators would scoff at the value of four to six weeks added to their undergraduate clinical clerkship time. Why then does it become of less worth as intern experience?

Those pediatric training centers which will not accept rotating interns, when conditions are such that this could be arranged, should reconsider their position in the light of their obligation to the community to advance the training of all physicians who will be responsible for child care, and of the knowledge that 75 per cent of this care is given by general practitioners.

Pediatric Training in Pennsylvania

The above remarks do not apply to hospitals in the State of Pennsylvania, where all pediatric services accept rotating interns. However, the amount of pediatric training received by rotating interns in this State is a matter of great moment.

The State Board of Medical Education and Licensure publishes a bulletin under the title of "Hospital Intern Year"² which sets forth "in more or less detail the specific requirements made of hospitals which will entitle them to the privilege of giving such training as will meet the approval of the Board in its interpretation of the law." This well-documented and thoughtfully prepared booklet evidences a full appreciation of the role of the hospital as an educational institu-

tion. Indeed it states that the hospitals "have become a part of the teaching system of medicine and surgery in this Commonwealth." In view of the general excellence of the bulletin and the broad viewpoint shown by those responsible for its preparation, it is all the more surprising to find that, except for a brief note on the manner of keeping a "Baby Sheet," it contains not one direct reference to pediatrics or to the training of the intern for child care. *We look upon this omission as an indictment of ourselves, the pediatricians of the State*, who have failed to bring about a proper concept of pediatrics as that branch of medicine which concerns itself with all aspects of child life from birth through puberty. We have failed to demonstrate that pediatrics is medicine in the broad sense, medicine applied to an age group which constitutes one-quarter of the total population. We have failed to impress the Board with the importance to the practicing physician of thorough training in child care.

Apparently the pathologists have been far more active than the pediatricians. In contrast to the paucity of reference to pediatrics, more than five of the fifty-six pages in the booklet are devoted to an excellent discussion of the importance of clinical pathology and the presentation of an outline for the conduct of a comprehensive course in that subject during the intern year.

The relative emphasis on pathology and pediatrics is reflected in the recommendations of the State Board of Medical Education and Licensure which indicates the following outline of services to meet the requirements of the Pennsylvania law.³

Medicine	14 weeks
Pediatrics	4 weeks
Neurology	
Surgery	16 weeks
Orthopedics	
Urology	
Eye, ear, nose and throat	
Obstetrics and gynecology	8 weeks
Laboratory	8 weeks
Roentgenology	2 weeks
Anesthesia	2 weeks

The above outline leaves a period of two weeks to be devoted to the special requirements of the individual hospital.

It will be noted that the regulations specify that eight full weeks shall be spent in the clinical laboratory, while pediatrics is paired with neurology for a total of four weeks. There is no wish to minimize the importance of good laboratory training. On the other hand, pathology and laboratory methods are subjects especially well-suited to medical school teaching. At graduation most students are fully capable of per-

forming the simpler laboratory tests and have a thorough basic understanding of the method and value of other procedures. As laboratory service is organized today, it is the rare practitioner indeed who performs more than the simplest procedures himself. On the contrary, there is no one to whom he can delegate the care of sick children. It is therefore of importance that we examine the total training time devoted to preparation for child care.

In 1947-48 the medical schools of the State of Pennsylvania averaged 239 actual hours in pediatrics.* To this should then be added the four weeks of part-time required internship in pediatrics. Since most general practitioners in the State are trained in Pennsylvania medical schools and hospitals, these physicians will enter practice with a total of less than ten weeks' experience directed specifically to child care. This represents less than 6 per cent of the time spent in preparation to practice medicine. It would seem that in five years devoted to this purpose a greater proportion of time should be allotted to a subject which will henceforth occupy one-third of their attention.

Our interest lies in the training of that large percentage of physicians who will enter general practice at the conclusion of their twelve months of internship. It is not possible to give to medical students the same direct responsibility for the care of the sick child that can be delegated to the intern. Therefore, greater emphasis should be placed on pediatrics during the intern year.

It is believed that the natural concern of the Board that the hospitals should be required to conduct a well-equipped, well-staffed clinicopathologic laboratory has led to an overemphasis on laboratory work when this is compared with the training needs of the intern for the practice of medicine as applied to child care. The attention of the Board is respectfully directed to this viewpoint. Meanwhile the pediatricians of the State are urged to strengthen their hospital services in order that they may be prepared to fulfill their obligation as training grounds for the health supervision and medical care of children.

Summary

It has been shown that in the medical schools of the country as a whole in 1947 the average amount of time actually devoted to pediatrics was 314 hours. Twenty medical schools which

* Three schools are known to have increased their hours for the 1948-49 session. An approximate average for that year is 285 actual hours. This is almost identical with the average number of scheduled hours for the country as a whole in 1947-48, but still 29 hours below the average of actual hours. Further, the average actual hours for the country as a whole would probably show an increase for 1948-49.

were rated as having the best pediatric departments on the basis of a detailed analysis of many factors averaged 384 actual hours. Students in the medical schools in the State of Pennsylvania averaged 239 hours of actual time in pediatrics in that year, which was increased to approximately 285 hours in 1948-49. The attention of the medical schools in this state is invited to this relative shortage of hours assigned to pediatrics as compared with the average allotment throughout the country and with that in a selected group of schools.

In 1947 only 40 per cent of the graduates from medical schools received their pediatric intern training in hospitals approved for residency training in that field. This is explained in part by the reluctance of many pediatric training centers to accept rotating interns. These hospitals should reconsider their position in the light of their obligations to the community to train general practitioners in child care.

Regulations of the State Board of Medical Education and Licensure recommend that during the required year of hospital training four weeks shall be devoted to pediatrics in conjunction with neurology. It is hoped that those in authority will review the recommendation re-

garding time to be allotted to pediatrics, in the light of the duty of the hospital to serve the educational needs of their interns and of data which are now available showing that the general practitioner devotes about one-third of his attention to child care and provides this care for three-fourths of the nation's children.

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ABSTRACT OF DISCUSSION

JOSEPH A. GILMARTIN (Pittsburgh): I know that Dr. Mitchell will be interested in learning that at yesterday's meeting of the State Society's Committee on Child Health we decided to send a recommendation to the State Board of Medical Education and Licensure that they increase the time of pediatric intern training from four to six weeks; also, that they have one or two questions on pediatrics in the State Board examination.

I am sure we all enjoyed Dr. Mitchell's excellent review. In order to get his information, he visited every medical school in the United States and two schools in Canada. I think that is quite a feat.

EXPERIENCE SPEAKS WISELY TO NEOPHYTE

. . . The life of a doctor consists of two periods: the first, when he grouses because he hasn't enough to do; and all the rest of his life, when he grouses because he has too much to do. Don't worry; the first period is all too short.

But, while it lasts, take time to chart your course for the future. Now more than ever you bear the whole responsibility of your *continued education*. That means regular reading of current journals and texts. It means looking up the many points and questions that each patient presents, and looking them up today. It means the regular attendance at medical meetings, not just passively, but with a view to taking part in discussion and in presentation. Even though you won't be reading a paper before a national society for some time, you can do it next month in the journal club that you and a group of your contemporaries form.

Remember that you are a *citizen* as well as a physician. Find out what makes your community tick. Take an active part in what goes on; it is your duty, not merely your privilege. Democracy doesn't just offer you rights; it places obligations upon you. If you and others fail to meet those obligations, then democracy will fail and you are to blame. Remember that one of those obligations, if you are physically fit, is to enter the Medical Reserve of the national military establishment.

Man shall not live by bread alone. Look now, and constantly, to the up-building of your *spiritual resources*. To them, in increasing measure during all the years ahead, you will owe your greatest happiness. . . .—RICHARD A. KERN, M.D., writing in *Philadelphia Medicine*.

A.M.A. COMMITTEE WILL AWARD SEAL OF ACCEPTANCE FOR COSMETICS

The Committee on Cosmetics of the American Medical Association announced recently that it will award a seal of acceptance for cosmetics that meet certain requirements of safety, usefulness, and integrity in advertising and promotion.

Cosmetics accepted by the committee will be eligible for advertising with the committee seal as long as they remain acceptable to the committee.

The committee will recognize the use of the term "hypo-allergenic," but not such terms as "non-allergic," "tissue cream," "hair tonic," and "cure." Nor will it recognize references to doctors and hospitals, unless such reference is based on work consisting of controlled scientific data and is offered with full knowledge and consent of all interested parties.

Roentgen Findings in Injuries of the Wrist

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FRACTURES and dislocations of the bones of the wrist are of major economic importance. These bones are injured in all age groups. The unfortunate sequelae which follow failure of diagnosis may be lessened by adequate radiographic examination.

Radiographic examination usually establishes the diagnosis. Severe injuries of the wrist may occur with clinical signs of fracture, but roentgen evidence of fracture of the carpal bones cannot be demonstrated either at the time of injury or later. Conversely, fractures are shown roentgenographically when injury to the wrist has been trivial.

Complete roentgenologic study consists of dorsopalmar, lateral, and oblique films of the entire wrist, and a special study of the navicular in the dorsopalmar projection with the fist clenched and in strong ulnar deviation. When there is clinical evidence of fracture and the complete radiographic study is negative, the examination should be repeated in two or three weeks in an attempt to demonstrate rarefaction at the site of fracture. Hairline fractures may be missed unless a magnifying glass is used to study the fracture line and bony trabecular pattern.

The symptoms of carpal fractures may be mild. A thorough physical examination should be made of the injured wrist and comparative examination of the uninjured one. Local tenderness should be searched for, and tenderness in the "anatomist's snuff-box" should cast suspicion on the navicular. In doubtful cases a roentgenogram of the uninjured wrist is imperative.

Injuries of the carpal bones comprise about one-tenth of all injuries of the wrist including Colles' fracture. The navicular is the most frequently fractured carpal. Next in order of frequency are dislocation of the lunate, fracture of the lunate, fracture of the triangular, and the complicated fractures involving the radiocarpal joint.

The mechanism involved in the production of carpal fractures is that of the third metacarpal

directing the force of a blow upon the palm of the hand to the capitate and thence to the navicular and lunate. This mechanism causes a variety of injuries to the carpus. Whether a fracture of the navicular or a dislocation of the lunate is sustained depends largely upon whether the extended hand is held in radial or ulnar flexion. With the hand in radial flexion, the navicular is brought into position directly under the radius and is fractured by the direct impact of the capitate. In ulnar flexion all but the proximal part of the navicular glides out of the way and the lunate is exposed to trauma between the radius and capitate.

Fractures of the navicular represent 70 to 80



Fig. 1. Old ununited fracture of the navicular in wrist injured ten years previously. Note the wide separation of the fragments, marked sclerosis of the bone margins, small cystic remnants, and spur formation.



Fig. 2. Bone peg inserted in drill hole in navicular. Note the density of the bone peg and its position across the fracture lines. If the graft takes, the density of the peg and the surrounding bone will be the same.

per cent of fractures of the carpals. They are observed especially in young adults. Castrucci, in Balli's *Diagnostica Roentgen*,¹ states that fractures of the navicular are seen most frequently in athletes, particularly gymnasts. Ruzicka and Heublein² observed the frequency of this fracture in soldiers. They are brought about by indirect force, as falling upon the palm of the hand, rarely by a direct blow. Usually only one navicular is fractured, and bilateral fractures are rare. Fractures of the navicular may be either complete or incomplete, extra-articular or intra-articular, recent or old. Fractures through the body represent the intra-articular type. Since these fractures require frequent changing of the cast, roentgenograms should be made whenever the cast is changed. If normal healing is progressing, callus formation will be present at the fracture site at the end of four weeks. If decalcification and absorption of the adjacent bone are present at this time, early non-union should be considered. At eight to ten weeks sufficient calcified osteoid tissue should be present to represent clinical union, although well-defined bony trabeculae are not evident.

Three to six months are required for complete bony union and obliteration of the fracture line.

Ununited fractures of long duration show separation of the fragments and marked sclerosis of the bone margins associated with cystic and hypertrophic changes (Fig. 1). In some cases of non-union a bone peg is inserted (Fig. 2).

Fractures of the lunate are rare. Dislocations are more frequent and occur in adults. Fractures of the lunate are oftentimes accompanied by fractures of other bones in the wrist, particularly the navicular and triangular. The distal end of the radius may also be fractured.

Dislocation of the lunate occurs because this is the least securely anchored of the carpals. It usually takes place with the hand in hyperextension, and the bone is forced toward the palm. When the lunate is dislocated anteriorly, a lateral roentgenogram shows it to be palmar to the

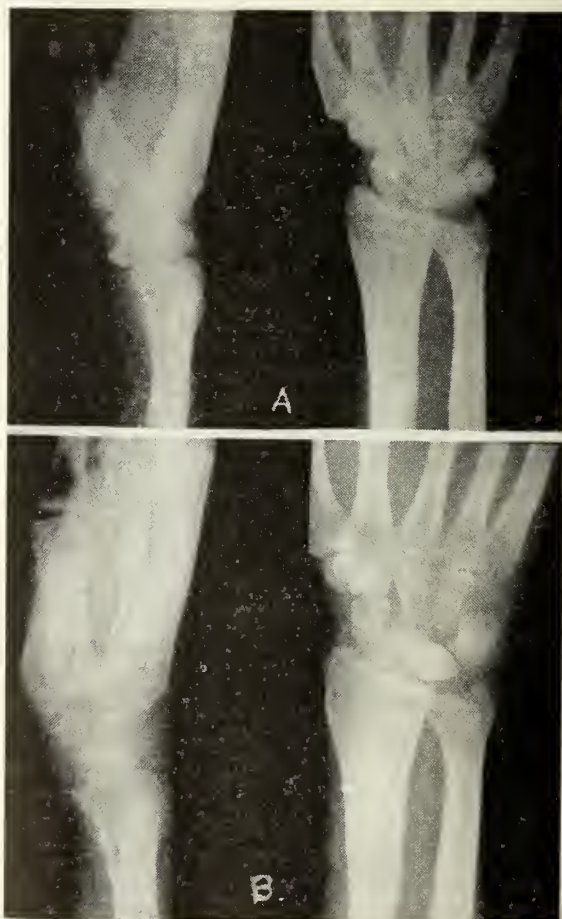


Fig. 3. (A) Fracture of the body of the navicular with dislocation of the lunate. Note the fissure fracture across the body of the navicular. In the dorsopalmar projection the outline of the lunate is triangular and overlaps the shadows of the triangular, capitate, and hamate. In the lateral projection the lunate is seen to lie below the other carpals with its deep concavity lying palmarly indicating 90 degrees' rotation. Note also that the other carpals are in alignment with the distal articular surface of the radius. (B) Same case three months later. Note that the fracture of the navicular has filled in and that healing is almost complete. All the regional bones except the lunate show a slight osteoporosis from disuse. The lunate, however, is much denser than the other bones, indicating avascular necrosis. This has taken place in spite of prompt and adequate reduction of the dislocation.

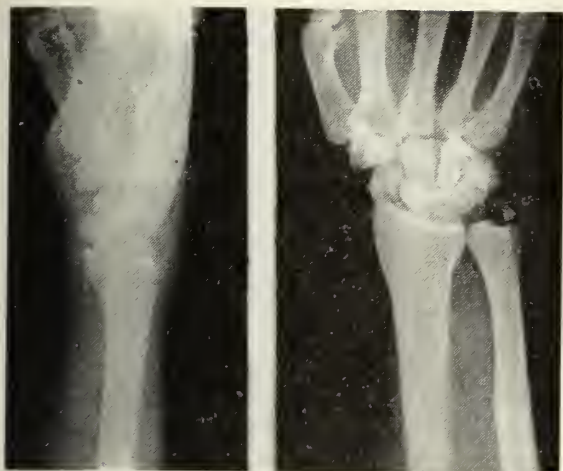


Fig. 4. Fracture of the body of the navicular with perilunar dislocation of the distal half of the navicular and the other carpals. In the dorsopalmar projection the shadows of the proximal half of the navicular and the lunate are overlapped by the shadows of the other carpals. In the lateral projection the relationship of the lunate to the distal articular surface of the radius is normal, but the other carpals are dislocated dorsally. There is also a fracture of the styloid process of the ulna.

capitate with its deep concavity plainly visible (Fig. 3-A). The angular direction of the concavity determines the degree of lunate rotation. Frequently bone circulation is disturbed by the periosteal injury, and at times injury to the median nerve follows compression.

Transnavicular fracture with dislocation of the lunate is readily diagnosed (Fig. 3-A). Aseptic necrosis may take place even though the dislocation of the lunate has been properly reduced (Fig. 3-B).

Transnavicular fracture with perilunar dislocation is more difficult to diagnose. In this injury the proximal fragment of the navicular and



Fig. 5. Fracture of the body of the navicular and fracture of the triangular. Note that the fracture of the navicular is of the fissure type, and that there are two fracture lines in the triangular. There is no evidence of dislocation of any of the bones.

the lunate remain in their normal positions in the radiocarpal joint. The other carpals, however, and the distal fragment of the fractured navicular are displaced dorsally (Fig. 4).

The opposite type of injury occurs when the proximal half of the navicular and the lunate are dislocated. The distal half of the navicular and the remaining carpals stay in normal position.

When multiple fractures of the carpals occur, any combination of them and the distal ends of the radius and ulna may be found. A fracture of the navicular associated with a fracture of the triangular is shown (Fig. 5). However, the navicular may be spared and another carpal may take the main force of the blow.

Isolated dislocations of the other carpals are rare. Dislocation of the lesser multangular bone is extremely rare. Sampson³ reported three cases and found only eight others recorded. He states that the diagnosis is made by observing overlapping of the shadows of the lesser multangular and navicular bones.

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NEW LOW MATERNAL MORTALITY RATE ESTABLISHED

Final tabulation of births and maternal deaths for 1947 by the national Office of Vital Statistics indicates a new record low maternal mortality rate of 1.3 per thousand live births, according to an editorial in a recent issue of the *Journal of the American Medical Association*.

No other nation has reported a lower rate.

In 1933 the American rate of 6.2 placed this country eleventh among the leading nations. Since then the drop to 1.3, amounting to a 79 per cent reduction, has "undoubtedly raised the rank of the United States to first place or close to first place" according to *The Journal*.

"The phenomenal reduction in maternal mortality in the United States," said *The Journal*, "has not been restricted to any single state or group of states, but has been relatively uniform throughout the entire country."

None of the states in 1947 had a rate above 2.6. Connecticut, Delaware, Iowa, Massachusetts, Minnesota, Oregon, Rhode Island, Utah, and Wyoming reported a rate less than 1.0, with Minnesota the lowest at 0.6 (Pennsylvania 1.3).

None of the states had a rate lower than 4.3 in 1933. In that year the spread between the highest and lowest was from 11.5 to 4.3, or 7.2. In 1947 the spread dropped to 2.0.

The great improvement in the rate was reflected among non-whites as well as white Americans. For whites the rate declined from 5.6 to 1.1 and for non-whites from 9.7 to 3.3.

Short History of Psychiatry and Neurology in Pennsylvania

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THE growth of neurology and psychiatry in Pennsylvania well represents the growth of the two specialties in the United States. In a brief review we have named only those pioneers who made their marks in history in the last century.

Up to 1840 the patron saint of psychiatry, Benjamin Rush, dominated the American scene by his work with mental patients at the Pennsylvania Hospital in Philadelphia and by his amazing book *On the Mind*. Far from being a specialist his amazingly varied accomplishments are well covered in an article by Dr. Clifford B. Farr.*

In 1844 the American Psychiatric Association was founded in Philadelphia by thirteen energetic and progressive superintendents of mental hospitals. Three physicians who attended the opening meeting, Thomas S. Kirkbride, John Curwen, and Pliny Earle, had importance for Pennsylvania. All three became president of the American Psychiatric Association. Earle had been a resident physician at Friends Hospital. Kirkbride was the author of a building plan which was adopted for the Harrisburg, Dixmont, Warren, and Allentown State Hospitals (with a variation at Norristown) and which spread to thirty-one states. Curwen was the first superintendent at Harrisburg, helped to select the sites of Danville and Warren, and became superintendent of Warren State Hospital.

Two decades later Pennsylvania, and particularly Philadelphia, began a long and rich tradition in the development of neurology in the United States, so much so that it has become customary to speak of the Philadelphia school of neurology. Because of the concentration of medical education in Philadelphia, much of the development of neurology in Pennsylvania is derived from that city, but significant contributions have come from other areas.

During the Civil War Dr. S. Weir Mitchell

made brilliant studies of peripheral nerve injuries and causalgia.

In 1888 it was a Philadelphia surgeon, a general surgeon (Dr. W. W. Keen) since neurosurgeons were unknown in those days, who first removed a brain tumor successfully. The operation was a radical departure and indicated that the brain could be exposed and handled at operation with complete recovery of the patient. The first good clinical description of Huntington's chorea came from Philadelphia. Furthermore, it is not generally realized that electrical stimulation of the human brain was first successfully performed in 1874 by a Philadelphian who was so bitterly criticized for his audacity that his experience left him embittered and frustrated. Today such a procedure has become routine and has contributed much to the understanding of the functions of the human cerebral cortex.

Neurology and psychiatry had these good records of advances in Pennsylvania, but they came to a violent clash in 1894. Then when Dr. Mitchell was educating the public to the fact that there existed such things as neuroses, he was invited to address the fiftieth anniversary meeting of the American Psychiatric Association—of course in Philadelphia. He took the opportunity to tell the assembled hospital psychiatrists that they were running boarding houses with not enough research, teaching, or treatment. He voiced a complaint which can be repeated today: "Your hospitals suffer from a shortage of trained personnel." An unkind remark, which was not cordially received, was "Your asylums are relentlessly watched by one of the ablest groups of men known to me, the neurologists." Half of Mitchell's suggestions were good; half of them were impractical as they ignored the limitations set by financial and other considerations.

In 1885 the Pennsylvania Hospital established an outpatient clinic at its general hospital—an experimental step to attack "incipient mental disease."

In 1917-19 World War experiences shared by many Pennsylvania psychiatrists brought attention to the neuroses and psychiatry began to extend out of its hospitals. Clinics for outpa-

Read before the Section on Nervous and Mental Diseases at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 7, 1948.
* *American Journal of Psychiatry*, Vol. 100, No. 6, April, 1944.

tients sprang up. And then children's clinics were started in Philadelphia, Pittsburgh, Harrisburg, and Wilkes-Barre, an important step in bringing all kinds of behavior disorders under psychiatric scrutiny.

Much of the early development of neuropathology in the United States owes its impetus to the researches of the Philadelphia school. These were directed primarily toward the correlation of clinical disease and pathologic changes in the nervous system, the result being a clarification of the life history of many diseases, from which understanding the neurologists of today borrow heavily. Among the most important of these studies was the clinical description and the anatomic correlations of the postero-inferior cerebellar artery syndrome and the clarification of the anatomic pathways of the spino-thalamic tract. In more recent years have come studies on pallidal degeneration and the relationship of the hypothalamus to emotional disorders.

It is clinical neurology, however, for which the Philadelphia school has become justly famous. It was here that the operation for section of the trigeminal root in trigeminal neuralgia was devised and carried out by an intimate correlation between neurologist and neurosurgeon. The operation was performed originally as a complete section, but later was modified to a partial section in order to spare the fibers to the cornea. This was made possible by an understanding of the anatomic situation of the various fibers in the trigeminal root, by studies made possible through the tic operation. The relief of pain by means of section of the spino-thalamic tract in the spinal cord, usually referred to as cordotomy, also originated in this city, and together with the operation for trigeminal neuralgia brought relief from pain to thousands of sufferers. Some of the most important early observations on cerebral localization came from clinical studies of one of the deans of American neurology. Philadel-

phia has contributed to the field of clinical neurology important studies on the functions of the cerebellum and the meaning of cerebellar asynergia; localization within the cerebellum; aphasia and correlated disorders of speech; adiposa dolosa; the treatment of epilepsy; the surgical treatment of pituitary tumors; the clinical features of cerebral aneurysm, to mention only the most outstanding of the studies. In addition, many minor studies have come, all of which have helped to clarify many neurologic syndromes.

From Philadelphia has come pioneer work in axonal physiology, which has resulted in the furtherance of fundamental understanding of conduction of the nerve impulse.

In the last quarter-century the understanding and treatment of the neuroses, and the fragments of neuroses in everyday people, have increased to an amazing extent. Understanding has spread back into the psychoses. Psychoanalysis has largely been responsible as it has made its appearance as a specialty and an influence in all psychiatric work. Psychotherapy in general has advanced for individuals and for groups. For patients who wish to consult physicians in their offices—in private practice or in clinics—there are in Pennsylvania more than a hundred psychiatrists and about fifteen psychoanalysts.

Pennsylvania psychiatrists led in activities in Army, Navy, and Air Forces in World War II and came out sadder but wiser men.

Present-day leaders know how to add the new to the old, which after all is in the Pennsylvania tradition. Neurology and psychiatry have taken their rightful place in Pennsylvania's six medical schools. Both specialties are reoriented to changed conditions. "The Philadelphia Story" brings many promising young physicians to Pennsylvania each year for training and inspiration. These physicians carry the "Story" to every corner of the country.



Inoperability Versus Incurability in Tumor Management

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IN VIEW of the increasingly important role the family physician is playing and will continue to play in cancer control, it is vital to the success of the over-all program that he maintain a viewpoint on the subject of cancer which is consistent with modern facts and beliefs and calculated to do the most good for the greatest number of people.

It is unfortunate that a defeatist attitude still persists among many of our colleagues. Too many of us have not been shown the benefits of carefully planned and courageously executed cancer therapy, both radiologic and surgical. Too many of us still believe that unless a patient with malignant disease can be cured by surgery, the case is hopeless; that is, too many of us still believe that a patient classed as "inoperable" is "hopeless" and "incurable." It is true that "inoperability" prior to the days of modern radiation therapy did mean "incurability." This picture has changed. Today a small but appreciable percentage of "inoperable" cases can be salvaged with adequate irradiation treatment, patiently delivered. Others of these "inoperable" patients, although not curable, can be given worth-while palliation (see Table I).

To bring into sharper focus this new group of "curable" patients and to develop the full picture of cancer therapy today, it may be well to review briefly the somewhat parallel development of surgical and radiologic effort with regard to oncology (see Table I).

Prior to the turn of the century, the development of aseptic surgical technique brought about a marked reduction in the incidence of sepsis, and, as a result, mortality rates dropped amazingly. Operations previously unsafe were now made technically safe procedures.

Possible at last were operations obeying fundamental oncologic precepts well recognized for years but previously impossible of attainment. In many instances radicalism ran wild. Two problems arose. First, it became necessary to establish just what cases were to be considered

"operable" or, in other words, at what stage in the extent of malignant disease the surgeon should refrain from attempts at curative surgery. This could be learned only by experience. The momentum of early enthusiasm swung the pendulum to the extreme of radicalism, but receded as it was learned that operative procedures failed to cure if the malignancy was advanced beyond a certain stage. Despite the technical feasibility of performing an ostensibly adequate radical operation, such advanced cases have come to be considered "inoperable"—"categorically inoperable."

Although the search for a full answer to the first problem still continues, a great deal has been learned about "operability" and "inoperability" since the days of Halsted and Willy Meyer. Recent advances in medical knowledge have encouraged some stout-hearted surgeons to attempt extension of the horizons of "operability" in fields perhaps previously not fully explored because of technical limitations now thought by some to be more or less removed. Despite the wave of radicalism now developing, it is to be hoped that a proper balance will soon be reached.

It must be borne in mind that for every cancer death after wild surgery we will tend to add to the army of propagandists who believe that cancer is "incurable"; who believe that surgery not only shortens life by speeding the progress of the disease but actually makes the disease less bear-

CANCER			
PRESENT CURE RATE MAXIMUM			
%	SURGERY	IRRADIATION	CHEMOTHERAPY
10	OPERABLE	OPERABLE	OPERABLE
20			
30			
40	INOPERABLE	INOPERABLE	INOPERABLE
50			
60			
70	DOUBTFUL	DOUBTFUL	DOUBTFUL
80			
90			
100			

SURGERY

CURABLE BY SURGERY 34%

INCURABLE BY SURGERY 66%

DOUBTFUL PALLIATION

IRRADIATION

SOME CURABLE BY IRRADIATION BUT BEST TREATED BY SURGERY 28%

ALL CURABLE AND BEST TREATED BY IRRADIATION 12%

PALLIATION BY IRRADIATION

DOUBTFUL PALLIATION 30%

CHEMOTHERAPY

ADJUVANT THERAPY MAY BE SHOWN TO BE WORTHWHILE (5%) NO CURES

SOME AGENTS PROBABLY EXERT PALLIATIVE EFFECT

NITROSTANDARD 1%
STILBESTROL 2%
TESTOSTERONE 3%
RADIOACTIN 1%
ANTI FOLIC ACID 2%

LITTLE REPLACEMENT VALUE OVER IRRADIATION

Read before the Section on Pathology and Radiology at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 6, 1948.

* INCIDENCE OF CASES WHERE APPLICABLE

CASTIGLIANO 48



Fig. 1. Example of uncontrolled basal cell carcinoma, with invasion and destruction of inner and outer tables of frontal bone and involvement of retro-orbital area and dura mater. This case represents a failure following previous x-ray, radium, and operative procedures over a period of more than twelve years. At present inoperable by previous standards. An attempt to extend surgical horizons.

able. Every patient who dies will leave behind brothers, sisters, father, mother, and friends, many of whom will spread the story of despair. It is possible—no, very probable—that many cancer deaths of today could be traced to the defeatist attitude among the laity and among our colleagues, which has developed directly as a result of failure to cure in cases which have been unwisely selected for operation. Operating the “inoperable” is not a new pastime. This practice has been indulged in for years by men of meager experience. What is new is that capable, indeed brilliant, men are performing these surgical exercises on “hopeless” cancer patients.

Further exploration of surgical possibilities is desirable, I believe. However, we should concern ourselves with extending surgical boundaries in cases that stand a fair chance of long-term survival—based on past experience. Many malignancies of the head and neck and carcinoma of the cervix, because of the relatively delayed and low rate of distant metastasis, lend themselves to this program of extension of surgical effort in properly selected cases (see Figs. 1, 2, 3 and 4). These malignancies, as a rule, but not always, do most of their mischief locally or at least regionally. It cannot be denied that in cases of this type the present wave of radicalism may advance our methods of management. In general, however, it is likely that more long-term good would be accomplished by reserving radical surgery for those patients in whom the prospect for cure is brightest.

The second problem which arose after the advent of the new era of surgery was the need for definition of adequate surgery for “operable” cancer of any given body organ. In other words, just how far should a surgeon go beyond ex-

cision of the gross tumor in the absence of clinically demonstrable extension? This problem even yet remains incompletely settled. Today there still are many surgeons who in planning operative limits are guided by the extent of the tumor rather than by knowledge of the career of the lesion and pathways of local extension. Many other surgeons are convinced that the extent of the disease more than the extent of surgery is the big factor in the end result, even in “operable” cases. Such surgeons believe that if a conservative operation cannot cure, no operation, however radical, will cure. It must be emphasized that it is just as true today as it ever was that for small or “operable” cancers, big operations are needed; for large or “inoperable” cancers, small or no operations should be the general rule.

To cite a classical example of “inoperability,” we will select a case of breast malignancy in which the supraclavicular nodes are involved with metastatic cancer. A patient with disease advanced to this degree is with rare exceptions doomed. The patient will die of the effects of remote and widely disseminated metastasis. Regardless of the “radicalism” employed in removal



Fig. 2. Appearance of patient after radical excision of frontal area, evisceration of orbit, left temporal region, glabellar region, and upper malar region, with heavy electrocoagulation of dura in retro-orbital area. Postoperative course was stormy. Patient showed personality changes suggestive of prefrontal lobotomy. Brain slough occurred. To date, one year has elapsed since performance of operation.

of the gross tumor, surgery cannot cope with the microscopic disease which has already spread beyond the reaches of the scalpel. Halsted, after performing many operations carried to the point of sacrificing the upper extremity and clavicle, concluded that malignant disease of the breast, after reaching certain gross limits, was "incurable" by surgery and, therefore, "inoperable." This point in the extent of malignant disease might well be within the technical limits of gross operability, but the operation, regardless of how radical, would fail.

The limits of "operability" in regions other than the breast have been worked out on the same general lines, but for the most part have not reached the point of general agreement that exists in the field of breast surgery. Nevertheless, "technical operability" and "categorical inoperability" are terms that all cancer surgeons recognize, even though there is not full agreement as to whether the base lines thus far established are to be accepted as unchangeable. Let us define these terms. "Technical operability" means simply that a malignant process can be grossly resected with apparent adequacy, without undue risk of an operative death. However, despite the fact that the gross tumor is still resectable, if experience with similar cases has taught that in an advanced tumor of given extent, microscopic spread beyond the compass of rational surgery has already taken place and always results in failure to cure, the patient is "categorically inoperable." That is to say, the patient in question will not be cured by surgical interference; curative surgery is useless, however radical it may be or however adequate it may appear. Therefore, when the surgeon speaks of "inoperability," he nearly always speaks of "categorical inoperability." It does infrequently happen that a patient may be such a poor risk from a medical standpoint that he may be considered "technically inoperable" even though he might be "categorically operable." Cancer surgery, however, is not surgery of election. Untreated, the disease is 100 per cent fatal. It is seldom that a case is denied "curative surgery" because of a poor risk status, unless amenable to irradiation therapy.

A patient classed as "categorically inoperable" may nevertheless be a candidate for palliative surgery. In uncommon instances the extent of palliative surgery may appear quite radical—even unwarranted—to the surgeon inexperienced in cancer work. Those surgeons who have had to live with but a few of these patients soon realize that what these patients desire above life itself is ease, physical and mental. These patients

are not concerned with mutilation. They want the comfort that comes with the absence of pain or distress, absence of constantly discharging wounds with unbearable odors, and the absence of intolerable encumbrances of one kind or another. By palliative surgery, some of these cases can be converted into clean nursing cases which can be taken care of at home.

While operative technique was being developed and indications for radical surgery established, therapeutic radiology had gained a foothold and was moving slowly forward. After the early period of groping, the specialty during the past fifteen years has entered a period of healthy growth. This period has been characterized by an orderly evolution of method and persevering refinement of technique with critical and bridled evaluation of supervoltage therapy. We all hope that evaluation of supervoltage therapy will continue without fanfare or overenthusiasm.

The proper indications for surgery, x-ray, and radium in the treatment of progressive stages of malignant disease involving the various body organs have been worked out by trial and error methods. After many years of pioneer work on the part of many tireless workers, we have arrived quite definitely at a point where surgery, x-ray, and radium alone or in combination are finding fairly definite indications for use in the



Fig. 3. Roentgenogram showing large defect in skull.

minds of those treating malignant disease. That this work is finished, I do not suggest; that we have come a long way can hardly be denied.

Although many have protested that irradiation therapy is *not* competitive with surgery, the fact remains that where irradiation is employed in cases which are yet operable, the two modalities are in direct competition. The truth is that the pioneer radiologist has tried to do a better job with his weapons than the surgeon could do with his. In this attempt, sponsors of irradiation have had to concede defeat on numerous occasions in their endeavor to show superiority over surgery in the "operable" group of cases. End results achieved by irradiation techniques nevertheless have brought about fundamental changes in the management of some malignant lesions previously managed by surgery alone.

Irradiation is an effective agent in destroying malignancy if the cancer is accessible and reasonably responsive to such treatment. If the cancer is inaccessible, the malignancy must show a relatively high degree of selective response to the roentgen rays or radium rays. The latter tumors are called "radiosensitive." Tumors which show no selective response whatever are termed "radioresistant," and irradiation in this group can be of no value.

Some examples of accessible lesions where irradiation has become the dominant agent in the treatment of the local lesion and has largely replaced surgery are labial, oral, tonsillar, and some pharyngeal and endolaryngeal carcinomas. Generally speaking, surgery still remains the method of choice in the management of "operable" metastases in these lesions.

Other examples of accessible lesions for which irradiation is the dominant agent in their management are basal cell and squamous cell carcinomas of the face. Irradiation replaces surgery as the method of choice in the management of these epidermal malignancies, not so much because of superiority of cure rate but rather because of improved cosmetic results with at least as good a cure rate. The larger the lesion, the more true is the statement.

Except when the lesions are small, surgery still gets the call when epidermoid carcinoma involves the extremities, trunk, penis, scrotum, vulva, or anus. The unbiased worker favors surgery in these situations because the lesions are, on the average, more radioresistant; the tolerance of the tumor bed to irradiation is remarkably lower; the incidence of complications resulting from irradiation is accordingly greater, and the cure rate lower.

Carcinoma of the uterine cervix is perhaps

best managed the country over by combined x-ray and radium therapy. Here, as elsewhere, irradiation was able first to suggest its superiority in these cases mainly by the response and cures following treatment of cases classed as "inoperable" by the surgeon. Notwithstanding recent murmurings, in all "operable" stages of cervical carcinoma, irradiation in the hands of skilled therapists has to a large extent placed surgery in a secondary role.

It is evident that in the management of carcinoma of the skin of the face, labial and oral carcinoma, some pharyngeal and laryngeal carcinomas, and carcinoma of the uterine cervix, *not only has irradiation taken over in the "operable" group but it has shown itself able to accomplish survivals tantamount to cures in the more advanced cases classed as "inoperable."* In this group of cases it must be appreciated that irradiation not only has replacement value for surgery but has gone beyond that. Irradiation methods today salvage cases previously considered inoperable and incurable. The salvage of these "incurable by surgery" cases has extended hope to a small but appreciable segment of the whole cancer picture. There is no longer justification for continuance of the time-honored custom whereby the terms "inoperable" and "incurable" are employed as though they were interchangeable and synonymous. The danger in this position lies in the possible denial of a full chance for cure or maximum palliation to an appreciable number of cancer patients.

Irradiation methods have gained a position of dominance in this group by reason of intelligent and aggressive action. Puttering, "treat awhile and observe" methods played no part in this advance. The tendency to gauge by the size of the lesion the vigor of therapeutic attack to be brought to bear should be relegated to the past. Too often do we find that small lesions receive mere token irradiation therapy and/or small operations, while large and hopeless lesions are overdosed by irradiation or are insulted by useless surgical intervention. We must avoid underbidding good "hands," but by the same token we must avoid overbidding poor "hands."

In addition to its role as the dominant agent of therapy in the several types of malignancy described, irradiation plays an adjuvant or complementary role in the management of "operable" malignancy where surgery is the dominant agent. Preoperative irradiation still remains a frequently employed and undoubtedly valuable procedure in certain malignancies. Postoperative irradiation is less often used and many wonder as to its value in the majority of cases.

Some important examples of lesions where preoperative irradiation is used in the "operable" group of malignancies are:

1. Carcinoma of the corpus uteri where preoperative irradiation is generally to be advised (American Oncologic Hospital technique).
2. Metastatic cervical nodes in labio-oral carcinoma (A. O. H. technique).
3. Osteogenic sarcoma—where intensive preoperative irradiation is used by some (A. O. H. technique).
4. Certain soft tissue sarcomas (A. O. H. technique).
5. The breast. I recommend so-called preoperative irradiation only when the breast lesion approaches the alleged borderline of "operability." With such treatment we spare many patients useless operations by later demonstrating distant metastasis not discernible on first admission.
6. Some cortical renal tumors. The question is, however, whether or not any of these cases are truly "categorically operable."

Some important examples of lesions where postoperative irradiation is used in the "operable" group of malignancies are:

1. In carcinoma of the breast where axillary metastasis has been proved, irradiation of the drainage basin theoretically is a sound procedure and has proved itself to be a complement to surgery.
2. In seminoma of the testicle, postoperative irradiation to retroperitoneal nodes is recommended. Other malignant testicular tumors are probably better managed by pure surgery.

The place of curative surgery in the "operable" group has been discussed. In addition, the role of curative and complementary irradiation in the "operable" group has been dwelt upon, as has the ability of irradiation to salvage "inoperable" patients previously considered "incurable."

There still remains a large number of cases which are not candidates for either curative surgery or curative irradiation. This large group is made up of cases which because of their nature or because of their far-advanced state cannot be cured by any method available today. These cases are classed as "incurable."

An appreciable number of patients with "inoperable" malignant disease, although "incurable," can be given the benefit of reasonably long-term survival in comfort, and still others can be offered worth-while palliation by means of surgery, irradiation, or both.

"Incurable" cases can be divided roughly into three groups, depending on *average* response to irradiation management:

Group 1. Prolonged palliation achieved.

Group 2. Definite though short-term palliation realized.

Group 3. No palliation obtained. For this group, generally speaking, irradiation is of no value and may even add to the patient's discomfort and shorten life.

Examples of these three different groups are as follows:

Prolonged Palliation (Group 1): Carcinoma of breast (bone metastasis from breast), oral cavity, larynx, uterus, skin, tumor of testis, some brain tumors, some lymphoblastomas, some leukemias, etc.

Short-Term Palliation (Group 2): Carcinoma of esophagus, rectum, bronchi (some), prostate, some intrathoracic metastases with hydrothorax, some ovarian carcinomas, bladder and kidney tumors, some bone tumors, etc.

No Palliation (Group 3): Carcinoma of stomach, vast majority of melanomas, intestinal tract carcinoma, metastasis to liver, metastasis to lungs, some leukemias, and some bone tumors. Cases in this group are those in which the patient does not tolerate irradiation.

Palliative therapy implies conservative therapy. Conservative therapy should not be interpreted to mean indifferent treatment. These patients with far-advanced and "incurable" malignant disease are just as deserving of carefully planned management as the earlier cases. It is well known that in the exceptional case of far-advanced disease, where the balance in growth rate, patient resistance to disease, and radiosensitivity are optimum, inexplicably brilliant results are encountered. This is the experience of any active tumor clinic. Such results are en-



Fig. 4. Appearance of patient after multiple-stage development of tube pedicle and flap. Patient is now ready for sequestrectomy and elevation of flap. There has been no evidence of recurrence. Patient is in excellent condition and commutes forty miles three times a week for dressings. She awaits final efforts at reparative surgery.

countered often enough that almost no patient should be refused treatment. But it must be emphasized again that if a therapist sets out in an unrestrained effort to destroy every lesion that comes his way, he will fail to perform his task as a physician; he will not prolong life, nor will he alleviate suffering; rather, he will hasten death and add immeasurably to the patient's discomfort.

Palliation may involve a combination of methods, that is, surgery, irradiation, and chemotherapy (including hormones). The best examples are seen in carcinoma of the breast and of the prostate. In carcinoma of the breast, palliation in some form can be achieved by various agencies:

For bone metastasis—testosterone, x-ray therapy, castration.

For soft tissue recurrence or metastasis—surgery, irradiation, testosterone?, stilbestrol??, castration.

In inoperable carcinoma of the prostate, palliation may be achieved by orchectomy, stilbestrol, and irradiation.

It should be borne in mind that irradiation is still an important part of the management of "in-

curable" carcinoma of the prostate. After the transient beneficial effects of orchectomy and stilbestrol have passed, irradiation can be used with benefit.

Attempts to alter the course of malignancy by the use of chemotherapeutic agents is not new. The great American surgeon, Nicholas Senn, at the turning of the 19th century, said that no medicine given internally could exert any influence whatever in limiting tumor growth.

Not long after Senn wrote so clearly on the worthlessness of medicaments in the treatment of cancer, Coley offered his serum to a skeptical medical profession. Now, many years later, out of Bethesda, Maryland, and the National Cancer Institute, comes Shear with what is undoubtedly the isolated active principle of Coley's vaccine. This new serum is known as polysaccharide and it has gone through several stages of improvement. At the Oncologic Hospital we were able to use this agent in the treatment of several cases. Although no claims can be made for this form of treatment, it must be admitted that polysaccharide does appear to exert an apparently specific necrotizing effect on certain tumors of mesodermal origin (Fig. 5). Recent clinical ex-

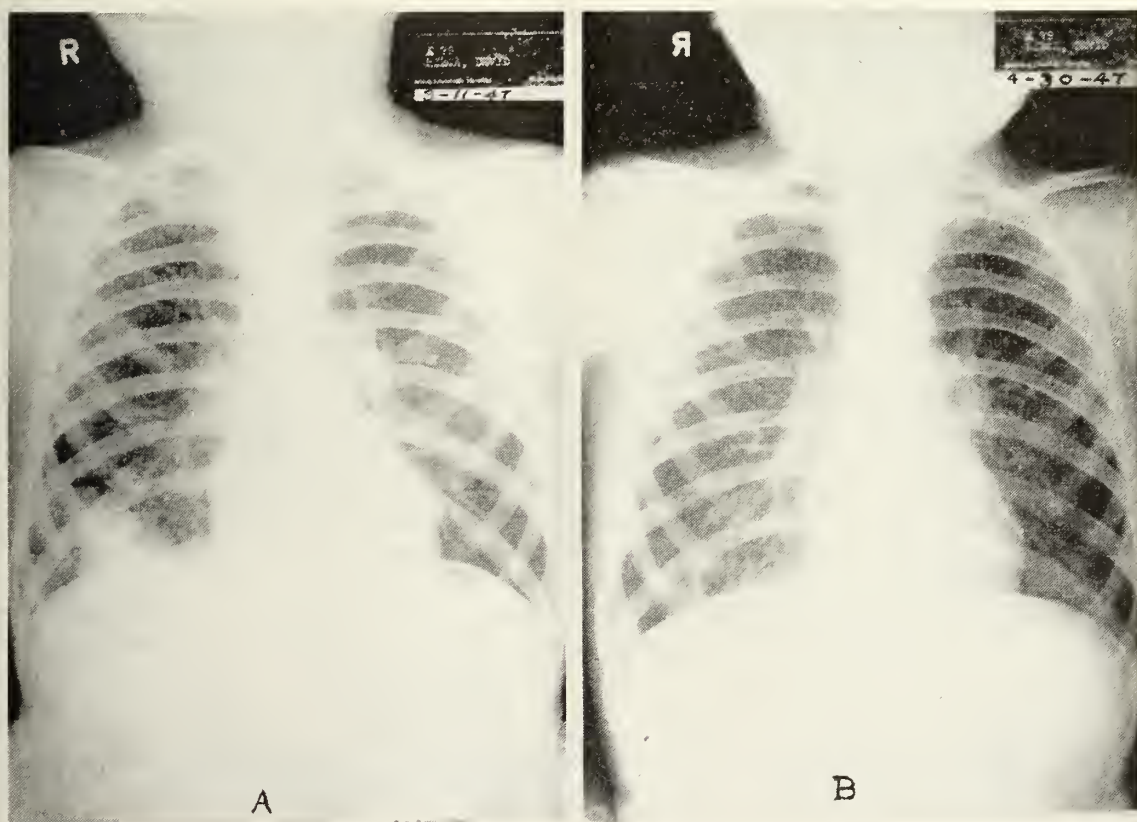


Fig. 5. (A) Pulmonary metastasis from primary fibrosarcoma of upper jaw as it appeared on March 11, 1947. (B) Clearing of pulmonary metastasis following polysaccharide therapy as it appeared on April 30, 1947. Recurrence apparent a few months later.

perience kindles a hope that a new and thrilling development in the treatment of malignancy may be within reach, and may not be more than a decade or two away. It is likely that the next significant advance in the treatment of malignancy may be the discovery of a chemical agent or agents which will exert sufficient tumor cell-destroying effect to permit irradiation or surgery or both to be successful in those cases in which today these agents so often fail. Success will be achievable because the new miracle chemicals when found will hold the local tumor at the stage reached when first seen and will prevent showers of tumor emboli from setting up metastatic foci, or, if metastases have developed in microscopic form, they will be destroyed. The new agents will in effect maintain the status quo and permit an all-out attack on the local lesion to bring about its destruction. If and when such an event comes to pass, complete re-evaluation of standards of "operability," "inoperability," and "incurability" will be necessary. Today such chemicals remain but a rekindled hope, but this hope burns bright in the hearts and minds of those best qualified to judge the prospects for the future.

Today testosterone in breast surgery and stilbestrol in prostatic surgery play their parts, and occasionally startlingly brilliant results are achieved. Nitrogen mustard employed in certain cases of the lymphoblastoma group has shown to advantage. Recent laboratory work with antifolic acid agents is stimulating. As for terofterin, the most that can be said is that the effects are unpredictable. An occasional rather startling palliative result has been obtained through the use of radioactive phosphorus or iodine, but the cost is still high and the results uncertain. It is highly possible that in the future there may be developed methods and agents for selective internal localized irradiation far superior to anything yet developed.

There are some few patients for whom rational surgery or irradiation can do nothing to allay distress or promote comfort; for these the least that can be done is to give mental rest through psychotherapy. For example, it is possible to have a patient with utterly hopeless metastatic cancer of the liver or lung draw his last breath still confident of recovery. This can be done by carefully preparing these patients to accept present and future symptoms as transient complications of treatment. Recent experience with prefrontal lobotomy suggests that another method of cancer palliation is being developed.

It must be said that he who treats a cancer patient accepts a heavy burden of responsibility.

Upon his shoulders will fall the guardianship of a patient who may live or may die but for his care. To meet this responsibility, the therapist among other considerations brings to his cancer patient:

1. A wholehearted interest in the cancer problem in general, and a burning interest in the welfare of each and every patient under his charge.
2. A full knowledge of the pathology of neoplastic disease in general, and the natural career and vagaries of the various types of malignant disease under treatment.
3. The realization that all cases of carcinoma that present themselves for study and treatment cannot be cured, and that radical treatment with curative intent should in general be reserved for those patients in whom the prospect for cure is bright.
4. The corollary appreciation that the advanced case, regardless of prospects for cure, requires just as much thought and planning, as occasional startling results may be achieved.
5. The ability to select wisely and without prejudice a tentative plan of management.
6. A thorough knowledge of the surgical indications and contraindications covering malignant disease.
7. The advantages which derive from a carefully controlled follow-up system in which patients are observed at regular intervals—not for five years but for life.

The therapist should be willing to educate his fellow staff members and general practitioners in the fundamental concepts of modern curative irradiation therapy. He must show that intensive treatment for properly selected patients is worth while; that long-term survival and apparent cure are possible; that a reasonable risk must be accepted; that intensive irradiation therapy is a far safer method of management than the still too commonly employed puttering irradiation methods and half-hearted surgical efforts; that temporizing methods can produce but a negligible percentage of cures, and, therefore, such management should have charged against it the sacrifice of those lives which might have been salvaged by adequate therapy.

Although measurable progress has been made in the management of cancer of the "inoperable" class, still too often the fight ends unhappily. Implemented as we now are, little further improvement in the management of advanced cancer is to be anticipated. Therefore, further improvement in the cancer picture must spring from better utilization on the part of patient and physician alike of existent knowledge to bring about adequate therapy in ever larger numbers of earlier cases. The need for research directed toward development of improved methods of treatment is paramount.

ONCHOCERCIASIS IN AMERICA

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ONCHOCERCIASIS is a relatively new clinical entity endemic in a small area of the Western Hemisphere, but widespread in Africa. The disease is known to few ophthalmologists, despite the fact that a million people are infected, many of them totally blind. It has been recognized as endemic in Africa since 1893, since 1916 in a small part of Guatemala, and since 1924 in two states of Mexico. In these limited areas of Central America about three-quarters of the natives are infected.

In America onchocerciasis is confined to the regions along the western slope of the Sierra Madre in Guatemala, an area 2000 to 4500 feet in altitude which extends several hundred miles from the slopes of the Fuego volcano in Northern Guatemala up into the states of Chiapas and Oaxaca, in Mexico. Many have suggested that the disease was brought into Guatemala by African slaves, but this remains without proof.

Although the disease prevails without regard to age, sex, or color, Europeans are rarely affected, possibly because they do not stay long enough in the infested areas. Ridley noted in 1945 that only 29 European cases have been reported, and only 4 of these had ocular lesions. In Guatemala, among a population of over two million, about 20,000 natives have onchocerciasis. Ocular lesions have developed in 30 per cent of these persons and 2 per cent are blind.

Onchocerciasis became endemic in Mexico a number of years after it developed in Guatemala, yet in 1926 Larumbe already found 4000 cases in Chiapas, with 800 showing symptoms of keratitis, iritis, and choroiditis, and 100 totally blind. Strong reported that 5 per cent of onchocerciasis patients in Guatemala were blind.

Onchocerciasis is a parasitic disease with man, the primary host of the *Onchocerca*, and a black fly, the *Simulium*, the intermediate host. Since this insect is necessary for the intermediate development of the parasite, man cannot infect man, but he can be a carrier of the disease and infect an uninfected insect. The parasitic na-

ture of the disease was first described in 1916 by Robles, a Guatemalan physician.

Calderon in 1920 suggested that the ocular lesions in onchocerciasis observed in America were caused by toxins from adult worms entering the blood stream, but since the parasite is not found in the blood, this theory was discounted, although toxins caused by the metabolism, excretions, and disintegration of the microfilariae in the eye tissues were long regarded as a primary cause of the lesions. That these toxins have an inflammatory effect in the eye was suggested by Robles, Calderon, and others, but the microfilariae are now generally considered the primary cause of the lesions. Puig Solanes suggests that acute ocular changes are due to general toxic factors, whereas chronic lesions are caused by local activities of the microfilariae.

Mode of Infection

Onchocerciasis can be caused only by the bite of the *Simulium* which has been previously infected by biting an infected man. The microfilariae ingested by the fly after biting the infected person develop into larvae within the insect and in turn are injected into the skin of man. Nodules are usually formed in the skin about the larvae, in the center of which the adult worms develop, male and female. The female produces hundreds of microfilariae daily, which penetrate the capsule of the nodule and crawl briskly through the neighboring superficial skin tissues.

The Intermediate Host. Although three species of *Simulium* exist in Central America which are carriers of *Onchocerca*, the main carrier is *Simulium ochraceum* (*Ochoterena*), first reported by Bequaert; in Africa the intermediate host is the *S. damnosum*.

The *Simulium* breeds in Central America in cold swiftly running streams in areas 300 to 1200 meters in altitude. They bite only in the daytime in America, and about five feet from the ground. In Guatemala and Mexico they infest the coffee plantations, hiding in the tall grass beside the streams, and usually bite only when disturbed.

Read before the Section on Eye, Ear, Nose, and Throat Diseases at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 5, 1948.

They are not found in the homes. The American flies rarely travel more than five yards from their breeding places, but on occasions have been found at a distance of 500 to 700 yards. In experimental studies it was found that if uninfected flies bite in the vicinity of an infected nodule on a man, 80 per cent will become infected; if the bite is at some distance from a nodule, only 17 per cent will become infected. While the fly is sucking blood, a process which takes several minutes, microfilariae are attracted toward the spot. The microfilariae imbibed by the *Simulium* during this process, as many as 100 at each bite, enter the alimentary canal of the fly, where development begins. The larvae then pass into the thoracic muscles for further growth and finally arrive at the proboscis, ready for transmission to the human being when the fly takes its next meal.

The Onchocerca. The former microfilariae have now advanced to the adult stage and upon injection into man crawl beneath the outer layers of the skin, and in most cases are gradually surrounded by a nodule, which may vary in size from a small nut to that of a pigeon's egg.

The adult filaria may live many years and the microfilariae have lived long after extirpation of onchocerca from the nodules. The female worm is 30 to 50 cm. long and the male 2 to 3 cm. in length.

Ocular Lesions

Eye infections in onchocerciasis were first described by Robles in 1916, by Pacheco-Luna in 1918, and by Calderon in 1917 and 1920 in Guatemala, and by Larumbe in Mexico in 1928.

The ocular lesions are caused by the microfilariae and their toxins which penetrate into every part of the eye. The most frequent route of invasion into the eye, according to Nettel, is through the skin of the lids by way of the palpebral conjunctiva. Once the microfilariae enter the eyeball, they are trapped and cannot make their escape.

The earliest symptoms are irritation and photophobia accompanied by lacrimation, a condition which may last for a long time. It is because photophobia is so distressing that patients from whom the parasites have been removed from the skin report a great improvement in vision. Actually the vision does not improve, but the process may be arrested because there is no further invasion by microfilariae.

The microfilariae enter the tissues of the eye, the conjunctiva, the cornea, the iris, the anterior chamber, the choroid, and even the optic nerve. The continual passage of these parasites about

the eye is now regarded by most writers as the cause of the inflammatory processes in the eye, rather than the toxins they create. By means of the slit lamp and the corneal microscope, it has been possible to observe the movements of the microfilariae moving about within the eye. Some patients report seeing the shadow of a moving foreign body in the eye. Torres Estrada found microfilariae more abundant in the vitreous than in the anterior chamber. They have been observed in the vitreous even when skin biopsies have been negative.

When photophobia is present, the patient may suffer needle-like pains, especially at midday when the light is brightest. There is also a slight impairment of sight. The conjunctiva feels dry and the pupil is fully contracted. Examination shows the cornea to be invaded by small white dots, developing into a superficial chronic punctate keratitis, mostly in the lower half of the cornea, and increasing toward the lowest point of the limbus. Gradually an acute plastic iritis develops, which later becomes fibrinous with an exudate into the anterior chamber. An iritis sometimes precedes keratitis, in which case Descemet's membrane is affected first. This is discovered only on examination, as there are no subjective symptoms. In some cases, keratitis and iritis occur simultaneously.

As the iritis becomes chronic, adhesions are formed between the iris and lens with deviation of the pupil and formation of an opaque membrane, forcing down the pupil until it is pear-shaped. The generalized atrophy of the pigment of the iris produces a spongy appearance. Finally, there is a gradual occlusion of the pupil.

The microscope may reveal small round white spots close to the surface of the cornea, a condition which Pacheco-Luna felt was especially characteristic. The deep lesions occurring on the cornea, Strong suggested, are due to toxic products of microfilariae or of degenerate parasites. When the corneal opacities increase and become confluent, the lower third of the cornea has the appearance of frosted glass. The superficial vessels then produce a form of pannus. Finally, the pannus progresses toward the center of the cornea and obscures most of the cornea.

Ridley found lesions of the cornea in 45 to 51 cases, a characteristic distorted pupil in 9 of the cases, cyclitis in 20 cases, and cataract in 20 cases. Choroidal retinal changes were observed in 12 of his 51 cases and optic atrophy in 14 of these cases. The optic atrophy was present in all cases in which there were gross choroidal retinal changes. Microfilariae found in the choroid, as observed by Torroella, Hissette, and

Bryant, if dead, seemed to produce a reaction with mononuclear inflammatory cells and occlusion of the small blood vessels, so that the outer layers of the hexagonal epithelium became heaped into masses.

Diagnosis

The diagnosis of onchocerciasis is usually simple. Snippings of skin from the area around a nodule or from the conjunctiva or aspiration of fluid from a nodule usually reveal the presence of microfilariae. If the snipping is placed in normal saline on a slide and slight pressure with the finger is exerted on the coverslip, worms may be seen to escape from the edge of the material and swim in the solution.

Observation of microfilariae within the eye is a positive proof of onchocercia infection, but their absence does not necessarily indicate non-infection, since every patient with this disease does not have parasites within the eye, particularly those in whom the infection is rather recent.

Silva reported that he saw microfilariae having very refringent bodies with golden shadows on the surface of the retina, by use of a Gullstrand ophthalmoscope. Torres Estrada found that microfilariae may be seen easily in the vitreous with the electric direct-image ophthalmoscope, using a plus 20 or plus 40 diopter lens. This method has been used successfully by a number of observers. When the microfilariae in the anterior chamber are seen with the corneal microscope they look like fine white active filaments with golden reflections, but when seen with the ophthalmoscope, they look like fine black filaments on a reddish background.

Treatment and Prognosis

The only effective treatment of onchocerciasis has been extirpation of the nodules. Unless the patient is bitten again by an infected *Simulium*, no more microfilariae will be produced and those present in the body will ultimately die. However, the microfilariae have been found to exist many years after the filariae have been removed from the nodules. Careful search for every possible nodule is necessary.

Drug therapy has proved generally to be of little value.

Clark, in 1946, made a preliminary report of an investigation made through the invitation of the Pan-American Sanitary Bureau, in the village of Yepocapa, Guatemala, a community of 8000 people. Complete ophthalmic examinations and biopsies of the skin and conjunctiva were made on 1215 persons having or suspected of having onchocerciasis.

In 967 of the 1215 patients, nodules were removed or had been previously removed. Although removal of the tumors is the accepted method of treatment, Clark said he doubted its value and hoped that useful drug therapy would be developed.

Pacheco-Luna said in 1946 that the sanitary authorities in Guatemala are doing their best to exterminate onchocerciasis. Groups of health workers have been organized who visit the infected regions periodically to operate on all tumors observed. Every infected individual is a potential carrier of the disease.

In Guatemala and Mexico, where only small circumscribed areas are infected, the vector may be destroyed by treating the streams in the dry season with oil and by cutting down the foliage in the neighborhood of the streams. With a much reduced number of human carriers and of insects, many feel that the disease can be brought under control.

Possible Extension of Endemic Areas

Many writers have suggested the possibility of extension of the infection into other areas, even into the United States where many species of the *Simulium* are found. The question has been forcibly brought forward by Brumpt in his description of the hazards produced by the new Pan-American Highway. He thinks that the road has created a medical entomologic problem.

The highway will cross Chiapas, one of the infected states of Mexico, and the infected district of Guatemala. The *Simulium* is found in many parts of Mexico, especially along the Gulf and Pacific plateaus and since the vectors are more widely spread than the disease itself, microfilaria carriers using the highway will constitute an international danger. Brumpt points out that there is no danger to tourists, since white people generally seem immune and require many bites before becoming infected. In 1946 Clark stated that he and his co-workers had been bitten a number of times when they had grown careless regarding protective measures, but none had become infected.

Twenty-eight species of the *Simulium* are found in the United States, half of which bite man, but none are infected with onchocerciasis. The species bearing the infection in Central America and in Africa are *not* among those found in United States, but whether any of the twenty-eight can become infected is not known. The only way this can be experimentally determined is to have these flies bite an infected person and then examine them for micro-

filariae. The National Institute of Health in Washington has been conducting studies in Guatemala and Mexico regarding treatment of onchocerciasis with various drugs. A recheck in Guatemala after a five-month period has not yet been reported. Apparently the antimony-containing drugs have been most successful. The fact that the *Simulium* in Central America re-

quires a high altitude for breeding is not considered too important. The chief concern is over the possibility of flies in the United States becoming vectors.

Since this article was written, it has been found that Hetrazan (Lederle), developed during the war for filariae, is an effective form of treatment.

OBSERVATIONS OF A DELEGATE

Well versed, as I thought, in county medical society procedure and impressed with my own righteous ability to reflect the opinion of the doctor-at-the bedside on all controversial matters, I sallied forth, pure neophyte, to the House of Delegates of the State Medical Society. I arrived in Buffalo with a slight but definite resentment at what I considered errors of conduct of the state society and the American Medical Association.

I envisioned a nice three-day vacation with plenty of sleep and little serious responsibility. I returned, however, with my mind thoroughly disabused of many ideas that I had held concerning our parent body and, incidentally, I came home to catch up on sleep and to realize that with the honor of a delegate goes responsibilities.

The House was in session from 9 a.m. to 11 p.m. with short interludes for lunch and dinner, and before and after each day's session many county delegations caucused in their quarters to crystallize opinions on impending legislation. I have never witnessed a business meeting so well organized or conducted. The reference committees, to which resolutions were given for discussion and recommendation, were headed by chairmen who were unusually able. Everyone was given ample opportunity for exhaustive discussion and presentation of arguments.

One was immediately struck by the seriousness of the deliberations and the conscientiousness of the members. The delegates were in place before the gavel fell, and practically every seat remained occupied until adjournment. Debate was lively, expansive, and free but the persuasive influence of the older delegates on opinion was noticeable. Also, the senior members managed to head the balloting. This is as it should be, since they had proved their worth and reliability by devoted service.

Observation of the House of Delegates in action answered many questions for me. Years of service to the county medical society are necessary before the position of delegate can be attained. Years of attendance at the House of Delegates are imperative before office in that body is the reward. Thus, necessarily, the delegates to the American Medical Association will be among our elder statesmen. Because major changes in policy must be ratified by the House of Delegates, the state society will of necessity trail the county society in adapting itself to changing social concepts.

We must choose our delegates carefully and consider the office as one of the highest obtainable in our society. Great responsibility devolves upon the individual members of the county society and, in turn, upon the delegates.

The county society must assure itself that delegates are thoroughly conversant with the local point of view. In turn, the delegates must be ready to interpret to the county society the action of the state society on all major problems. A delegate must consider himself responsible to the county unit, regardless of his progress in the halls of the parent body.

All in all, I am proud of our state society, its officers, its delegates, and its competent, business-like conduct of affairs. I am particularly proud of and indebted to our own delegates for their faithfulness to their responsibilities. The health interests of this state are being guarded competently and altruistically by an organization in which we can take justifiable pride in being a small but no less essential cog in the wheel. —WARING WILLIS, M.D., *Westchester Medical Bulletin*, New York.

RADIOIODINE EFFECTIVE AGAINST TOXIC GOITER

Ninety-five of a series of 100 patients treated for toxic goiter with radioiodine show improvement, reports Robert H. Williams, M.D., Seattle, formerly of the Department of Medicine, Harvard Medical School, Boston.

Writing in the April 16 *Journal of the American Medical Association*, Dr. Williams says that the condition has persisted in only five of the group. The disease has been in remission more than a month in 92 of the patients, and 80 have had no reappearance for more than four months. Three have been well more than two years.

Forty of the group had been treated previously with thiouracil, a drug frequently used against toxic goiter, and 21 had surgery for the condition.

"In most of the 78 subjects with diffuse enlargement of the thyroid, the gland decreased to an essentially normal size," Dr. Williams points out. "Each of 22 patients with toxic nodular goiter had a decrease in size of the thyroid, but, in a few, significant enlargement persisted despite large doses of radioiodine."

Treatment with radioiodine is "relatively inexpensive" and is not associated with significant physical or emotional discomfort, according to Dr. Williams. In the majority of cases, he found, a remission of hyperthyroidism can be produced in six months.

"The main drawback of the treatment is the difficulty involved in selecting the appropriate dosage, errors in which may cause myxedema or permit the thyrotoxicity to persist," he says.

THE GUEST SPEAKERS

Pittsburgh, September 26 to 29

Monday



SILAS M. EVANS, Milwaukee, Wis. — *Pathogenesis — Symposium on the Present Status of the Silicosis Problem, Monday, 1:30 p.m.* Dr. Evans, a graduate of the University of Wisconsin Medical School, was certified by the American Board of Internal Medicine in 1945. He is assistant professor of medicine at Marquette University and a member of the staff of Columbia Hospital, Milwaukee Hospital, Milwaukee Children's Hospital, and Milwaukee County Hospital.

WALTER KEMPNER, Durham, N. C. — *Treatment of Heart and Kidney Disease and of Hypertensive and Arteriosclerotic Vascular Disease with the Rice Diet — Symposium on the Newer Aspects of Cardiovascular Disease, Monday, 4:20 p.m.* Dr. Kempner was graduated from Heidelberg University and interned at the University Hospital. He was research associate and assistant to Professor O. Warburg at Kaiser Wilhelm Institut f. Zellphysiologie in Berlin and assistant physician at University Hospital of Berlin. He was associate physician at Duke Hospital from 1934 to 1947, and is presently associate professor of medicine at Duke University School of Medicine.

Tuesday



ARTHUR R. COLWELL, Chicago, Ill. — *Types of Diabetes Mellitus and Their Treatment — Symposium on Diabetes Mellitus, Tuesday, 9:00 a.m.* Following his graduation from Rush Medical College, Dr. Colwell did graduate work in physiology at Harvard Medical School and specialized in metabolic diseases in Chicago and Evanston. He is associate professor of medicine and director of medical specialty training at Northwestern University Medical School, attending physician at Evanston Hospital,

consulting physician at the Wesley Memorial Hospital and Municipal Tuberculosis Sanitarium in Chicago. He is president of the Chicago Diabetes Association and director of the American Diabetes Association. He was certified by the American Board of Internal Medicine in 1937. Dr. Colwell has been particularly interested in the use of insulin modifications and will highlight an excellent program dealing with various phases of diabetes mellitus.



FLETCHER D. WOODWARD, Charlottesville, Va. — *Medical Criticism of Modern Automotive Engineering — Eye, Ear, Nose and Throat Diseases, Tuesday, 9:40 a.m.* Dr. Woodward is professor of otolaryngology and chairman of the department at University of Virginia Hospital, Charlottesville, Va. He has been certified by the American Board of Otolaryngology and is a member of the American Academy of Ophthalmology and Otolaryngology, the American Laryngological Association, the American Laryngological, Rhinological and Otological Society, the American Otological Society, and the American Bronchoscopic Society.



WOLF ZUELZER, Detroit, Mich. — *Anemias of Infancy and Childhood — Symposium on Pediatric Endocrinology, Tuesday, 11:25 a.m.* Dr. Zuelzer received the degree of Doctor of Medicine at the Prague German University and Wayne University, Detroit. He was certified by the American Board of Pediatrics in 1946 and has been director of laboratories and associate pediatrician-in-chief at Children's Hospital of Michigan. He also has been professor of pediatric research and assistant professor of pathology at Wayne University.



JOHN D. STEWART, Buffalo, N. Y. — *Surgical Aspects of Peptic Ulcer — Symposium on Advances in Surgery, Tuesday, 10:40 a.m.* Dr. Stewart was graduated from Harvard Medical School and was surgical staff member at Massachusetts General Hospital and Harvard Medical School. He is now professor of surgery and chairman of the department at the University of Buffalo and head of the department of surgery at Edward J. Meyer Memorial Hospital in Buffalo. During World II, he was consulting surgeon to the Army Air Forces in the North African-Mediterranean Theater of Operations. He is a member of the American Society for Clinical Investigation, the American Surgical Association, the

American College of Surgeons, the Society of University Surgeons, the International Society for Surgery, the Society of Clinical Surgery, and a member of the Committee on Surgery of the National Research Council.



LOUIS SCHWARTZ, Washington, D. C.—*Dermatitis and Fabrics—Dermatology, Tuesday, 1: 20 p.m.* Dr. Schwartz is a graduate of Jefferson Medical College of Philadelphia and entered the U. S. Public Health Service in 1906. He served as medical director and chief, Office of Dermatology, Industrial Hygiene Division, and is now consultant dermatologist to the Celanese Corporation of America. During World War II, he made dermatologic investigations of skin hazards in Army and Navy manufacturing plants, recommended methods for the prevention and treatment of skin diseases, and supervised dermatologic clinics for the treatment of members of the armed forces. He is a member of the Committee on Dermatology Nomenclature of the American Medical Association; a diplomate of the American Board of Dermatology and Syphilology; associate clinical professor of dermatology and syphilology at New York University College of Medicine, and adjunct professor in dermatology at Georgetown University School of Medicine. He is a fellow of the American Public Health Association and of the American Academy of Dermatology and Syphilology, an honorary fellow of the American College of Allergists, a member of the New York Academy of Medicine, the Association of Military Surgeons, the Society for Investigative Dermatology, Inc., the American Academy of Occupational Medicine, the American Association of Industrial Physicians and Surgeons, the Baltimore-Washington Dermatological Society, the Industrial Division of Essex Medical Foundation, the Ramazzini Society, and the Founders Group, International Association of Allergists.



DONALD A. COVALT, New York City — *Rehabilitation — Symposium on Surgery of Trauma, Tuesday, 2: 20 p.m.* Dr. Covalt was graduated from the Indiana University School of Medicine and practiced in Muncie, Indiana, prior to entering military service in 1942. He was assistant medical director of the Medical Rehabilitation Service, Veterans Administration; chief of convalescent training division, Office of the Air Surgeon, Army Air Forces; executive officer, convalescent training division, Office

of the Air Surgeon; convalescent officer, Headquarters Western Technical Training Command, Army Air Forces. He is presently clinical director at New York University Institute of Rehabilitation and Physical Medicine, associate professor of rehabilitation and physical medicine at New York University College of Med-

icine, and visiting physician in rehabilitation and physical medicine at Bellevue Hospital in New York. He is a member of the American Congress of Physical Medicine, the Baruch Committee on Physical Medicine for Rehabilitation, the American Society of Physical Medicine, and the New York Academy of Medicine.

CHARLES A. GORDON, Long Island, N. Y.—*Obstetric Hemorrhage, Cesarean Section—Obstetrics and Gynecology, Tuesday, 4: 05 p.m.* Dr. Gordon is a graduate of Cornell University School of Medicine and interned at St. Catharine's Hospital in New York City. He has been attending obstetrician and gynecologist at St. Catharine's Hospital, consultant in gynecology and obstetrics at Beth-El Hospital, consultant in gynecology at Beth Moses Hospital, and director of obstetrics and gynecology at Long Island College Division, Kings County Hospital. He is professor of clinical obstetrics and gynecology at Long Island College. He is a fellow of the American Medical Association, the American College of Surgeons, and a member of the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons.

Wednesday

ORVAR SWENSON, Boston, Mass.—*The Etiology and Treatment of Hirschsprung's Disease—Symposium on Pediatric Surgery, Wednesday, 9: 40 a.m.* Dr. Swenson, a graduate of Howard University School of Medicine, was certified by the American Board of Surgery in 1946. He held a surgical residency at the Peter Bent Brigham Hospital in Boston and is now on the staff of that institution. He is visiting surgeon at the New England Peabody Home for Crippled Children and associate in surgery at Harvard.

ROBERT M. ZOLLINGER, Columbus, Ohio—*Some Practical Aspects of Nutrition in Surgical Patients—Section on Surgery, Wednesday, 11: 15 a.m.* Dr. Zollinger, a graduate of Ohio State University, was certified by the American Board of Surgery in 1938. He was resident surgeon at Peter Bent Brigham Hospital, Boston, and Lakeside Hospital, Cleveland, as well as assistant professor of surgery at Harvard Medical College. At the present time, Dr. Zollinger is professor and chairman of surgery at Ohio State University. He is a fellow of the American College of Surgery, the International College of Surgeons, and the American Surgical Association.



LOUIS J. KARNOSH, Cleveland, Ohio—*The Problem of Neuritis—Mental and Nervous Diseases, Wednesday, 2: 05 p.m.* Dr. Karnosh is a graduate of Western Reserve University School of Medicine and was certified by the American Board of Psychiatry and Neurology in 1937. He is clinical professor of neurology at Western Reserve University; director of neuropsychiatry at the Cleveland Clinic; department head, Neurological Division, Cleveland City Hospital, and trustee of Berea College, Berea, Ky. He is a member of the American Neurological Association, the American Psychiatric Association, the Society of Biological Psychiatry, and a past president of the Central Neuropsychiatric Association.



tion and a member of the American Urological Association.

LYOYD G. LEWIS, Washington D. C. — *Testis Tumors — Urology, Wednesday, 3:20 p.m.* Colonel Lewis is chief of the Urological Section, Walter Reed General Hospital, Washington, D. C. He was graduated from Johns Hopkins University School of Medicine and is an associate in urology at Johns Hopkins. He is assistant visiting urologist at Johns Hopkins Hospital (on leave of absence since 1942.) He is a fellow of the American Medical Association and a member of the American Urological Association.

Thursday



DAVID J. SANDWEISS, Detroit, Mich.—*The Present Status of the Treatment of Duodenal Ulcer — Symposium on Gross Gastro-intestinal Hemorrhage, Thursday, 9:30 a.m.* Dr. Sandweiss is a graduate of the University of Michigan School of Medicine, and has been assistant physician, Division of Internal Medicine, Harper Hospital, Detroit, and instructor in internal medicine at Wayne University College of Medicine, Detroit. He is a special consultant

in gastroenterology and a member of the Ad Hoc Committee on Gastroenterology, U. S. Public Health Service. He is a fellow of the American College of Physicians and the National Gastroenterological Association and a member of the American Gastroenterological Association, the American Gastroscopic Society, the Physiological Society, the Federation of American Societies for Experimental Biology, and the American Federation of Clinical Research. He is especially qualified to discuss his subject since he has conducted considerable research on peptic ulcer and has been chairman of the Committee on Peptic Ulcer of the American Gastroenterological Association.



EMANUEL M. PAPPER, New York City—*Evaluation of Analgesics — Symposium on Anesthesia, Thursday, 9:45 a.m.* Dr. Papper was graduated from New York University College of Medicine. He is associate professor of anesthesiology at New York University—Bellevue Medical Center, New York City. He is a diplomate on the American Board of Anesthesiology and a fellow of the American College of Anesthesiology.

PERRIN H. LONG, Baltimore, Md.—*A Future for Preventive Medicine — Preventive Medicine and Public Health, Thursday, 10:40 a.m.* Dr. Long was graduated from the University of Michigan School of Medicine and interned at Boston City Hospital. He was resident physician at Thorndike Memorial Laboratory in Boston and associate physician at Johns Hopkins Hospital. He is consulting physician at Sydenham Hospital and professor of preventive medicine at Johns Hopkins University. He was consultant to the Secretary of War during World War II. He is a member of the American Society for Clinical Investigation, the Association of American Physicians, the Society of American Bacteriologists, the Society for Experimental Biology and Medicine, and the Southern Medical Association.



GEORGE T. PACK, New York City—*Carcinoma of the Stomach — Symposium on Surgery of Malignancy, Thursday, 11:30 a.m.* Dr. Pack is a graduate of Yale Medical School and is presently attending surgeon at Memorial Hospital for Cancer and Allied Diseases in New York. He is also clinical professor of surgery at New York Medical College. He is a fellow of the American College of Surgeons, a member of the American Association for Cancer Research, the American Association of Pathologists and Bacteriologists, the American Radium Society, and the Society for Experimental Biology and Medicine.



STEWART H. CLIFFORD, Boston, Mass.—*Infections of the Newborn and Premature Infant — Symposium on Problems of the Newborn, Thursday, 2:00 p.m.* Dr. Clifford was graduated from Harvard Medical School in 1925 and was certified by the American Board of Pediatrics in 1937. He was formerly house officer on the East Medical Service of the Massachusetts General Hospital, pediatric house officer of Children's and Infants' Hospitals of Boston, and also was on infectious service at Willard-Parker Hospital. At present he is an associate in pediatrics at Harvard Medical School, and for twenty years has been visiting pediatrician to the Boston Lying-in Hospital. For five years he has been chief of the Premature Infant Service at the Children's Medical Center of Boston and physician to the Children's and Infants' Hospitals of Boston. He is chairman of the Committee on Fetus and Newborn of the American Academy of Pediatrics and is a member of the American Pediatric Society, the Society for Pediatric Research, the New England Pediatric Society, the Association of American Physicians, and the Society for Research in Child Development.

DANGEROUS DRUGS

Published Through the Cooperation of the Pennsylvania Department of Health and
The Medical Society of the State of Pennsylvania

Act 407, P. L. 1935, an act to regulate the sale of certain hypnotics, analgesics, and body-weight reducing drugs, in the interest of public health, amended by Act 228, which increases the penalties and extends requirements as to the contents of labels.

It is clearly the intent of Act 407, P. L. 1935, to regulate the dispensing of barbitol and other hypnotic drugs in such a manner as to prevent their harmful effects. The medical profession appears to be convinced that these drugs have a tendency to become habit-forming and that their continued use results in an addiction which is difficult to overcome. Acute and chronic intoxication frequently results from the lay use of the drugs incorporated in the act.

The fact that this bill was introduced in the Legislature by the Committee on Public Health Legislation of The Medical Society of the State of Pennsylvania, at the request of the members of the medical profession, and was endorsed by the Public Health Legislative Conference of Pennsylvania, which includes The Medical Society of the State of Pennsylvania, the Pennsylvania State Homeopathic Association, the Pennsylvania Eclectic Association, the Pennsylvania Pharmaceutical Association, the Pennsylvania State Nurses' Association, and the Hospital Conference of Pennsylvania, indicates that all the allied healing arts professions recognize that the uncontrolled use of these drugs is harmful and dangerous.

SECTION 1. That the following words and phrases shall, for the purpose of this act, have the meanings respectively ascribed to them in this section, except where the context clearly indicates a different meaning. "Hypnotic drugs" shall mean the drugs known as barbitol and the salts of barbituric acid, also known as malonyl urea, or any derivative or compounds, or any preparation or mixtures thereof, possessing hypnotic properties or effects. Other hypnotic drugs, or body-weight reducing drugs, shall be held to mean and include trional, sulfonal, tetronal, carbromal, cinchophen, atophan, amphetamine, and thyroid.

SECTION 2. No hypnotic drug or analgesic or body-weight reducing drug as defined herein shall be sold at retail or dispensed to any person except upon the *written* prescription of a duly licensed physician, dentist, or veterinarian, etc. It also has the following provision: That the provisions of this section of this act shall not apply to a duly licensed physician, dentist, or veterinarian: Provided, however, that they keep a record of the amount of such drugs purchased and a dispensing record showing the date, name of, the quantity of the drugs dispensed, and the name and address of the patient. To the container must be affixed a label bearing the name and address of the dispenser, the date dispensed, the name and address of the patient, and the directions for the use of the drug by the patient.

Prescriptions under Act 407, P. L. 1935, cannot be renewed by a pharmacist unless the prescriber, a duly licensed physician, dentist, or veterinarian, endorses on the face of the prescription blank the specific number of times to be renewed, as defined by the opinion of the Attorney General's office, viz.: "If a prescription calls for a renewal or refill, the pharmacist may refill or renew it the number of times and according to the stipulation specified on the prescription of the practitioner. Otherwise, the pharmacist is limited to filling the prescription once only on presentation."

Pharmacists must put date of each renewal on back of original prescription. Invoices or bills of sales or equivalent records covering the sale of drugs coming under Act 407 must be kept on file by manufacturers, wholesalers, retailers, and medical practitioners for a period of at least two years and must be open to inspection. Sales of drugs coming under Act 407 by retailers to physicians, dentists, or veterinarians must be made on an order written by the practitioner for the drug desired, and such order must be kept on file by the pharmacist.

Penalties provided in the act read in part: Any person who shall violate or fail to comply with any of the provisions of this act shall be guilty of a misdemeanor, and, upon conviction, shall be sentenced to pay a fine of not more than \$1,000 for the first offense and not less than \$1,000 nor more than \$2,000 for the second and each subsequent offense.

The provisions of this act shall be enforced by the Department of Health of the Commonwealth of Pennsylvania, Division of Narcotic Drug Control. The Secretary of Health is hereby authorized to make such rules and regulations as may be deemed necessary for the proper enforcement of this act.

DON GILLUNG, Chief, Division of Narcotic Drug Control.

THE PENNSYLVANIA MEDICAL JOURNAL

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EDITORIALS

FEDERAL HOSPITAL CONSTRUCTION ACT ALLEGED A FAILURE

At the meeting of the A.M.A. and State Medical Society Committees on Rural Medical Service on Feb. 3, 1949, the panel discussions were divided into hospital development and improvement under voluntary community effort and under the Hospital Survey and Construction Act.

Dr. Humphrey, the moderator of the panel discussion, made this statement:

"The Hill-Burton Act, in my opinion, in the small community—the one that we have at the present time where the community raises two-thirds and the Federal government gives one-third—is an absolute failure. I think a small community can take its two-thirds and eliminate the red tape attached to the building of a hospital and build a better hospital for that particular community. I'm speaking of a 15 or 20-bed hospital. I admit that they want 50-bed hospitals, but I'm speaking of 15 or 20-bed hospitals.

"You can build a hospital that is of more benefit to that community for the two-thirds they raise than the building that they would get as a result of complying with all of the red tape of the Hill-Burton Act."

Public Law No. 725 of the 79th Congress amends the Public Health Service Act by authorizing grants to the states for: a survey, hospitals and public health centers, planning construction of additional facilities, and grants to assist in such construction. It is cited as the "Hos-

pital Survey and Construction Act" and was approved Aug. 13, 1946.

An appropriation of \$3,000,000 was authorized for the survey. For the purpose of assisting the states in building more hospital facilities, \$75,000,000 was authorized to be appropriated for the year ending June 30, 1947 and for each of the four succeeding fiscal years.

Under this act the states must authorize a state agency to carry out the instructions of the Surgeon General of the United States Public Health Service in building the new hospital and health center facilities.

Generally speaking, $33\frac{1}{3}$ per cent of the cost of the approved projects within the state is allocated in the form of allotments to the state. The states and local communities therefore must provide two-thirds of the cost.

There is also a complicated formula based upon the per capita income of the state and provides that it shall be no more than 75 per cent or less than $33\frac{1}{3}$ per cent. The exceptions are Alaska and Hawaii, which are 50 per cent each, and Puerto Rico, which is 75 per cent.

At the Feb. 3, 1949 conference above referred to, the criticisms were substantiated by a number of physicians in attendance. They cited instances in which the cost of building hospitals was much less when done by community effort than if plans and specifications had been adhered to under the Hill-Burton Plan.

A physician from Indianola, Iowa, indicated that \$200,000 of their own funds was raised for a hospital plus \$100,000 government money. After rechecking their plans, they discovered that if they left out a number of fancy niceties, they could build their hospital for \$200,000, forget the government help, and still the hospital would meet all the requirements of their state.

He also stated that a town near Indianola had just let its contract for four hundred and some thousand dollars for a 25-bed hospital under the Hill-Burton Plan. The same hospital without Federal aid would cost \$300,000.

The statement was made that the same plan and specifications are provided by the United States Public Health Service for 125 or 150-bed hospitals as are provided for 700 to 1000-bed hospitals that have all services completely up to date.

In the smaller communities, hospitals are needed which will serve people for ordinary illnesses and for the simplified forms of major surgery. It is difficult to understand how the people in small areas are going to insure the operation of a \$400,000 hospital unless they have marvelous voluntary community cooperation.

Along this line of thought, it was felt that in many of these areas a health center with emergency hospital facilities would be more practical and more easily financed than a larger institution with more modern equipment.

The small town of Lake Preston, South Dakota, was able to build a 16-bed hospital for \$50,000. They admit they do not have a separate battery of sterilization equipment for major surgery, but the community finds that it is able to maintain the hospital for a year on about one-third of the original cost.

In Volga, South Dakota (population 690), there has been a 16-bed hospital since 1909. It is not fireproof. It doesn't have all the modern equipment, but the staff members deliver 186 babies a year, do about 100 major operations, and in addition take care of other needs of the community.

The general opinion in this discussion was that hospitals should be similar architecturally to other buildings in their respective communities and should not cost more than the community can afford to support and use.

The fact was cited that two hospitals were to be built with the same blueprints and same specifications. The hospital built under the Hill-Burton supervision cost \$250,000, while the other hospital with the same blueprints and same specifications cost \$200,000.

It was stated that only about 10 per cent of

the rural hospitals needed in California were provided for in this five-year plan.

In Sonoma, California, a building was leased and renovated at a total cost of \$26,000. As there were 23 beds, the cost was about \$1,100 a bed. With Hill-Burton aid it would cost in the neighborhood of \$250,000 for 25 beds.

Doctors should take the leadership in planning for hospitalization by emphatically enlisting community effort.

Our state health departments or other agencies supervising hospital construction should be aware of the fact that certain luxury items are not needed in a hospital in a small community.

These are only a few of the experiences that many are having under the federally controlled hospital construction program.

The high standards set up by governmental bureaus and agencies are valuable and should be adhered to where possible and practical. In many instances, however, higher standards of construction and added hospital facilities prove impractical for local community maintenance and increase unwisely the costs of hospital care.

Everyone is in favor of increased hospital facilities, but the question is where to get the funds. The experience under the Hospital Construction Act is the same that occurs under all governmental activities where expenditure of tax funds is involved.

As United States Senator Edward Martin has often said in his public addresses, whenever the Federal government socializes local projects, instead of forming a true partnership on an even and equal basis, it becomes the senior partner and usually assumes command of the entire program.

C. L. PALMER, M.D.

THE HARD-OF-HEARING PROBLEM IN THE PUBLIC SCHOOLS OF PENNSYLVANIA

The Committee on the Conservation of Hearing reports that there are approximately forty-five thousand school children in the State with various degrees of deafness. This means that there are from one to three children in every schoolroom who have trouble with their hearing, or from 3 to 4 per cent of all the school children in the State.

Hearing tests alone do not constitute an adequate conservation-of-hearing program. The tests performed in the schools only reveal the identity of the children in need of special med-

ical and educational attention. In order to be effective, conservation-of-hearing programs must have the hearty cooperation of local physicians, audiometric technicians, and local school personnel. The tragedy of impaired hearing is the fact that while early care can prevent most of these children from growing into adult life with defective hearing, so little is done about it by the parents, and if they do take their children to the family physician, as a rule the family physician is inadequately equipped to determine the true status of their condition. The public needs to be educated to the fact that neglect and improper care will create a serious handicap in the pupil. Further proof of the seriousness of defective hearing is obtained when we realize that these children lag from three to four years in acquiring an education that is normal for children their own age. Moreover, a psychologic state develops which prevents normal progress and normal relationship in their association with other children.

In approaching this problem, the method of testing in the schools is the first important step. These children are tested with either a pure tone audiometer or a multi-audiometer with phonograph records, or a speech reception apparatus. The combination of pure tone audiometer and the speech reception apparatus is the most adequate method.

The types of deafness that have to be considered are, first, conductive deafness. This is the deafness that obstructs sound waves that travel through the ear canal and middle ear up to the footplate of the stapes. Second, perceptive deafness, is that which involves the organ of hearing or the pathway to the brain. Third, otosclerosis, or the inherited type, is due to osteogenic changes at the footplate of the stapes.

After audiometric tracings are made on children, we must determine what type of deafness exists and how it is to be handled. The first type is the low tone deafness found in the conductive type. This is most frequently encountered and most amenable to treatment. The high tone deafness is loss in high tones, and is due to involvement of the organ of hearing or the auditory nerve. The plateau type of deafness in which all tones are depressed is usually a combination of conductive and perceptive deafness, or may be considered due to otosclerosis after further studies have been made. The fourth type is called island deafness, in which only one tone is lost.

In testing school children, we select the first, third, fifth, seventh, ninth, and eleventh grades, and individually test the pupils with a pure tone audiometer. The cases that are found defective

IMPORTANT CHANGE

History repeats itself even when it concerns *The Pennsylvania Medical Journal*. Volume 4 of the *Journal* contained sixteen issues running from June, 1900 to September, 1901.

After forty-nine years a similar change is occurring. This September number of the *Journal* would normally conclude the present volume. However, the December issue will write finis to Volume 52 and the comprehensive index for the volume will appear in that issue.

This change is being made so that all transactions of the Society for a given year will be included within one volume.

are reported to the parents, who are requested to seek medical advice from a certified otologist, for which the Department of Health will pay. After this examination, they can consult their own physician as to further care, or if they are unable to consult with a private physician, they are to be referred to an ear clinic in the State that specializes in hard-of-hearing problems.

In the clinic the procedure consists of a complete medical history and thorough medical examination, with special attention to the existing conditions in the ears, nose, and throat. The hearing examination consists of audiometric and speech reception tests, the use of tuning forks to determine the Rinne, Weber, and Schwabach tests.

To correct these conditions, we must remove or improve the causative factor. Then the rehabilitation of the deafened individual can be undertaken. Various operative and mechanical procedures have been devised to assist these cases. First, the fenestration operation devised by Lempert, Kopetzky, and others for use in otosclerosis has not produced the results that were first expected. However, it does improve the hearing in selected cases, and those whom it will improve are those on whom a hearing aid will work most satisfactorily. Second, recently Dr. Crowe of Baltimore revived the use of radium for these cases. It has been most effective in conductive deafness and accounts for 25 to 40 per cent improvement in selected cases. Third, when hearing aids are to be used, it is essential that they be fitted properly to the individual for his particular type of deafness, and the fitting should be done by an audiologist or in a hearing clinic. It is important that this be done in order that the individual may receive the greatest benefit from a proper fitting. Dr. Kenneth M. Day, of Pittsburgh, reported that in the

rehabilitation centers of the Army and Navy, where aural casualties were properly fitted, 80 per cent continued to wear their hearing aids. In the manner in which hearing aids are fitted to the laity, approximately 30 per cent continue to wear them. This is due to the improper adjustment and adaptation of this mechanical instrument.

There are two types of hearing aids—one that transmits sound through the ear, the other, through the bone behind the ear. The greatest comfortable improvement that a hearing aid can produce is 60 per cent. Therefore, totally deafened individuals or those with 80 per cent hearing loss are not good subjects for this form of assistance. Wherever possible, air receivers are preferable to bone receivers when an aid is worn.

In order to test a hearing aid, an individual ear mold must be made for each person. Then various hearing aids are tested under the same conditions, preferably in a soundproof room. In this manner the most adaptable hearing aid is found for each individual.

When the hearing loss is above 70 per cent, the best method of understanding is through lip reading. All persons with a hearing loss of over 40 per cent should learn lip reading, for it is desirable at times to depend entirely upon lip reading, as hearing aids can be annoying in noisy surroundings and confusing to the wearer.

Auditory training is the next important step after a person has had the proper fitting. Many times one who has been deaf over a long period of time loses the art of conversation because he no longer pays attention to sounds. He must again be taught to rephrase his thoughts, also the proper use and meaning of words. He loses this faculty because of the lack of attention that is customary with deafened individuals. This training is done under the guidance of a speech correctionist, after which he should be put in the hands of a psychologic guidance instructor, which is necessary for readjustment and vocational rehabilitation.

If these procedures are carried out, deafened individuals can formulate their life pattern to a better degree and assume a more stable economic position in later life. The profits of such a program are manifold; an education is acquired more rapidly, they have more adaptability in keeping up with their classmates, and there is a better social relationship with other children. Later on in life a better employment and economic status with a readjustment for the individual are the fruits of these endeavors.

However, the success of this program depends entirely upon adequate clinics with trained per-

sonnel, cooperation with physicians and medical societies, cooperation with school boards and social agencies, education of the general practitioner, and fundamentally under the supervision of the otologist, who recognizes deafness early. With these uniform working plans, a successful and effective program can bear fruit.

JAMES E. LANDIS, M.D.

IMMEDIATE OPERATION IN ULCERATIVE LESIONS OF THE STOMACH

Cancer of the stomach accounts for more deaths among the male population than any other tumor. Operability has increased, resectability has increased, and the extent of the resection has increased, but gross salvage in terms of five-year survival remains low. Under 5 per cent of all patients with gastric cancer seen in most clinics are alive five years later.

Radiation therapy as applied thus far has not been effective in gastric cancer, nor has chemotherapy. Unless some new therapeutic agent appears, our main hope of saving more of these patients lies in earlier diagnosis.

Gastric lesions often grow to a considerable size before the patient has sufficient symptoms to induce him to consult a doctor. If a good x-ray examination is made, the chances of demonstrating a lesion are fairly high, but according to Allen and Welch the diagnostic error in designating the lesion as a cancer is 14 per cent. The error in differential diagnosis based on gastric analysis is probably much higher. The diagnostic error by electro-gastrography was 13 per cent in a series reported by Sawyer, Panzer, and Rhoads, excluding 8 per cent in which no conclusion was reached, and the error in recognizing gastric lesions as carcinoma at laparotomy is given by Allen and Welch as 14 per cent.

In the past the mortality of gastric resection was sufficiently high that few patients submitted to operation unless the diagnosis was made fairly certain by failure to respond to a medical ulcer regimen. There are several pitfalls in using "a trial of medical treatment" to determine the malignancy of a gastric ulcer. First, many cancer patients obtain symptomatic relief on an ulcer regimen. Occasionally such a lesion, because of cell growth, is reported as improving when x-ray examinations are used as the criteria of healing. The natural disposition of patients and doctors to procrastinate often leads to the lapse of much longer periods of time between ex-

aminations than the physician originally contemplated.

No one knows how much difference three or four weeks make in the growth of a carcinoma of the stomach. It is evident that there is wide variation in the rate of growth of these tumors. It is also evident that in some patients the growth does become incurable in a period of three weeks. It would seem that the major hope for improved results in cancer of the stomach now lies in eliminating periods which delay operation.

The mortality of gastric resection for benign ulcer is now below 1 per cent in certain clinics and, in the opinion of the writer, nearly every patient with a gastric ulcer who is a fair surgical risk should have an immediate gastric resection, if facilities and personnel are available and capable of doing such resections with a high level of safety. It is understood that the mortality rate is higher for resection of cancer. These resections must be done anyway. The mortality is also higher in benign duodenal ulcer, but these cases are not included in the subject under consideration.

It is estimated that if only 8 to 10 per cent more patients with gastric carcinoma were cured of their tumors, this policy would be fully justified, even without taking into consideration such intangible factors as the possibility of benign gastric ulcer acting as a premalignant lesion, the possibility of deaths from ulcer during medical treatment due to hemorrhage or perforation, and the loss of time, comfort, and inconvenience in certain cases that require a rigid medical regimen over long periods of time.

Since the recognition of malignancy of the stomach when the lesion is viewed at laparotomy is uncertain, it seems wise for every resection for gastric ulcer to be carried out on the assumption that malignancy may be present, including the greater omentum, the gastrocolic and gastrophrenic omenta with the specimen.

While it is impossible to predict what the outcome of such a policy may be, it would seem fully justifiable to conduct a trial of it in those hospitals in which the mortality experience with gastric resection for benign ulcer can be maintained at a reasonably low level.

JONATHAN E. RHOADS, M.D.

JUVENILE DIABETES

There are living today in the United States a group of diabetics in whom the onset of diabetes occurred before the fifteenth birthday. This group numbers approximately 50,000 individuals. These juvenile diabetics show a high incidence of premature vascular disease.

Vascular damage in this group commonly appears long before the age at which it is usually observed in the average individual. Although it may appear prematurely in diabetics who experience onset after reaching adult life, many such individuals, when vascular damage becomes evident, have arrived at the time of life when arterial disease is frequently seen, regardless of diabetes, in contrast to the still young age of the juvenile group.

This vascular damage in the juvenile group commonly becomes evident first in the retina. The next most common evidence arises in the kidney. The heart, brain, and general vascular tree also present degenerative manifestations.

The nature of these degenerative vascular lesions remains almost entirely controversial. There are those who claim that they are the direct result of diabetes, especially when poorly controlled. Among diabetics with onset in adult life, any natural constitutional or hereditary tendency to premature vascular age could possibly be aggravated by the occurrence of diabetes, but this factor would not likely be operative in the juvenile group. Because atheromatous vascular degeneration is the type of vascular disease which is most characteristically observed in the diabetic, there are those who believe that these clinical pictures are the

product of a disordered fat metabolism. If one is to believe that premature vascular disease occurs as a direct result of and secondary to especially poorly controlled diabetes, it is difficult to explain the exceptions.

Furthermore, all those who observe any considerable number of diabetics over a period of time are at a loss to explain why certain patients, whose records show continuous poor diabetic control in spite of higher doses of insulin, still fail to reveal after fifteen years or more of diabetes and after thorough examination any evidence of vascular disease inconsistent with age, while other patients, with much milder diabetes of much shorter duration, show extensive damage. These exceptions to the rule would suggest that in some, and perhaps in most but not in all diabetics, there is a metabolic disorder which is not always part and parcel of the primary disease. It is these exceptions which affirm the fact that our knowledge of the metabolic defect in diabetes is far from complete.—*Northwestern Medicine*, February, 1949.

"The subject of socialized medicine is not merely a matter of the rights of physicians; it goes much deeper than that. If the doctors of the country can be socialized, why not the lawyers, the teachers, the newspapermen, the farmers, or labor? If medicine can be socialized, why not steel or bread? If the argument for socialism is good at all, it is good for everything."—GEORGE E. SOKOLSKY in *The Columbus Dispatch*.

Non-Group Blue Shield Enrollment Instituted by MSAP

As a further step in carrying out the original purpose for which Blue Shield was organized by The Medical Society of the State of Pennsylvania, the Medical Service Association of Pennsylvania is now offering Blue Shield services on a non-group basis.

This means that persons who are 65 or under and who are self-employed, retired, or not working may become Blue Shield subscribers in this state. Subscribers may choose either the Surgical Plan or the Medical-Surgical Plan.

Institution of non-group enrollment by MSAP has been authorized by the Insurance Commissioner of Pennsylvania.

The broad services provided by the new non-group agreements are the same as those which are available to group subscribers, but there are several important changes:

1. *Waiting periods*—There are waiting periods of twelve months for removal of tonsils and adenoids, conditions existing at or prior to enrollment, and medical care resulting from pregnancy; twenty-four months for obstetric delivery and other surgical operations arising from pregnancy.

2. *Subscription rates* are slightly higher and must be paid quarterly, semi-annually, or annually. They are:

Non-Group Surgical Plan

	<i>Quarterly</i>	<i>Semi-annually</i>	<i>Annually</i>
Single subscriber	\$2.10	\$3.90	\$7.80
Husband and wife (or parent and child)	3.90	7.50	15.00
Family (with maternity benefits)			
Husband, wife and all unmarried children under 19.....	6.30	12.30	24.60

Non-Group Medical-Surgical Plan

Single subscriber	3.60	6.90	13.80
Husband and wife (or parent and child)	6.90	13.50	27.00
Family (with maternity benefits)			
Husband, wife and all unmarried children under 19	10.05	19.80	39.60

OFFICIAL TRANSACTIONS

Ninety-ninth Annual Session

REPORTS OF OFFICERS

REPORT OF SECRETARY-TREASURER

To the President and House of Delegates:

Financial Statement

As set forth in the August issue of the JOURNAL, the financial portion of the annual report of the Secretary-Treasurer cannot be completed for the fiscal year, ending September 30, in time for publication in August.

GENERAL FUND

Balance on hand Sept. 1, 1948 \$137,111.04

RECEIPTS

Allotment from dues (1948-1949) ...	\$128,685.50
JOURNAL	47,767.00
Annual Session (Centennial)	27,009.50
Graduate Education Committee	20,342.50
Withheld from employees' salaries for pension fund and Fed. Old Age Sec.	1,955.33
Refund—A.M.A., a/c collecting \$25 membership assessment	1,886.48
Rent, 226 State St.	1,542.50
Advance sale, History MSSP	1,055.00
Unexpended balance, Secys.-Eds. Conf.	542.81
Refund, Medical Bureau, Harrisburg	400.00
Refund from units of Cancer Coordinating Committee	174.44
Library	145.85
Unused check No. 636, April, 1948 ..	100.00
Sale of used typewriter	65.00
Postage remittance, letter-bulletin service	65.00
1948 Rosters	61.00
Miscellaneous	360.15

Total administrative receipts	\$232,158.06
Transfer of funds—	
From Medical Benevolence Fund, payment of check No. 1295 to Benevolence Committee for payments to beneficiaries	14,150.89
From Medical Defense Fund, payment of check No. 488	79.12
Total	\$383,499.11

DISBURSEMENTS

JOURNAL* (printing and mailing only)	\$45,903.01
Executive secretary and Harrisburg office staff, salaries†	34,392.91
Annual session	27,243.85
Secretary-treasurer-editor and Pittsburgh office staff, salaries†	17,626.00
Federal social security current and delinquent taxes, in full	8,427.39
Library	4,416.75
230 State St., taxes, repairs, upkeep	4,407.54
Purchase real estate, Harrisburg	4,300.00
Officers' travel expense	4,150.49
Secretaries-editors conference	4,000.00
Employees' pension fund, 1949 premium	3,345.88
Telephone service and toll calls‡	2,914.52
Stationery and supplies‡	2,906.29
Office equipment and furnishings	2,584.39
Reimbursement petty cash funds—	
Harrisburg office	\$1,739.80
Pittsburgh office	532.90
Total	2,272.70

* Equitable distribution of salaries and other expenses brings actual JOURNAL costs to \$57,000.

† Does not include salaries connected with functioning of Committees on Graduate Education, Diabetes, Preventive Medicine and Public Health, Medical Economics, Physical Medicine, Cancer Commission, and Public Relations.

‡ These expenditures provide facilities for routine office procedures, but are freely used by Committees on Public Health Legislation and Public Relations.

Special printing—1948 and 1949 Roster, 1949 trip— licate receipts, by-laws, etc	\$2,164.60
Rent	2,061.00
Collecting A.M.A. \$25 membership assessment ...	1,886.48
Pennsylvania unemployment taxes	1,676.55
Postage‡	1,607.91
Testimonials to 50-year practitioners and secy.- treas., Georgia Medical Assn.	1,835.47
Travel expenses, A.M.A. delegates	1,546.13
Councilor district meetings	1,205.31
World Medical Association	1,000.00
MSSP History	598.25
Soliciting participating physicians MSAP	527.56
Legal counsel, retaining fee	500.00
Annual audit of accounts	450.00
Dues—Pa. and Hbg. Chambers of Commerce, Conf. State Socy. pres. and secs., Council Medical Re- search, Middle Atlantic States Conf.	345.00
Insurance premiums—officers' bonds, workmen's comp., over-all liability 230 State St.	214.77
Maintenance of office equipment	196.97
Federal excise tax	195.49
Miscellaneous	61.20

Committees:	
Public relations	\$41,763.29
Graduate education	33,864.18
Public health legislation	19,877.17
Centennial celebration	7,367.12
Cancer commission	2,025.33
Diabetes	1,614.56
Medical economics	741.37
Rheumatic fever	711.69
Preventive med. and public health	563.96
Syphilis and venereal diseases	625.03
Laboratories	479.15
Industrial health	271.68
Physical medicine	251.34
Appendicitis	250.00
Conservation of vision	233.61
Mental hygiene	226.28
Woman's auxiliary	191.14
Disaster emerg. med. service	181.42
Rural medical service	133.06
Advisory council med. service ...	128.21
Hospital relations	108.97
Archives	89.08
Revision of constitution	89.80
Miscellaneous	79.81
Total administrative expenditures	\$111,867.25

Total administrative expenditures \$298,831.66

OTHER DISBURSEMENTS

Medical benevolence (see receipts above)	\$14,150.89
Medical defense (see receipts above)	79.12
Total	14,230.01

Total	\$313,061.67
Balance on hand Sept. 30, 1949	\$70,437.44

MEDICAL DEFENSE FUND

Balance on hand Sept. 1, 1948 \$7,808.61

RECEIPTS

Interest on deposits	\$64.12
Proceeds U. S. Savings Bonds, series "D," due July 1, 1949	10,000.00
Total	10,064.12
Balance on hand Sept. 30, 1949	\$17,872.73

DISBURSEMENTS

Transferred to checking a/c in payment of check No. 488	\$79.12
Balance on hand Sept. 30, 1949	\$17,793.61

ENDOWMENT FUND

Balance on hand Sept. 1, 1948 \$12,411.52

RECEIPTS

Interest on investments	805.00
Interest on deposits	98.75
Total	\$13,315.27

DISBURSEMENTS

Withdrawn for purchase of U. S. Savings Bonds, series "G"	\$10,000.00
Balance on hand Sept. 1, 1949	\$3,315.27

EDUCATIONAL FUND

RECEIPTS

Allotment from 1949 dues (\$2.00 per capita)	\$21,142.00
Interest on deposits	41.86
	<u>\$21,183.86</u>

DISBURSEMENTS

Withdrawn for purchase of U. S. Treasury 1¼ certificates due July 1, 1950	\$20,032.06
Balance on hand Sept. 30, 1949	\$1,151.80

BUILDING FUND

Balance on hand Sept. 1, 1948	\$56,164.86
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RECEIPTS—None

DISBURSEMENTS

Withdrawn for purchase of U. S. Treasury ctf. of ind. series "B" 1¼% due Feb. 1, 1950	\$50,016.47
Balance on hand Sept. 30, 1949	\$6,148.39

MEDICAL BENEVOLENCE FUND

Balance on hand Sept. 1, 1948	\$66,529.58
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RECEIPTS

Allotment from dues (\$1.00 per capita)	10,717.50
Interest on investments	4,500.00
Interest on deposits	450.56
Contributions	9,200.33
	<u>\$91,397.97</u>

DISBURSEMENTS

Withdrawn for purchase of U. S. Savings Bonds, series "G," due 1961	\$75,000.00
Transferred to checking a/c in payment of check No. 1295*	14,150.89
	<u>\$89,150.89</u>

Balance on hand Sept. 30, 1949	\$2,247.08
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CONTRIBUTIONS FROM WOMAN'S AUXILIARIES AND OTHERS

State Society	\$500.00	Lancaster	\$200.00
Allegheny	1,018.18	Lawrence	75.00
Armstrong	50.00	Lebanon	150.00
Beaver	150.00	Lehigh	538.30
Berks	330.00	Luzerne	215.00
Blair	125.00	Hazleton Branch	100.00
Bradford	66.00	Lycoming	300.00
Bucks	144.00	Mercer	150.00
Butler	75.00	Mifflin	40.00
Cambria	165.00	Montgomery	705.00
Carbon	16.00	Montour	38.50
Centre	55.00	Northampton	355.00
Chester	150.00	Northumberland	55.00
Clearfield	50.00	Philadelphia	150.00
Clinton	75.00	Potter	21.00
Crawford	175.00	Schuylkill	116.35
Dauphin	250.00	Somerset	75.00
Delaware	150.00	Susquehanna	8.00
Delaware Co. Med. Club	25.00	Tioga	50.00
Elk	30.00	Venango	50.00
Erie	200.00	Warren	75.00
Fayette	500.00	Washington	80.00
Franklin	75.00	Westmoreland	200.00
Greene	100.00	New Kensington Branch	136.00
Huntingdon	50.00	Wyoming	12.00
Indiana	125.00	York	100.00
Juniata	10.00		
Lackawanna	486.00	Total	<u>\$9,140.33</u>

* This amount is the total of contributions and interest on investments and deposits which is transferred to the Benevolence Committee's account for disbursement to beneficiaries. See also report of Medical Benevolence Committee.

COMPARATIVE FINANCIAL STATEMENT

Assets	Sept. 30 1949	Sept. 30 1948	Increase Decrease*
<i>Current Assets</i>			
<i>Cash</i>			
General Fund Regular Account	\$56,207.44	\$124,294.19	\$68,086.75*
Medical Defense Fund	17,872.73	7,808.61	10,064.12
Medical Benevolence Fund	16,397.97	79,346.43	62,948.46*
Endowment Fund	3,315.27	12,411.52	9,096.25*
Building Fund	6,148.39	56,164.86	50,016.47*
Educational Fund	1,151.80	.....	1,151.80
Petty cash—Pittsburgh	200.00	200.00	.....
Petty cash—Harrisburg	1,000.00	600.00	400.00
<i>Total cash</i>	<u>\$102,293.60</u>	<u>\$280,825.61</u>	<u>\$178,532.01*</u>
<i>Investments (cost values)</i>			
Medical Benevolence Fund	\$242,500.00	\$167,500.00	\$75,000.00
Medical Defense Fund	54,464.00	61,964.00	7,500.00*
Endowment Fund	39,705.44	29,705.44	10,000.00
Social Security Tax Reserve Fund	7,020.88	7,020.88	.....
Building Fund	50,014.76	.....	50,014.76
Educational Fund	20,029.32	.....	20,029.32
<i>Total investments</i>	<u>\$413,734.40</u>	<u>\$266,190.32</u>	<u>\$47,544.08</u>
<i>Total current assets</i>	<u>\$516,028.00</u>	<u>\$547,015.93</u>	<u>\$30,987.93*</u>
<i>Fixed Assets</i>			
Land and buildings, Harrisburg	\$86,506.66	\$82,206.66	\$4,300.00
Furniture and fixtures, Harrisburg	12,855.78	10,376.39	2,479.39
Furniture and fixtures, Pittsburgh	2,448.10	2,343.10	105.00
<i>Total fixed assets</i>	<u>\$101,810.54</u>	<u>\$94,926.15</u>	<u>\$6,884.39</u>
<i>Total assets</i>	<u>\$617,838.54</u>	<u>\$641,942.08</u>	<u>\$24,103.54*</u>
<i>Liabilities—None</i>			
<i>Surplus</i>			
Assets in excess of liabilities	\$617,838.54	\$641,942.08	\$24,103.54*
<i>Total Liabilities and Surplus</i>	<u>\$617,838.54</u>	<u>\$641,942.08</u>	<u>\$24,103.54*</u>

GRANT L. BELL, Auditor.

* SECRETARY/TREASURER'S NOTE: In most instances, decreases in cash balances will be offset by increases in investments for the same fund. Exception—increase of cash in Medical Defense Fund is balanced through maturing of bonds.

Additional contributions:

"A member," Philadelphia County, \$10; Dr. C. T. Buckingham, Franklin Co., \$50	\$60.00
Total contributions	\$9,200.33

INVESTMENT OF SPECIAL FUNDS
(Maturity Valuation Listed)

MEDICAL DEFENSE FUND	
United States Savings Bonds, Defense Series "F" as follows:	
Due 1953—No. X4068F, registered 1954—Nos. V36387F-36388F-69922F, registered	15,000.00
Due 1954—Nos. M143123F-143124F-240481F-249482F-442945-6-7-8-9-442950F-449190-1-2-3-4-5-6-7-8-9-200-1-2F	23,000.00
Nos. D71876F-186934F-234896F	1,500.00
Nos. C192362F-274873-4-5-6F-596704F	600.00
Due 1955—No. X119266F, registered	10,000.00
M447842-3-4F ..	3,000.00
D243976F	500.00
Due 1956—No. X175155F, registered	10,000.00
Total	\$73,600.00
MEDICAL BENEVOLENCE FUND	
United States Treasury Bonds, due 1972-67, 2½%, No. 196502B ...	
United States Treasury Savings Bonds, Series "G," due 1958, No. X690449G	10,000.00
United States Savings Bonds, Series "D," due 1950, Nos. 1542162-3-4-5-6-7-8-9-70-71	10,000.00
United States Savings Bonds, Defense Series "G" as follows:	
Due 1953—No. X4156G, registered	10,000.00
Due 1954—Nos. X159758G-173579G-173580G, registered	30,000.00
Nos. V83721G-121809G-128860G-178894G-186812G-187363G-187364G	35,000.00
Nos. M119553-54G-683545-6-7-683548G	6,000.00
Nos. D155217G-231345G	1,000.00
Nos. C897766G-67G-928209G-10G-11G-935220G-935221G	700.00
Due 1955—Nos. X246103G-246104G-246339G, registered	30,000.00
Nos. M1290745G-6G ..	2,000.00
Nos. C1109842G-3G-1110673G	300.00
Due 1956—No. X504348G, registered	10,000.00
Due 1960—No. V842499	5,000.00
No. X875960	10,000.00
Due 1961—Nos. 906420-21, V906401G, 906432-33, 906444, 906483,	

Due 1961—Nos. 929701, V906705G, V942324G, V942266G-67-68-69-70G	\$75,000.00
Total	\$245,000.00

ENDOWMENT FUND	
United States Treasury Bonds, due 1963-68, Nos. 88352C-53D-54E-55F-56G	
United States Savings Bonds, Series "G," as follows:	\$5,000.00
Due 1953—No. X893639	\$10,000.00
No. V911639	5,000.00
Nos. M480339-340	2,000.00
Due 1954—No. V911640	5,000.00
Nos. M6480341-342	2,000.00
No. D2932835	500.00
Nos. C5210298-299	200.00
Due 1961—Nos. V942265G, 906419	10,000.00
Total	\$39,700.00

SOCIAL SECURITY TAX RESERVE FUND	
United States Savings Bonds, Defense Series "F" as follows:	
Due 1956—Nos. M688282F-283F-284F-285F, M856330F	\$5,000.00
Nos. C1223381-82-83F ..	300.00
Nos. Q539445F-539446F, Q752085-86F ..	100.00
Due 1957—No. M1251879F	1,000.00
Nos. C1460122F, C1460130F, C1460131F	300.00
Nos. Q1034384F, Q103438F	50.00
Due 1958—No. M1374738	1,000.00
Nos. C1597145-46-47 ..	300.00
Nos. Q1118880-81	50.00
United States Treasury Bond, 2½%, due 1972-67, No. 578032	1,000.00
Total	\$9,100.00

BUILDING FUND	
U. S. Treasury Certificates of Indebtedness, Series B-1950, 1¼%, due 1950, Nos. 3204-5-6-7, Nos. 13835-6-7	\$50,000.00

EDUCATIONAL FUND	
United States Treasury Certificates of Indebtedness, Series F-1950, 1¼%, due 1950, Nos. 16867-8	
	\$20,000.00
Total maturity value of investments	\$437,400.00
Total cash balances:	
in checking account	\$70,437.44
in savings accounts—medical defense, medical benevolence, endowment, building fund, educational fund	\$30,656.15

The Society holds title to headquarters properties in Harrisburg.

Respectfully submitted,
WALTER F. DONALDSON,
Secretary-Treasurer.



A Concentrated Capsule of Medical Knowledge Prescribed for the General Practitioner

Your State Society is again making graduate study possible for you by bringing it to your very doorstep. Sessions for the 1949-50 Graduate Education Institute will begin in eleven centers during the week of October 3, 1949.

Can You Afford to Say No?

Progress in medical research has made it impractical for physicians to rest on their laurels. Your patients expect the newest and latest in diagnosis and treatment because they are deeply concerned with the chances for their families' future health.

Don't Fail to Register, For the Best Is Yet to Come

Included in this program is a special course on the Care and Treatment of Patients in the Event of Atomic Disaster. Major G. M. McDonnel, M.C., of the office of the Surgeon General, U. S. Army, will present: (1) "Background Nuclear Physics for Physicians," (2) "Biologic and Medical Effects of Ionizing Radiations," and (3) "Medical Aspects of Atomic Explosion." This and the other presentations should be a "must" with you. Don't put it off—register now.

Commission on Graduate Education,
230 State Street,
Harrisburg, Pa.

Please enroll me in the Graduate Education Institute Program for 1949-50 in the center indicated. I enclose a check for \$25 as my registration fee. (Make checks payable to The Medical Society of the State of Pennsylvania.)

Allentown ☐ Harrisburg ☐ Oil City ☐ Williamsport ☐ Clearfield ☐

Johnstown ☐ Erie ☐ Reading ☐ Scranton ☐ Lancaster ☐ Washington ☐

Name Street

City County

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*

8104 Jenkins Arcade

Pittsburgh 22, Pa.

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

ARE YOU PROUD OF YOUR PART?

Perhaps the Pennsylvania doctors who for various stated reasons are critical of the A.M.A., and have thus far refused to pay the current A.M.A. \$25 membership assessment, would relent if they would read the appended excerpts from an appeal to a committee of the 81st Congress as made recently by Dr. Lowell S. Goin, of California.

Said Dr. Goin, "During recent weeks and months, through false implication and outright distortion of fact, deliberate attempts have been made to make it appear that the American Medical Association is engaged in devious, unethical tactics in its opposition to national compulsory health insurance.

"The American Medical Association—openly, frankly, and honestly—is engaged in a national education campaign to give people the facts about compulsory health insurance and the facts about voluntary health insurance.

— "In the best American tradition we take our case before the forum of public opinion. We are asking for a vote of confidence in the American medical profession and in the American medical system, the finest in the world. We are doing exactly what you gentlemen do at election time. We are using the same avenues of approach—the press, the radio, the speaking platform, pamphlets and leaflets, and all other accepted, ethical means of submitting our case to the people.

"The Committee for the Nation's Health, the Physicians' Forum, and other groups favoring compulsory health insurance, are conducting a constant propaganda in behalf of it. For ten years or more, the Federal Security Agency and other government agencies have been spending unauthorized tax funds to thump the drum for socialized medicine. Now, however, when the American Medical Association finally strikes

back at the distorted propaganda of the socializers and government payrollers, we suddenly hear unfounded and intemperate charges that the American Medical Association is invading Washington with a high-powered lobby and a huge slush fund.

"These charges are absolutely false, and those who have been making them know they are false. As you gentlemen undoubtedly know, the Washington office of the American Medical Association is one of the smallest, most conservative legislative offices maintained by any of the national associations in the capital. It is staffed by men of unquestioned integrity, who are highly respected in Washington.

"We doctors are simply exercising one of the greatest rights which Americans have as a free people—the right of petition as set forth in the United States Constitution. We are exercising that right not simply to protect the medical profession from degradation but to protect the health of the nation.

"The people have a right to know that government-controlled medicine means inferior medical care doled out according to bureaucratic regulations and rule books, ever increasing payroll taxes, invasion of privacy and freedom of action, and destruction of the voluntary health insurance plans which provide good medical care at a lower cost than government ever could provide it.

"In the final analysis, the American people, through their representatives here in Congress, will decide this issue. The objective of the American Medical Association national education campaign is to get the facts to the people. We want them to make their opinions known to their United States Senators and Representatives. We believe you want it that way.

"If that is lobbying, it is lobbying in the finest American tradition, and every doctor is proud of his part in the program."

WISCONSIN PASSES POUND LAW

The Wisconsin Senate, on July 1, passed an animal procurement law previously approved by the Assembly which makes Wisconsin the second state to save unwanted dogs and cats from mass slaughter in pounds and "shelters" so that the animals may be used, instead, for medical studies. Minnesota had previously enacted a similar law.

Pennsylvania will try it again in 1951. Keep that in mind when thinking of the choice of State Representatives and Senators from your district.

INVITATION EXTENDED

The Executive Committee of the Board of Trustees of the American Medical Association has announced that physicians of the National Medical Association will be welcome to attend the scientific sessions and exhibits of the American Medical Association at its clinical session in Washington, D. C., Dec. 6 to 9, 1949, whether or not they are members of the A.M.A. As reported in our August issue, this organization of Negro physicians (many belong also to the American Medical Association*) held its fifty-fourth annual convention Aug. 8 to 12, 1949, in Detroit, Mich.

ACKNOWLEDGMENT

GILSON COLBY ENGEL, M.D., President,
Medical Society of the State of Pennsylvania.

DEAR DR. ENGEL:

It was a pleasure to have Dr. Catharine Macfarlane with us at our Centennial Convention. We enjoyed her excellent scientific paper as well as her charming personality very, very much. One of the highlights of the meeting was the presentation of the generously expressed and handsomely mounted Greeting from The Medical Society of the State of Pennsylvania to the Medical Association of Georgia. They will hang it on the wall of the Association's office at 875 W. Peachtree Street in Atlanta.

The feeling of fellowship and affection which has been demonstrated to exist between the members of the profession in our two states is very gratifying and has afforded me a great deal of happiness during my term as president of this Association. I look forward to the time when you will be able to visit us.

With best wishes and kindest regards,

Sincerely yours,

EDGAR H. GREEN, M.D., President,
Medical Association of Georgia.

May 13, 1949

FIGHT FIRE WITH FIRE

Research Scientists Fight Back. The National Society for Medical Research, founded a few years ago by Drs. Anton J. Carlson and Andrew C. Ivy for the protection of animal experimentation, is now going to the courts to fight the antivivisectionists.

The society, which maintains an office in Chicago, reports that two libel suits for one million dollars each have been filed in federal court against the Chicago *Herald-American* and the Hearst Publishing Company, which supports antivivisection as a national editorial policy.

One suit was filed by Dr. N. R. Brewer of the University of Chicago, who asks "punitive and compensatory damages." He charged the newspaper referred to him in news articles and editorials as a "torturer," a "sadist," and a "cruel experimenter."

The other suit against the same paper was filed by Dr. Virgil H. Moon, of Wake Forest School of Medicine in North Carolina. He charged that the Chicago

* SECRETARY'S NOTE: More than a hundred Pennsylvania negro physicians are active members of the American Medical Association.

NOTICE OF AMA MEMBERSHIP ASSESSMENT

(Clip this form and mail with your check today if you have not already done so.)

The American Medical Association has requested your state medical society to collect this year a \$25 assessment. Please make check in favor of *American Medical Association — Assessment* and mail to The Medical Society of the State of Pennsylvania, 8104 Jenkins Arcade, Pittsburgh 22, Pa.

To The American Medical Association, Debtor

Special Assessment \$25.00

....., M.D.
Name

.....
County (Pa.)

paper "maliciously misrepresented his views on animal experimentation." The complaint alleged that the newspaper carried articles quoting him as saying that the medical profession indulges in "useless dog torture."

In reporting the suits, President Carlson said that from now on "we are going to fight fire with fire."

He explained that this was the beginning of a policy which took shape when a nation-wide legal committee was formed by the society to protect the medical worker and his institution against what appears to be an organized program to vilify and slander medical science and scientists.

Members of the newly formed Legal Committee for Medical Research will perform "minutemen duty" throughout the country in protecting medical researchers. Membership includes the attorneys and counsel of leading colleges, universities, and medical institutions throughout the country. Representatives are located in every state.

Papers Comment on Irons' Talk. Clippings of newspaper editorials on Dr. Ernest E. Irons' inauguration speech, delivered at the A.M.A. meeting in Atlantic City, are beginning to come in. We saw two of them last week, both very laudatory.

One of the editorials, which appeared in the Kokomo (Ind.) *Tribune-Dispatch*, said in part:

"The American Medical Association has come in for a lot of vicious criticism by those who want to enact a compulsory health insurance program. . . .

"There is no necessity to put this nation into a system of socialized medicine which could well be the opening wedge for the socialization of other fields of endeavor. Such a system, as Dr. Ernest E. Irons, A.M.A. president, pointed out this week, would require 'a confused organization of hundreds of councils, boards, committees, and similar agencies just to collect and distribute money.'"

"Mistakes have been made by the A.M.A. . . . But the A.M.A. has a wonderful record for the most part. Certainly it has the right to fight the trend toward socialization of its profession. Why shouldn't it? At stake is the principle of individual initiative which is basic in the American experiment of democracy. . . ."

An editorial in the Greensburg (Pa.) *Morning-Review* said that Dr. Irons "had no sooner been given the cap of office than he lit into the Truman compulsory health insurance program with both fists flying."

Then the editorial quoted several paragraphs from Dr. Irons' speech, closing with reference to "the double-barreled" article by Past President R. L. Sensenich of South Bend, which appeared in *Look* magazine. The editorial quoted briefly from Dr. Sensenich's article which presented the medical profession's views against compulsory sickness insurance.

Dr. Louis H. Bauer, Hempstead, N. Y., chairman of the A.M.A. Board of Trustees, has voiced strong opposition to the President's plan to give cabinet status to a Department of Welfare, including health.

Dr. Bauer said that under the President's Reorganization Plan No. 1 a Department of Welfare would be set up to assume all the functions and duties of the Federal Security Agency headed by Oscar Ewing. The former New York lawyer would become acting Secretary of Welfare until the president appointed a Secretary of Welfare.—Excerpts from A.M.A. Secretary Lull's letter of Aug. 1, 1949.

DR. LULL AWARDED LEGION OF HONOR MEDAL

His activities on behalf of the French people immediately after World War II have won for General George F. Lull, former Deputy Surgeon General of the United States Army and now Secretary and General Manager of the American Medical Association, the coveted Legion of Honor medal from the French government. Formal presentation of the medal was made by Jean Joseph Viala, French Consul General, in Chicago, Wednesday, July 27.

His appointment as Deputy Surgeon General of the United States Army in 1943 climaxed a career in Army medicine started in 1912, during which he served in all grades from lieutenant to major general. He was awarded the Distinguished Service Medal for his activities in World War II.

ORIENTATION OF NEW MEMBERS

GEORGE S. KLUMP, M.D.

WILLIAMSPORT, PA.

To orient is defined in all dictionaries as "to place so as to face the east." This is a relevant definition, especially since what happened last November.

There is another definition that bears on our discussion today: "to bring into due relation one's ideas regarding new surroundings, circumstances, facts, or conditions." This is a large order, and, in attempting to fill it, it has become apparent to me that the orientation applies to all of us. In addition to being large, there is the further difficulty that several individual topics, each of which is complex, must be tied up and given coherent relationship.

Such a problem once was solved by a bright school boy. Johnny's teacher, suffering from a slight hangover, or perhaps it was migraine, and hoping to have some free time to recuperate, told the class to write a theme on *Royalty, Sex, Religion and Crime*. After only a few minutes Johnny waved his paper in the air. It read: "The Queen had a baby. My God! Who dunnit?"

Johnny found a solution by getting down to fundamentals. Perhaps that will give us a clue.

There is a point that should be emphasized in approaching these fundamentals. Physicians by scientific training and bedside practice have developed unusual objectivity regarding the patient's physical disease. However, regarding the patient's political philosophy, if it happens to be contrary to our own, we are likely to be intolerant. Being people long before we were doctors

Read at the thirty-seventh annual Conference of Secretaries and Editors, Harrisburg, March 3, 1949.

we often become emotional—even over politics. Our reaction when compulsory health insurance or other evidences of social change are discussed is likely to be so explosive that we defeat our own purpose. An example of this, in my opinion, is the statement, so often loosely made, that the drive for socialized medicine is by men whose sole objective is to fasten Communism upon us.

No doubt there are those in high places who would cold-bloodedly do anything to extend their power, centralize control, and rule our lives. There is another group of high-minded idealists who want to help people. They often lack the background to see that the ends do not always justify the means. They need education. But I submit to you that the vast majority of our citizens, including our labor and farm groups, will have none of Communism. When they understand the story, and it is our job to see that they do understand it, socialized medicine and Communism won't have a chance.

We have a big job to do and my appeal is to divorce emotionalism, loose thinking, and loose talking from our approach to it. Health insurance, whether compulsory or voluntary, is a burning American issue today and organized medicine must recognize it as such.

I have ventured to subdivide the topic into four parts: (1) objectives of organized medicine, (2) medical ethics, (3) public and professional relations, (4) medical economics.

Objectives of Organized Medicine

Organized medicine is concerned primarily with serving the interests of the public. In so doing it must preserve a high degree of scientific knowledge among its members. It is not surprising then that the objectives of organized medicine may be largely summed up in the word *education*.

Professional education comprises (1) aids and grants in research, (2) preparation and publication of scientific papers, (3) maintenance and elevation of the standards of medical education.

Lay education consists of (1) support of legislation that will accrue to the well-being of the public and (2) public health, hygiene, and preventive medicine.

The importance of county society scientific programs, of planned reading and regular attendance at meetings, and an understanding approach to the problems of education of legislative bodies and the public, all are matters of great importance to you and to your individual members.

We came by our primary medical education the hard way. There is no easy way to continue

our education. Constant study of scientific advances and organizational activities is necessary if we are to serve the public well and assist in the educational program so sorely needed today.

Medical Ethics

Ethics may be defined as the principles of morality. It includes both the science of the good and the nature of the right.

It is hardly necessary to state that each member should study and understand the Principles of Medical Ethics of the A.M.A. I don't for one moment believe that such a study will change a man's fundamental nature. I do believe that if he is indifferent or calloused in mind, a true understanding of our ethics may awaken in him a desire to do better, perhaps only because it seems to be the expedient thing to do.

There are those who have stated that the present Principles of Medical Ethics are outmoded, Victorian, or unrealistic. Others have said that they may not be legal; others that we spend too much effort defending our members under these principles and not enough in cleaning our own house.

My own opinion is that the county medical societies mean business. If there is a documented case of violation of ethics, the Board of Censors acts. The county society is the only body from the A.M.A. down that has disciplinary power. It is the only segment of medical organization that should have such power.

It is possible that the matters of legality and outmoded approach would be disposed of if we all understood this quotation from Article V, Section 3, dealing with contracts: "The decision as to its ethical or unethical nature must be based on the ultimate effect for good or ill on the people as a whole."

Ladies and gentlemen, that phrase applied by men of good will at the local level can go a long way in the solution of all ethical and economic problems. The solution regarding staff appointments, arrangements for remuneration of physicians, fee splitting, and all the rest of these plaguing matters, lies in honest, open-minded, local application of that principle.

Public and Professional Relations

A medical organization's public relations and your individual public relations with the people are inseparably bound up with the professional relations between individual doctors and between doctors and their societies. The best we can do here is to call attention to several important considerations that bear on both public and professional relations in every county medical society

and which should be brought to each member's attention.

Woman's Auxiliary: Orientation of wives of all members is necessary if organized medicine is to achieve its educational objective. The Auxiliary is the good right arm of the doctors and it undertakes all assigned tasks with rare good will. Under the present able leadership of Mrs. Paul C. Craig, whose clear thinking and verve were displayed to you in her talk yesterday, the Auxiliary is getting things done that previously had been paper projects. You as a county society officer and your wife have a great responsibility to the Auxiliary. See to it that the new member's wife is made welcome. If she is as smart as most doctors' wives, she will help orient him.

Consultations: All members must realize that frequent consultation is needed. Some hospital staffs require consultations under certain circumstances. In our own obstetric department these are given freely, often without fee even in private cases, if the department rules require them. This is certainly an advantage to the courtesy staff and in the interest of the patient.

Introduction of New Members: Depending on local conditions the orientation of new members may be undertaken at one or more meetings, which may be formal or informal. The rank and file of the county medical society will not be expected to attend these meetings and therefore may not know the new members. We have found that it gives a lift to the new member if he is escorted to the rostrum and properly presented. Most new members have had a military career and all of them have family and educational details the recitation of which will be informative to us and pleasing to them. Formal presentation of the A.M.A. Handbook and other organizational literature is carried out at this time.

Malpractice: The PENNSYLVANIA MEDICAL JOURNAL frequently has published the admonition to obtain a written consent for autopsies and operations. This has a valuable public relations aspect.

The new member needs to know this; he must practice in accordance with the standards of skill, care, judgment and diligence which are commonly possessed and exercised by the ordinary reputable practitioners in the community.

A professional relations angle should be mentioned. In the ordinary malpractice case, to make proof in court, it is necessary that some physician testify on behalf of the patient. A malpractice case will fail unless some doctor gives testimony that condemns the defendant—physician's conduct of the case.

You would have to be thoroughly convinced of the justice of the plaintiff's case before you would put yourself in that position, wouldn't you, doctor?

Let us try to be as honest and objective as we should be when Mrs. X tells us that Dr. B prescribed the wrong remedy, made the wrong diagnosis, or botched the delivery. Mrs. X puts words in the mouth of her then attending physician. Don't let her quote you too.

The Physician and the Community: The profession has not been blind to medicine's sociologic aspects, but has done little about them.

The new member, from the moment he entered medical school, has tended to have his interests more and more narrowed. He is in the midst of the social fabric and sees the people's needs, but he just hasn't had the time to take part in the community's efforts to find correct and workable answers.

Reorientation probably is needed in medical education to include more emphasis on sociology. We can make a start by orienting ourselves and the new member to the importance of developing interest and leadership in: (1) all phases of preventive medicine; (2) lay health and welfare organizations; (3) school, service club, and church activities; (4) community betterment and recreation projects.

The Physician and His Patient: Preservation of the traditional relationship between the physician and his patient is the one solid anchor to windward which the profession and the people have to prevent all of us being swept along in the world's drift toward socialism.

We must recognize and orient all of our members to changes in medical practice which seem at first glance to disturb this relationship. For example, health centers, public health units, group practice, and government medicine practiced through Federal agencies such as the Veterans Administration may seem to militate against this personal relationship. However, after more mature consideration we see the need for some of the changes and we recognize that the family doctor's role has been strengthened by them.

Unselfish conscientious service to the patient, plus recognition by the new member of his own personal responsibility for building and keeping good will, will insure his material success. More important, it will provide the public relations tool that medicine most needs today.

Medical Economics

Fees: Discussion of the local fee schedule and explanation of the usual charges is extremely

helpful. The unfortunate public relations resulting from overtreatment, overcharging, fee splitting, and acceptance of rebates or kickbacks is obvious. The main emphasis may properly be placed on the shattering effect on the moral sense of one who indulges in such dishonesty.

Voluntary Health Insurance: Blue Shield is growing so rapidly that it may well become the number one success story in voluntary insurance. Certainly new members should be indoctrinated with the general philosophy of prepayment plans and specifically instructed regarding the Medical Service Association of Pennsylvania.

We all must recognize that at the present stage of their evolution voluntary plans have been criticized because they do not provide either complete coverage or full service benefits and are largely unavailable to the medically indigent. Those underwritten by medical societies have suffered from the additional criticism that they do not provide adequate consumer representation on their policy-making boards. Whether or not these criticisms are all valid ones may be controversial. However, the new member and the old should orient his thinking to approach them objectively and with understanding.

In closing our discussion of the new member, he should be assured by our attitude that we are interested in him as a person and as a physician. He will appreciate invitations to departmental and general staff meetings. He may request help in presenting an application to the credentials committee of your hospital. Certainly he should be encouraged to ask questions and to feel free to confer with one or two older colleagues who are both sponsors and counselors.

Suppose he asks you a question that I have been asked: "Doctor, what of the future? What hope do you see?" The reply will be based on your personal orientation.

The medical profession stands for unselfish labor in behalf of the people, for mercy to friend and enemy alike, and for a sane scientific attitude in a mad world. Others have forfeited the trust of the people for whom they work. We have not—yet—lost this trust. Others have bartered the free spirit of adventure and enterprise for a mere hope of security. The medical profession has not—yet—yielded.

In the spirit of selflessness embodied in our ethics and with the resolve to keep the torch of scientific achievement burning brightly, let us rededicate ourselves to education and service.

Who then may doubt the issue?

EXCERPTS FROM BOARD OF TRUSTEES MINUTES

July 14, 1949

A regular meeting of the Board of Trustees of The Medical Society of the State of Pennsylvania was held Thursday evening, July 14, 1949, in the Governor's Room of the Penn-Harris Hotel, Harrisburg.

Members in attendance: Drs. Hugh M. Miller (1st), John J. Sweeney (2d), Francis J. Conahan (3d), James Z. Appel (5th), Joseph S. Brown (6th), George S. Klump (7th), Frank A. Lorenzo (9th), James L. Whitehill (10th), Leard R. Altemus (11th), and Thomas R. Gagion (12th).

Officers present: Drs. Gilson Colby Engel, president; Walter F. Donaldson, secretary-treasurer; E. Roger Samuel, president-elect; Harold B. Gardner, first vice-president; and Park Berkheimer, assistant secretary-treasurer.

Committee chairmen and others present: Drs. Louis W. Jones (Medical Economics), Howard K. Petry (Public Relations), and Elmer Hess (Hospital Relations), Mr. Lester H. Perry, executive secretary, and Mr. Leo E. Brown, executive assistant of the Public Relations Committee.

Chairman Lorenzo called the meeting to order at 7:55 p.m.

Report of Committee on Hospital Relations

It was the consensus that the regular order of business be suspended in order to permit Dr. Elmer Hess to present the report of the Committee on Hospital Relations. (Mimeographed report distributed to members of Board at this meeting.) Dr. Hess then read the report.*

DR. HESS: At A.M.A. headquarters a volume of all the investigative work of the Legal Department for the committee of which I was chairman regarding the laws regulating corporation practice of medicine of all the states has been compiled. We advise that a request be made from this Board of Trustees for a copy of these laws to be sent to each Pennsylvania hospital for its information.

Following a short discussion, the chairman stated that consideration would be postponed until Friday morning when a copy of the Columbia County Medical Society resolution would be available.

Secretary Donaldson reported the receipt of changes and corrections to the minutes of the May 19 and 20, 1949 meetings of the Board:

Page 7, line 13, May 19 meeting—"Klein" instead of "Kline."

Page 7, line 20, May 20 meeting—"prerogative" instead of "property."

DR. KLUMP: The list of chairmen to supervise the preparation of the mailing list of names to whom copies of the recent Pennsylvania Health Survey are to be sent, as provided in Dr. Gagion's motion, should have included the name of Chairman Lucchesi of the Commission on Preventive Medicine and Public Health.

It was the consensus that Dr. Lucchesi's name should be added to the motion appearing on pages 7 and 8 of the minutes of the May 20, 1949 meeting as circulated.

It was moved (Dr. Altemus), seconded (Dr. Conahan), and unanimously carried that the minutes of the May 19 and 20, 1949 meetings be approved as corrected.

* SECRETARY'S NOTE: See page 1264, August PENNSYLVANIA MEDICAL JOURNAL.

*Reports of Board Committees**Finance Committee:*

Chairman Whitehill commented on a copy of the June 30 financial statement by the Secretary-Treasurer which had been mailed to each board member.

It was moved (Dr. Altemus), seconded (Dr. Miller), and unanimously carried that the report of the Finance Committee be approved.

Following a statement by Dr. Whitehill comparing balances in the General Fund of previous years, the following discussion ensued:

PRESIDENT ENGEL: In support of Dr. Whitehill's comments, I believe that one of our heaviest expenses will probably be that of the Committee on Public Relations.

DR. PETRY: Doubtless we will have a heavy drain next year if we are to offer our best efforts locally.

It was moved (Dr. Gagon) and seconded (Dr. Altemus) that the Finance Committee prepare recommendations for the financing of the Society in its next year and that a copy of their recommendations be in the hands of each trustee and general officer by September 1.

SECRETARY-TREASURER DONALDSON: Dr. Whitehill and I are in agreement that it is scarcely fair to ask the members who pay dues in the year 1950 to provide needed funds for completing the Society's building operations. Therefore, he suggests borrowing funds when needed, to be paid back in annual installments. That's one point for future planning that may help to avoid a heavy increase in the dues for 1949-50.

VOTE ON THE MOTION: Unanimously carried.

Building Maintenance Committee:

CHAIRMAN CONAHAN: It proved to be impossible for our architects to provide remodeling construction bids in time for this meeting. The committee recommends that it be granted authority to proceed with the remodeling (226 and 230 State Street) at a cost not to exceed \$80,000.

Each Board member had received in June a set of blueprints of the architect's plans and after a free discussion it was moved (Dr. Whitehill), seconded (Dr. Altemus), and unanimously carried that the Building Maintenance Committee be given power to open the bids and let contracts, using its own best judgment within the cost limit of \$80,000.

Library Committee:

Chairman Klump submitted the report of the Library Committee as distributed to the Board.

It was moved (Dr. Klump), seconded (Dr. Sweeney), and unanimously carried that the report of the Library Committee be adopted.

Reports of Medical Defense Cases

First District: One case (No. 379) approved by Philadelphia County Medical Society board of censors and the councilor.

Fourth District: Reported by Secretary Donaldson. Two cases (Nos. 377 and 378), both properly approved by the board of censors and councilor.

Report of President

President Engel touched on his correspondence with Dr. R. B. Robbins, a member of the Planning Commission of the A.M.A.

He next opened a discussion of the recently published health survey in Pennsylvania, which covered news-

paper discussions of the report by Secretary of Health Vaux and the Public Charities Association. Dr. Engel stated that Philadelphia newspapers supported the Public Charities Association. He also said that our state society should take a definite stand because it concerns the health of the citizens of this Commonwealth.

DR. KLUMP: I think that since we sponsored the report we should study it carefully through our proper commissions and committees. It will later demand legislation in some instances.

DR. PETRY: This board directed a committee to develop a list of recipients of the copies of the survey report that were to be turned over to our society. The number of copies finally available were several hundred less than the promised 900. We have distributed copies to the chairmen of the committees concerned requesting them to study the portions of the report which concern the functions of their respective committees so that they may be in a position to advise and guide the reaction. We sent a copy to the secretary of every county medical society with a request that he place it with some local library or depository where it will be available to the public. We are trying now to reduce a list of about 700 recommended recipients to about 200.

It was moved (Dr. Sweeney), seconded (Dr. Conahan), and unanimously carried that the report of President Engel be accepted.

Report of President-Elect

DR. SAMUEL: I have attended most of the councilor district meetings in the State. I observed that one councilor district had about 8 per cent of its members in attendance, another 12 per cent, another 20 per cent, and one had only 1 or 2 per cent. In some instances I question whether the expenditure of energy, time, and money is justified. The presentation of the fifty-year testimonial is important in our public relations program and excites much newspaper comment. The time may have come when we ought to make some definite decision as to whether the councilor district meetings are what the by-laws intended. Perhaps we should return to the former type known as councilor commission meetings.

It was moved (Dr. Gagon) and seconded (Dr. Klump) that Chairman Lorenzo in his report to the House of Delegates advise their thoughtful consideration of the rescinding of Chapter IV, Section 4, of the By-laws.

DR. BROWN: That may be well and good in some districts, but in others not so good. I would be against doing away with the councilor district meeting in our district where as a rule we have good meetings. We had 20 per cent of our membership at this year's councilor meeting. I think that the councilor and his executive assistant have much to do with the success of this meeting and the men on the program have a lot to do with attendance.

DR. APPEL: I would like to speak in favor of the motion. I have conducted only one councilor district meeting. However, I have only missed about three since I practiced medicine. The attendance at all of them has been very poor. In my first year I tried experiments to improve the attendance. We had an afternoon session limited almost entirely to medical society affairs. In spite of that, we had a total attendance of only about fifty at the luncheon with fifteen coming in afterwards.

SECRETARY DONALDSON: I think the failure of the councilor district meeting in some areas of the State has been due to combining two or more councilor dis-

tricts in a single meeting. It is a gesture toward the county medical societies when we bring into the district such evidence of state society interest. I don't think you can correct this situation by revising the Constitution and By-laws.

MR. PERRY: Do you think it might be a good idea to make it flexible rather than mandatory, by leaving to each councilor his own decision as to whether or not the meeting should be held? The Public Relations Committee setup could help to stir up attendance at these meetings. Mr. Hutchison, of public relations, in the western part of the State, has done much along the lines of newspaper publicity with planned radio programs in connection with at least three such meetings. Admittedly the attendance may be disappointing, but do the members in your own districts believe that those who do attend may serve as a haven to stir up additional interest in current problems on return to their own counties?

DR. MILLER: In Philadelphia we dropped the scientific program features and followed this specific wording (from Section 4, Chapter IV, of By-laws), "each councilor district shall hold one or more meetings for increasing acquaintanceship, good fellowship, and organization among the physicians of the district." We made ours a dinner meeting with presentation of the fifty-year testimonials, a single talk, and had 160 members present.

VOTE ON DR. GAGION'S MOTION:

First District—No	Seventh District—Yes
Second District—No	Eighth District—Absent
Third District—No	Ninth District—No
Fourth District—Absent	Tenth District—No
Fifth District—Yes	Eleventh District—Yes
Sixth District—No	Twelfth District—Yes

Yes—4 No—6

The motion lost.

Report of Executive Secretary

MR. PERRY: The first part is informative—about the A.M.A. convention.

On this railroad tour to San Francisco in 1950, in my report, I raise questions which should be answered.

DR. GAGION: Would State Society sponsorship bind us to any financial obligation?

MR. PERRY: It would not.

After further discussion, it was decided that no further time should be spent in discussing this matter and that doctors wishing to take the tour could make arrangements through local agencies.

It was moved (Dr. Miller), seconded (Dr. Klump), and unanimously carried that the report of the executive secretary be accepted.

Report of Committee on Public Health Legislation

Secretary Donaldson stated that this report had been circulated to each member of the Board of Trustees. Inasmuch as Dr. Palmer was not present, Chairman Lorenzo ruled that discussion of this report be postponed until the Friday morning meeting.

Report of Committee on Public Relations

DR. PETRY: Mr. Brown reports to me that in the first four months of our field service representation, 158 visits have been made to component county societies and auxiliaries.

Public Relations Counsel

DR. WHITEHILL: On this point I would say that you cannot possibly transfer a balance from your current budget to your committee's budget for next year; therefore, that motion is out of order. If you want to set up that item in your request for your budget next year, you are permitted to do so. Make your plans and put in your request for the 1949-50 budget, and it will be carefully considered.

MR. PERRY: This proposal to retain counsel involves more than appraisal alone. It involves, first, an appraisal, second, a pointing of the way we might better follow, and it projects a one year's counseling service with periodic meetings with Ketchum, Inc.

It was moved (Dr. Gagion) and seconded (Dr. Sweeney) that the Board reconsider its action endorsing the employment of Ketchum, Inc., for the purpose of making this survey.

DR. KLUMP: Some of you will recall the 1946-47 discussion of the submitted Rich Report, followed by the resignation of the then chairman of the Committee on Public Relations and the establishment of the Coordinating Committee, which suggested that professional help be obtained from time to time to review the program and the progress of our Committee on Public Relations. It strikes me that it is good business judgment to review this program since the committee's annual budget approximates \$50,000. We do need the opinion and advice of these professional organizations.

DR. WHITEHILL: What about accepting their \$2,000 proposition for a survey?

MR. BROWN: Nothing has been mentioned regarding contacting Ketchum about the survey only, but if they were properly approached, it would be alright. After they determine how far wrong or how nearly right we have been in the program to date, it will be possible to determine if we need counseling service in the future.

QUESTION ON DR. GAGION'S MOTION: In favor—7, opposed—1.

It was moved (Dr. Whitehill), seconded (Dr. Altamus), and unanimously carried that the Committee on Public Relations employ Ketchum, Inc., for the sum of \$2,000 plus traveling expenses to survey our present public relations program and submit a report.

Promotion of National Education Campaign

It was moved (Dr. Miller) that the Pennsylvania State Medical Society send a request to the A.M.A. for reimbursement for the mailing cost incurred. (SECRETARY'S NOTE: Has been repaid in full.)

Benjamin Rush Awards

DR. PETRY: The Benjamin Rush Award doesn't seem to draw sufficient participation. I think we should re-evaluate it and give it further trial.

Health Poster Contest

It was moved (Dr. Gagion), seconded (Dr. Sweeney), and unanimously carried that paragraph VI of the report be approved.

It was moved (Dr. Altamus), seconded (Dr. Miller), and unanimously carried that the report of the Public Relations Committee be accepted.

Discussion Regarding History of MSSP

DR. PETRY: The material for the history of the Medical Society is in shape at the present time, and we

have 170 paid subscriptions (\$4.50). The cost of the publication and mailing of a volume of that type on a 1500 basis will approximate \$6,000, toward which we may expect to collect between \$2,000 and \$3,000. It will be ready for issue in December or January.

It was moved, seconded, and unanimously carried that the meeting be adjourned until 9:30 a.m., Friday, July 15, at 230 State Street.

The meeting was adjourned at 11:25 p.m.

FRANK A. LORENZO, *Chairman*,

WALTER F. DONALDSON, *Secretary-Treasurer*.

July 15, 1949

The Board of Trustees of The Medical Society of the State of Pennsylvania reconvened Friday morning, July 15, 1949, in the board room of the headquarters building, 230 State St., Harrisburg.

Members in attendance: Drs. Hugh M. Miller (1st), John J. Sweeney (2d), Francis J. Conahan (3d), James Z. Appel (5th), Joseph S. Brown (6th), George S. Klump (7th), Frank A. Lorenzo (9th), James L. Whitehill (10th), Leard R. Altemus (11th), and Thomas R. Gagon (12th).

Officers present: Drs. Gilson Colby Engel, president; Walter F. Donaldson, secretary-treasurer; E. Roger Samuel, president-elect; Harold B. Gardner, first vice-president; and Park Berkheimer, assistant secretary-treasurer.

Others present: Drs. Louis W. Jones, chairman of Committee on Medical Economics, and J. Arthur Daugherty, president of MSAP; Mr. Curtin Windsor, representative of the Farm, Business and Professional League; Mr. Donald T. Diller, executive vice-president of MSAP; Messrs. Lester H. Perry, Leo E. Brown, Alex H. Stewart, and Robert L. Richards, of the staff of the Harrisburg office.

Chairman Lorenzo called the meeting to order at 9:35 a.m.

Report of Board Publication Committee

Chairman Gagon then read the report of the Publication Committee.

DR. GAGON: Our committee has approved a recommendation from the editor and managing editor whereby for practical reasons the make-up of the annual volume of the JOURNAL will be changed from October to September inclusive as of many years to January to December in 1950. This will save time and money, and will simplify materially the reader's search in a bound volume for continuity between annual reports and the action on same by the House of Delegates.

Referring to the failure of members to meet the publication deadline set by the editor of the PENNSYLVANIA MEDICAL JOURNAL when submitting articles, reports, or comments for publication, the committee will urge Managing Editor Stewart to observe the set deadline, hoping thereby to get the JOURNAL to the members at an earlier date each month.

It was moved (Dr. Altemus), seconded (Dr. Miller), and unanimously carried that the report of the Publication Committee be accepted with approval of the suggested changes in policy.

Report of Committee on Medical Economics

Pennsylvania Interscholastic Athletic Association Insurance Program

It was moved (Dr. Gagon) and seconded (Dr. Miller) that the first part of the report of the Committee on Medical Economics as circulated be approved and

that such approval be interpreted as a definition of principle and policy.

DR. APPEL: In certain school districts the compensation coverage of teachers does not include their participation as athletic coaches.

DR. JONES: I learned that the compensation law requires that an employer must furnish protection for all of his employees either by posting a bond at Harrisburg or through complete coverage by a compensation insurance carrier.

QUESTION ON THE MOTION: Unanimously carried.

DR. JONES: Does our committee have authority to negotiate with an individual insurance company?

CHAIRMAN LORENZO: I think not.

A Proposed Retirement Program

DR. JONES: We don't have the time nor the personnel to analyze various retirement plans one against the other. We considered this as simply a plan to get the Medical Society to send out soliciting literature about an insurance plan.

It was moved (Dr. Whitehill), seconded (Dr. Miller), and unanimously carried that this part of the report of the Committee on Medical Economics be accepted with the understanding that the Board desires no further study of the proposal.

MSAP Request for Opinion

DR. JONES: The committee believed that it could take no action since our society's contract with the VA has nothing to do with any provision for any other agency to pay doctors rendering professional service under the Veterans Administration.

It was moved (Dr. Gagon), seconded (Dr. Miller), and unanimously carried that the Committee on Medical Economics return the correspondence to the MSAP with the notation that it is the sense of this board that this problem is not within its province.

DR. JONES: Last night another insurance proposition addressed to the State Medical Society was handed to me. It covers twenty some pages of conversation between Mr. Richards and an insurance agent regarding a combination health and accident insurance policy by which individual members (minimum 600) join as a group and get a preferred rate, etc. Is my committee to throw it in the wastebasket?

SECRETARY DONALDSON: I am in a position to observe how many times this has been undertaken by county medical societies and how much pressure is necessary to maintain the required minimum number of subscribers. It's an imposition to bring such proposals before you. They waste time of the office staff, of committees, and of this board. I think you should adopt a policy today to prevent further waste of time in such discussions.

It was moved (Dr. Miller), seconded (Dr. Gagon), and unanimously carried that such people be promptly informed that the State Society is not interested in their plans.

Report on Practice of Medicine by Hospitals

SECRETARY DONALDSON: I have prepared from material previously sent you a report to the 1949 House of Delegates which should restate the resolution which was presented by the Columbia County Medical Society to the 1948 House of Delegates. This report, or one similar to it, should avoid the pitfall of discussing the legality of hospital policies and should inform the pro-

fession on that which should be observed in equity to the patient, the hospital, the community, and the physician. If provisions of the report are not observed harmoniously, the profession of course has no police power over the hospitals.

It was moved (Dr. Miller), seconded (Dr. Whitehill), and unanimously carried that the Board of Trustees recommend the Secretary's compilations to the House of Delegates. (SECRETARY'S NOTE: The report is incorporated in Chairman Lorenzo's report to the House of Delegates as printed in the August PMJ, page 1243.)

World Medical Association

DR. WHITEHILL: My study and conclusions on the request that our society contribute to the advancement of the purposes of the World Medical Association (W.M.A.) are based on my own reading as a member since last December, and more especially from facts and recommendations based on the association's special investigative report No. 1 on the medical profession in 23 countries.

Needless to state, it was soon determined that "doctors in one-half of the world do not know how their colleagues in the other half live, under what conditions they practice, and what difficulties confront them, and the association believes that the world-wide publication of comparative factual surveys of particular aspects of medical practice and of medical problems of general interest will fill a serious gap in the literature of the profession."

There is no doubt that the post-war conditions under which most of the physicians must work in European countries are appalling and it is firmly believed that the doctors in America should promptly contribute as individuals by becoming members of W.M.A., and that American medical societies should also contribute (some have in amounts ranging from \$50 to \$10,000—the A.M.A. \$50,000).

I have individual membership application blanks with me and recommend that The Medical Society of the State of Pennsylvania contribute \$1,000 for the sake of our colleagues in devastated and remote countries and of the people they serve professionally.

It was moved (Dr. Whitehill), seconded (Dr. Gagon), and unanimously carried that The Medical Society of the State of Pennsylvania send to the World Medical Association a contribution of \$1,000.

MSAP Orientation

MR. PERRY: This matter was tabled at the last meeting of this board pending further study on some proposals from Associated Medical Care Plans to the MSAP. The MSAP board has come to no conclusion. Probably the advisable thing to do would be to let it remain on the table until they decide.

It was moved (Dr. Gagon), seconded, and unanimously carried that the matter of MSAP orientation of county medical society representatives be tabled.

Presentation of Fifty-Year Testimonial to Non-members

Secretary Donaldson read a letter, omitting names, which he had received from Executive Secretary Irwin of the Philadelphia County Medical Society regarding the presentation of the State Society's fifty-year testimonial to three non-members.

It was moved (Dr. Sweeney) and seconded (Dr. Gagon) that the request from the Philadelphia County Medical Society be denied.

SECRETARY DONALDSON: I speak in favor of this motion because in my opinion the vast majority of the thousand or more of the testimonials, first presented in 1933, have been gratefully received by members loyal to our organization throughout all or most of their half century in practice. Furthermore, I have knowledge of but two non-members who received that form of state society recognition.

To grant it now to one Pennsylvania practitioner who never became a member, and to a physician from another state but one year in public health work in Pennsylvania and a member of the Society since 1948, may be considered ill-advised.

I prize my own fifty-year testimonial very highly, as do most recipients, and don't like either ill-considered approval or informal unscheduled presentation which may tend to minimize its inherent value.

Action was deferred for additional information.

Reports on Collection of A.M.A. Membership Assessment

Informatory reports on the collection of A.M.A. membership assessment were received from all councilor districts except the fourth and eighth. They reflect very largely the report made by Mr. Brown, executive assistant of the Committee on Public Relations, which follows immediately.

MR. BROWN: You have received recently from Dr. Donaldson's office reports on a percentage basis of the payment of the various members in the county societies of your district of the \$25 A.M.A. membership assessment, and the secretary of each county society has been given the names of those who are delinquent. These percentages range from as low as 50 per cent to as high as 100 per cent paid. Secretary Donaldson has advised that the state over-all percentage is 71 per cent paid, and expresses the hope that it may soon reach at least 90 per cent.

A.M.A. National Education Campaign

MR. BROWN: We have been attempting to encourage all county society officers to organize their societies as was explained to them at the last Secretaries-Editors Conference. Currently only twenty-two county societies have done this and are operating successfully. The other 39 societies have not yet even appointed their education campaign committees. Their speakers' bureaus are working periodically. Too many county societies have not reported any resolutions against socialized medicine from lay organizations. We must have good organizations at each county level in September. Our field representatives are available full time to help in the counties. We need the introductory help that only you can give in the county societies in your respective councilor districts. Please encourage them. Only 18 county societies have adopted resolutions condemning compulsory insurance, and yet we are asking lay organizations to do this. Ask us regarding delinquent county societies, then as councilor talk personally to the officers of such societies. Let them know that their activities are your concern. You will find in the current report of the Public Relations Committee a list of the few county societies that have adopted resolutions against compulsory health insurance.

DR. WHITEHILL: I suggest that the Committee on Public Relations prepare sample resolutions condemning compulsory health insurance to be sent to all county societies who have not adopted such and tell them they must act and obtain similar resolutions from lay groups in all communities.

MR. PERRY: Will the trustees, particularly from the western part of the State where we have had a field man working longer than in the eastern part, offer suggestions or comments about the work Mr. Hutchison is doing, or in the eastern part, Mr. Young? Are they doing a good job?

Drs. Altemus, Whitehill, and Donaldson all reported favorably on the work of Mr. Hutchison in the western part of the State. Secretary Donaldson asked especially that Mr. Hutchison be given openings for more and more personal demonstration to the membership in the various counties of existing everyday opportunities for expanding local public relations.

Election of Associate Members

Secretary Donaldson read the names (see p.r.) from duly submitted applications for eight associate memberships, after which it was moved (Dr. Gagon), seconded (Dr. Miller), and unanimously carried that these applicants be granted associate membership.

Committee on Scientific Work

SECRETARY DONALDSON: The 1949 Committee on Scientific Work has had the benefit of the advice of a chairman and a secretary from each one of the former specialty sections, and this year's committee would like the Board of Trustees to approve of the committee asking each of those two specialty representatives to continue in the same capacity next year, or to recommend two others from their particular specialty for the purpose of advising the 1950 Committee on Scientific Work.

It was moved (Dr. Altemus), seconded (Dr. Sweeney), and unanimously carried that the recommendation of the Committee on Scientific Work be approved.

The date and place of the next meeting of the Board of Trustees was set for 10:30 a.m., Sept. 25, 1949, at the Hotel William Penn, Pittsburgh.

Report of Board Committee on Benjamin Rush Awards

Dr. Appel stated that the committee recommends to the Board that the following receive the 1949 Benjamin Rush Award:

Individual—Mrs. Leonard Doggett, State College, Pa.

Organization—The Emergency Aid of Pennsylvania, from Philadelphia.

It was moved (Dr. Whitehill), seconded (Dr. Conahan), and unanimously carried that the report and recommendations of the Committee on 1949 Benjamin Rush Awards be accepted.

Report of MSAP

Dr. J. Arthur Daugherty, president of MSAP, read the report as well as a letter addressed to the members of the Board of Trustees on the determination of persons to be considered of low income (see Appendix A appended).

It was moved (Dr. Klump), seconded (Dr. Altemus), and carried that this action of the Medical Service Association regarding income limits be approved, Dr. Gagon dissenting.

It was moved (Dr. Altemus), seconded (Dr. Klump), and carried that the report of MSAP be accepted with the recommendation that a committee be appointed.

(Dr. Gagon did not vote on this motion because of lack of knowledge of the report.)

Chairman Lorenzo appointed the following committee in accordance with the request of MSAP: Drs. Louis

W. Jones, chairman, Leard R. Altemus, and Francis J. Conahan.

Request from Commission on Physical Medicine

Secretary Donaldson then read a communication, dated June 17, from the Commission on Physical Medicine, which he had mailed to Board members.

SECRETARY DONALDSON: This committee takes the same chances that other committees do in holding meetings during the annual session, namely, they hold their meeting Wednesday, September 28, after 5 p.m., without expense to the Society.

It was moved (Dr. Miller), seconded (Dr. Altemus), and unanimously carried that the name of the commission be recommended as requested—Commission on Physical Medicine and Rehabilitation.

It was moved (Dr. Sweeney), seconded (Dr. Altemus), and unanimously carried that they be informed that they may hold their meeting on Wednesday between 5 and 8 p.m. without expense to the State Society.

Communication from Pennsylvania State Dental Society

DR. GAGON: I recommend that in a reply we incorporate the suggestion, if there be a change in the nomenclature "doctors and dentists," that it be "doctors of medicine and doctors of dental surgery." Seconded by Dr. Altemus and unanimously carried.

Communication from Bloomsburg Hospital

Secretary Donaldson read a communication from the Bloomsburg Hospital regarding a resolution adopted by the Columbia County Medical Society for expelling members for non-attendance upon county society meetings.

DR. GAGON: Does this society have the right to dictate the rules of its component societies?

SECRETARY DONALDSON: The by-laws of a county medical society are subject to the approval of this society.

It was moved (Dr. Gagon), seconded (Dr. Altemus), and unanimously carried that the action of the Columbia County Medical Society, as reported to this board, be disapproved as it does not conform with the by-laws of the MSSP.

Report of Committee on Public Health Legislation

It was moved (Dr. Gagon), seconded (Dr. Altemus), and unanimously carried, inasmuch as Dr. Palmer, by reasons of health, could not be present, that consideration of the report of the Committee on Public Health Legislation be deferred until the next meeting of the Board of Trustees.

Report of Commission on Graduate Education

It was moved (Dr. Miller), seconded (Dr. Altemus), and unanimously carried that the report of the Commission on Graduate Education be approved as received.

Report of Committee on Hospital Relations

It was moved (Dr. Klump), seconded (Dr. Gagon), and unanimously carried that the report of the Committee on Hospital Relations, which should be addressed to the House of Delegates, be tabled until such time as Dr. Hess is present to answer questions regarding the report.

Mr. Perry advised the Board that he had been informed that Dr. Laurie D. Sargent, former chairman

of the Board of Trustees, recently had another operation on his eyes.

It was moved (Dr. Gagon), seconded (Dr. Altemus), and unanimously carried that a telegram of felicitation and good wishes be sent to Dr. Sargent.

Chairman Lorenzo declared the meeting adjourned at 12:30 p.m.

FRANK A. LORENZO, *Chairman*,
WALTER F. DONALDSON, *Secretary-Treasurer*.

APPENDIX A

The Board of Trustees,
The Medical Society of the State of Pennsylvania,
Harrisburg, Pa.

GENTLEMEN:

At a meeting of the members of the Association held on June 23, 1949, the By-laws of the Association were amended to include the following provision: "The members of the Corporation shall determine what persons are to be considered to be of low income provided, however, that such determination shall be approved by the Board of Trustees of The Medical Society of the State of Pennsylvania and the Insurance Commissioner of the Commonwealth of Pennsylvania."

Subsequent to the adoption of this By-law amendment, the members of the Corporation unanimously voted to continue in effect the definition of persons of low income that has existed since the inception of the Association.

We would appreciate your approval of this action in order that these income limits may be submitted to the Insurance Commissioner for his approval in accordance with the Acts 332 and 334 of the 1949 session of the General Assembly.

Sincerely yours,

J. ARTHUR DAUGHERTY, M.D., *President*,
Medical Service Association of Pennsylvania,
Harrisburg, Pa.

July 13, 1949

CHANGES IN MEMBERSHIP OF COUNTY SOCIETIES

New (12) and Reinstated (12) Members

CAMBRIA COUNTY: (Reinstated) John J. Silensky, Madera.

CHESTER COUNTY: (R) George E. Dietrich, Coatesville; Charles T. Atkinson, West Chester.

LACKAWANNA COUNTY: Michael G. Yevitz, Scranton. (R) Walter E. Loftus, Carbondale.

PHILADELPHIA COUNTY: John DeCarlo, Jr., Helen Fornwalt, Leonard L. Malamut, John J. Meehan, Nicholas V. Melchiorre, Domenic J. Pontarelli, Eugene B. Spitz, J. Earl Thomas, and Harold Wilf, Philadelphia; Joseph J. Corson, Plymouth Meeting; Gilbert B. Meyers, Jr., Oreland. (R) Harry R. Draper, Eleanor M. Anthony, Morris Gallen, Horace J. Forman, Jr., Albert V. Lampe, Arthur Levenson, and George W. Truitt, Philadelphia.

SCHUYLKILL COUNTY: (R) Asa D. Young, Baltimore, Md.

Transfers (2), Resignation (1), Deaths (9)

ADAMS: *Transfer*—David I. Thompson, Carlisle, to Cumberland County Society.

ALLEGHENY: *Transfer*—Jerome Chamovitz, Sewickley, from Beaver County Society. *Deaths*—Lloyd W. Johnson, Pittsburgh (Univ. Pa. '13), aged 62, June 6; Charles K. Shanor, Sewickley (Univ. Pgh. '09), July 20, aged 66.

BUTLER: *Death*—Robert B. Greer, Butler (Univ. Pa. '99), June 17, aged 74.

LANCASTER: *Death*—Hagop G. Barsumian, Lancaster (Jeff. Med. Coll. '04), June 27, aged 74.

LUZERNE: *Death*—Jacob George Silewski, Nanticoke (Univ. Berlin '23), July 21, aged 52.

MONROE: *Resignation*—David B. Johnson, Coldwater, Mich.

PHILADELPHIA: *Deaths*—Elizabeth F. C. Clark, Ventnor, N. J. (Woman's Med. Coll. '09), June 28, aged 70; William J. Carey, Philadelphia (Hahn. Med. Coll. '36), July 3, aged 38; Charles A. Blayney, Upper Darby (Jeff. Med. Coll. '00), July 11, aged 80; Ralph Pemberton, Philadelphia (Univ. Pa. '03), June 17, aged 72.

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since June 29. Figures in first column indicate county society numbers; second column, State Society numbers.

July 1	Allegheny	1635-1649	10502-10516	\$225.00
	Venango	26	10517	15.00
	Fayette	119	10518	15.00
8	Chester	117	10519	15.00
	Philadelphia	3109-3158	10520-10569	750.00
22	Lycoming	143-144	10570-10571	15.00
28	Chester	119	10572	15.00
29	Lackawanna	285	10573	15.00
29	Cambria	169	10574	15.00

ARE YOU USING THE PACKAGE LIBRARY SERVICE?

Are you taking advantage of the facilities offered by the package library service of The Medical Society of the State of Pennsylvania? There are, at the present time, over 101,000 reprints and tear sheets from current periodicals filed in the library for your use.

Prior to 1944 the average yearly number of requests was approximately 350. However, from 1944 to 1948 inclusive, there has been a continuous increase in borrowers. A total of 1192 requests were received during 1948, an increase of 293 requests over the total for 1947.

A package of reprints will be sent immediately for a loan period of two weeks to any member of the State Society. There is a charge of 25 cents

for each subject requested to cover postage and part of the expense of collecting the material. Send requests to the Librarian, 230 State St., Harrisburg, Pa.

The following requests were filled during the month of July:

Diabetes in pregnancy	Centennial stamp
Painful shoulder	Psychiatry (2)
Fibrositis	Convalescent homes
Water sanitation	Chorionepithelioma
Synovitis of the knee	Treatment of migraine
Lymphedema praecox	Studies in epilepsy
Hernial operations	Backache
Serum bilirubin	Pathology of epilepsy
Socialized medicine	Abdominal adhesions
17 ketosteroids	Heart diseases
Hemoptysis	Hygiene
Hair coloring	Dermatitis
Cancer of the cervix	Arteriosclerosis

Thioglycolic acid	Mastoiditis
Seborrhea	Rh factor
Vivisection	Social hygiene
Periarthritis nodosa	Diagnosis of cancer
Venereal disease	Use of thephorin
Dyspnea	Cancer
Nitrogen mustard in Hodgkin's disease	
Metabolism in pregnancy	
Early postoperative ambulation	
Vagotomy for peptic ulcer	
Treatment of undulant fever	
Herniation of the gastric mucous membrane	
Involutional depression	
Polycystic disease of the kidneys	
Treatment of diabetes mellitus	
Carcinoma of the fallopian tubes	
Hemiatrophy of the face	
Quinidine therapy in heart diseases	
Surgical induction of labor	
Chlorophyll in treatment of dermatoses	
Weight gain in pregnancy	

"PLEASE, DOCTOR, I WANT A SLIP"

Frequently the profession is approached by individuals requesting "slips" from the family doctor. The slip is to indicate to the patient's employer that "he needs lighter work," "she is in need of a rest or leave of absence," or "the bearer may return to work but is not to be asked to lift any great weight, stand for any period of time, or be required to walk."

There are certain persons who have been ill or have conditions that require special consideration. If they are under a physician's care and proper study has been made and diagnosis determined, a communication to the employer is helpful to all concerned, but please send this information to the employer. Do not give it to the employee. If there is a physician employed by the company, call him on the phone and talk it over with him.

Honest cooperation between the family physician and industrial organizations can exist. Frequent and repeated written requests for forms for individuals harm the employee and put the M.D. in a questionable position. Make your communications as intelligent as you would your presentation of the matter to a professional colleague. Be sure they are necessary and 100 per cent true. Don't submit a diagnosis of "nervous condition," "run down," "needs change of job," "anemic," etc. You cannot so label your diagnosis on your hospital chart. Let's not insult the industrial firm by implying that it is credulous enough to accept such statements.—*The Stethoscope*, Erie County Medical Society, May, 1949.

BLOOD BANK CONFERENCE

There are approximately 1,513 blood banks in the United States (Pennsylvania 112) according to the progress report of the American Medical Association's Committee on Blood Banks which met in Chicago, July 21.

Dr. Leonard W. Larson of Bismark, N. D., chairman

of the committee, and two members, Drs. H. P. Ramsey and W. D. Stovall of Washington, D. C., and Madison, Wis., acting as a subcommittee, met with representatives of the American Hospital Association, American Association of Blood Banks, American College of Surgeons, American Protestant Hospital Association, American National Red Cross, American Society of Clinical Pathologists, Catholic Hospital Association, College of American Pathologists, and National Research Council.

The committee has been charged by the House of Delegates with the responsibility for making a survey of the blood bank situation in the United States with a view to appraising the quantity of the blood procured, processed, and distributed as well as to formulate tentative plans for coordination of blood banks in any national emergency.

CURARE PREPARATION RELIEVES SYMPTOMS OF ARTHRITIS

A preparation of a South American arrow poison, curare, is bringing relief to persons suffering from the painful chronic disease, rheumatoid spondylitis, a form of arthritis that affects the spine.

Use of the preparation, d-tubocurarine suspended in oil and wax, is reported by Bernard M. Norcross, M.D., and Harold M. Robins, M.D., of the University of Buffalo Medical School, Buffalo, N. Y., in the May 28 *Journal of the American Medical Association*.

In six cases in which the doctors administered the preparation after other treatment usually prescribed for the disease had failed to produce improvement, the patients were relieved of pain, their muscles were relaxed, deformity of the spine was corrected, and they were able to take more exercise.

Practically no toxic effects from use of the preparation were noted, the doctors say.

PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division, American Cancer Society, in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

A Philosophic Aspect of Cancer

Those of us who are especially interested in cancer ought to take a bit of time off every now and then to look for the traditional silver lining that is supposed to embellish every dark cloud. With a subject such as cancer, it may be hard to find, and except for the occasional news release from the research laboratories about promising blood tests, or hopeful leads in regard to chemotherapy or virus transmission, there is precious little which is in any respect reassuring. We are to a large extent forced to admit that little is forthcoming which is of practical, applicable value to our own patients. We are forced to take refuge in renewed preaching of the gospel of early diagnosis and we find little solace or reason to feel any satisfaction in the statistics which inform us that cancer is becoming an even more prominent cause of death, rather than a less prominent one. It often appears that our battle against Public Killer Number Two is a losing one, and that in spite of our efforts it may surge on to be Public Killer Number One. Such reflections might well be sufficiently discouraging to some of us to make us throw in the sponge and turn to less depressing interests.

All the old gags about statistics are applicable here, however, and it may not be amiss to look upon them from a slightly unorthodox point of view. It may not help the patients any, but it might do something for our own morale. Since earthly immortality appears to be beyond human reach in the foreseeable future, we must accept as a major premise that man must die of something. What, then, is the affliction with which he may most decorously depart this life and still be a credit to the medical profession? Perhaps, like the Deacon's "wonderful one-hoss shay," he should plod along in physiologic equilibrium until a general and sweepingly simultaneous breakdown of all parts is visited upon him. If this be our goal, we still have much progress to make, but even so it does strike me that we are making progress in the right direction. Assuredly we do not want man dying of plague, cholera, typhoid, tuberculosis, or any of those diseases which we now have the power to control and combat. We are entitled to be a bit proud as a profession that, in our country at least, they have been pushed

far down the list. We might be somewhat relieved of responsibility if accidental and violent death were to head the list, but perish the thought that we should promote anything in this direction. Here is preventable death in its purest culture—a form of death that everyone has an obligation to combat.

If we do not want men dying of violence or infectious disease, and if we grant that they must die, what do we want them to die of? Well, preferably of the diseases of old age—of disintegration and decay. Outstanding among such diseases is cardiovascular disease—the inevitable running down and petering out of the circulatory system, which must have been the item which finally gave in back in those biblical days when men lived nine hundred years. Actually, and actuarially, heart disease is the Number One Killer—so we needn't be too ashamed of that. Next among these potential causes of death due to degeneration must be cancer, which is assuredly predominantly a disease of the older age groups. If we can preserve the product of conception from stillbirth and neonatal death, if it can be guarded against the ravages of bacteria and viruses, if it can be shepherded through the perils of industry and the crossing of streets, and brought to a comfortable dotage with elastic arteries and supple joints, it seems reasonable that somewhere, some time neoplasia will set in.

At any rate, the fact seems to be that the advances of medical science as applied by the practicing profession and the agencies of preventive medicine have safeguarded the population to the point where the average life expectancy now carries John Citizen well into the cancer age. It is much more of a tribute to you, Doctor, to have cancer as Killer Number Two than it would be to have it Number Six or Seven.

And now, in case such a little philosophic excursion has made anyone feel better about his problems in general, let us leave it at that and get back to the job of diagnosing cancers earlier, so that we may save the individual patient from succumbing to his particular cancer, even if it means preserving him simply for another cancer later on, if not for the fate of the "wonderful one-hoss shay."

RUSSELL B. ROTH, M.D.

A "soft matrix for bulk for the stools"*



Metamucil®

Principles ascribed by this author* to Metamucil—the "smoothage" management of constipation—are:

- ... *demulcent action*
- ... *ability to absorb and hold water*
- ... *nonirritating to the intestinal mucosa*
- ... *providing a soft matrix for bulk in the stools*

Metamucil promotes smooth, normal evacuation by furnishing a nonirritating, water-retaining colloidal residue in the large bowel.

Metamucil is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

G. D. Searle & Co., Chicago 80, Illinois.



Searle

Research in the Service of Medicine

*Gauss, H.: Present Trends in Mucous Colitis, *Am. J. Digest. Dis.* 13:213 (July) 1946.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the co-operation of the Pennsylvania Tuberculosis Society
and The Medical Society of the State of Pennsylvania

TODAY there are thousands of workers whose prime objective is the control of tuberculosis. A method of attaining that objective is known. It consists of finding and persuading each person with tuberculosis to seek medical care and providing his physician with the knowledge necessary to treat the disease effectively. In it is included restoring the individual to the fullest possible usefulness and protecting others from contagion.

THE PRESENT STATUS OF TUBERCULOSIS CONTROL

The control of tuberculosis involves acquiring new knowledge—research; and distributing existing knowledge—education. Education involves the public and the medical profession. The doctor in his office is impotent unless the patient comes to him. The patient is in jeopardy unless he knows that he is a patient, and unless the doctor knows how to treat him. These principles are inseparable. The physician and the health educator are mutually dependent and inseparable allies in the campaign against tuberculosis.

One of the ways in which the progress of tuberculosis control is being retarded is putting the emphasis upon accomplishments, not upon the unfulfilled tasks. To believe the job is nearly done is dangerous, and the facts should be faced.

Forget about the reduction in tuberculosis mortality statistics for a moment and look at the present situation! Tuberculosis, today in the United States, remains the most important chronic fatal disease to be caused by a "germ," the most important of all diseases of young people, the most important of the truly preventable diseases.

More than this should be said—much more. Mortality statistics list tuberculosis in comparison with groups of other diseases. "Heart disease" is not one disease but many. It includes arteriosclerotic heart disease of the aged, rheumatic heart disease of the young, hypertensive heart disease of middle life, infectious diseases of the heart, and many rarer conditions.

Cancer is not a single disease, presenting one medical problem. Yet the various cancerous dis-

eases are grouped for comparison with tuberculosis. Most cancer appears to be a degenerative disease of older age; most deaths from heart disease are incident to old age. Everyone has to die some day from some cause and these degenerative conditions will increase as our people live longer and longer lives.

Tuberculosis is also displaced on the list of causes of death by accidental deaths of all types—obviously an unfair comparison. Tuberculosis would rank higher if mortality tables grouped diseases properly. If listed according to preventability, or to age groups affected or to years of potential life lost, or to actual cost in dollars, or according to sorrow, hardship, and frustration caused—there would be less complacency and more alarm at the present tuberculosis death rate.

If causes of death were listed according to organs affected, diseases of the lungs would stand high on the list. Diseases such as tuberculosis, asthma, bronchiectasis, and pneumonia stand high. Pulmonary embolism and, among males, cancer of the lung are also extremely important.

There has been so much talk about scientific medicine that some people seem to think of medical practice as a technologic pursuit—applying fixed formulas to compute the diagnosis. *Medicine is a ministry as well as a science, and the practice of medicine a calling as well as an occupation.*

Patients are people. They have intellect, imagination, and emotions—they have souls. No

Findings from the Saratoga Spa records*



INHALATIONS

The results obtained in the treatment of 738 patients with inhalation at the New York State-owned Saratoga Spa show interesting tendencies.

Marked relief of the condition treated was noted in 38 patients (5.2%); moderate relief in 468 patients (63.4%); temporary relief in 46 (6.4%); and no change in 185 (25%).

Conditions for which the treatments were given included sinusitis, coryza, bronchitis, chronic rhinitis, bronchial asthma, laryngitis, allergic rhinitis, hay fever, and pharyngitis. The treatments consisted of the inhalation of finely nebulized saline-alkaline, naturally carbonated mineral waters, and medicated oils.

The relief obtained bore a definite relation to the number of treatments taken. In

acute conditions, from four to six treatments were necessary to obtain consistent improvement while in chronic conditions, twelve to fifteen treatments were usually required.

Inhalations are taken without discomfort, which is an important factor in therapy.

The safety of the therapy can be stressed. Reactions of significance occurred in only three patients. One patient may possibly have had a sensitivity to chlorenan, one developed an acute asthmatic paroxysm, and the third noted a general reaction to epinephrine.

Attention to the general condition of the patients suffering from respiratory disorders is an important factor. Inhalations have a definite place in the general "cure" regimen of a spa.

** As printed in the New York State Journal of Medicine, 44:1214 (June 1) 1944.*



"Physician, Give Heed to Thine Own Health"

Many physicians have come to the Spa for the same kind of treatments that have helped their patients here. After a restorative "cure" at the Spa, you, too, will return to your practice refreshed—revitalized—ready for the busy days that lie ahead.

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Listed by the Committee on American Health Resorts of the American Medical Association

THE EMPIRE STATE'S CONTRIBUTION TO THE MEDICAL PROFESSION

two people react alike to the same disease and few human miseries are caused entirely by pathologic alterations of body structure. Symptoms are almost always caused by a blend of pathology with fear, apprehension, and perhaps fatigue. The majority of persons seeking medical advice have no significant organic disease. Their symptoms are due to misbehaving organs, not diseased organs. These complaints are called "functional" as distinguished from "organic" or structural defects. But functional complaints are real, not imaginary, and often they are curable. And when organic disease strikes—tuberculosis, heart disease, cancer—the emotional aspects, the functional disturbances are as real and often more disturbing than are the pathologic alterations. Even major surgery is to the normal person frequently more of an emotional than a physical experience.

The modern school of medical practice believes in full and complete instruction of the patient. He not only may but must know the facts, good and bad. He is not the subject of medical treatment but the partner of his physician and shares the task of achieving recovery. Patients see their x-rays; they know about laboratory tests; they know the diagnoses and something of the future.

The modern physician sees a greater duty than that of restoring to a state of health people who feel ill. He advises normal well people how to remain well, happy, and productive. He is learning how to examine well people and to avert

many of the tragedies which occur when his advice is sought belatedly. Through his knowledge of personal hygiene, immunization, nutrition, and the nervous system, he may prevent disease and interpret functional symptoms.

In the prevention of disease the physician has allied himself with public health experts, field workers, and executives. These are trained educators, inspired and diligent crusaders, who not only work beside the physician—they work ahead of him. They make possible the application of his skills and arts to vast numbers of people otherwise beyond the doctor's reach. Physicians should know more of these professional allies and the knowledge and training which they may possess. He should use them as consultants in medical problems of social and community significance.

We are now on the right track to achieve the great task remaining—the control of tuberculosis. There are vastly more effective methods of detecting and treating tuberculosis and other chest diseases than ever before. The relative roles of health educators, epidemiologists, sanatorium physicians, and private practitioners are beginning to be seen quite clearly. Let no disrupting revolution in medical practice prevent this major achievement of the progressive American system of medicine.

The Present Status of Tuberculosis Control, H. Corwin Hinshaw, M.D., National Tuberculosis Association Bulletin, July, 1949.

AIR SURGEON INITIATES GENERAL PRACTICE BRANCH

Air Surgeon Major General Malcolm C. Grow has announced the initiation of a General Practice Branch in the Air Surgeon's office of the National Military Establishment, to be charged with the development of training opportunities and careers for general practitioners serving at USAF installations.

According to current Air Force organization, approximately 70 per cent of physicians serving with USAF units are general practitioners. Of the remainder, 5 per cent are staff and administrative personnel and 25 per cent are specialists.

Initiation of the new General Practice Branch was considered imperative by General Grow, who characterized the general practitioner as "the backbone of the Air Force medical service."

Under the new program the general practitioner will be enabled to enter into a proposed residency program to be operated in the general hospital setup. The res-

idency program will offer the general practitioner access to latest technical developments in medical and surgical specialties. Special emphasis will be placed on internal medicine, surgical practices, pediatrics, and obstetrics.

The new General Practice Branch will work cooperatively with the Surgeon General's career program for medical officers.

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INCOMING PRESIDENT'S ADDRESS



There is nothing so likely to stir one's imagination as the contemplation of a long and perilous journey—nothing I say, unless it is the thought of a year ahead as president of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania. From

the moment one knows that she is to assume the duties of that high office, exciting plans and ideas run riot through her mind; and when the actual minute of installation arrives, she finds herself looking forward to her year of service with great expectation.

This past year has been one of challenge and change, the like of which has never before been experienced in auxiliary history. I would be remiss if I did not here pay tribute to the one who has brought the Auxiliary safely through these times. Her insight into the problems confronting our organization was tremendous; her foresight and vision as to the trends that would affect auxiliary endeavor were uncanny; and her courage and willingness to work for the accomplishment of the necessary progressive changes never failed. To Mrs. Paul C. Craig, our immediate past president, we all owe a debt of gratitude for her leadership in preparing and planning for our journey along the 1949-50 auxiliary road.

Looking forward to continued progress and accomplishment in service to The Medical Society of the State of Pennsylvania, we shall consider the *goal* toward which we strive, the *highway* we must travel, and the mode of *transportation* and the *motive power* we must employ.

Our *goal* has been set for us by the medical societies (national, state, and county)—full participation by every county auxiliary in the National Education Campaign. Our aim must of necessity be to travel as far as possible along the highway toward knowledge of every phase of auxiliary endeavor. Only insofar as we ourselves are educated in the fundamentals of auxiliary background and purposes can we hope to

use our knowledge and wisdom to interpret our actions into purposeful service to the medical society that we are pledged to support. Let us look searchingly into our know-how to see if we are prepared for this journey which will assist the profession in preserving the great institution of private medicine. Education of ourselves must be accomplished before we can hope to educate others.

Consider then the road we must travel—a wide and modern super-highway—the dual speedway of *program* and *public relations*. Our program is the road to education of ourselves as auxiliary members; public relations is the implementation of those phases of our program which are designed to educate the lay groups with whom we come in daily contact. Each county auxiliary can travel the *highway*, whether large or small in number, whether urban or rural in character. There is room on the highway for each to roll along. Some phase of the program will fit into its plans and needs, giving it interesting assistance which will carry it on toward the *goal*.

Leading into the highway, to bring supplies for our programs, are the trunk lines from the American Medical Association and the National Auxiliary, and our own State Medical Society, particularly those lines coming from the legislative and public relations committees. They urge, for the program of educating ourselves, study of the A.M.A. 12-point program and all phases of national legislation affecting the profession and the public. On the state level, we will endeavor to study local public health departments, how and where the auxiliary can serve them; and it is expedient that physicians' wives become more familiar with the work of the State Board of Medical Education and Licensure. Animal research is now a national as well as a state issue. Our knowledge of this subject in all its phases is needed more than ever if we expect to supply the public with unemotional and authentic information.

Every crossroad on our highway provides an excellent opportunity to carry information to lay organizations. Every auxiliary member should

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be a member of some lay group, whether it be P.T.A., a woman's club, church group, or even a bridge club. To all of these and similar ones she can carry or send some bit of information that serves as public relations for the medical profession. No bit of educational material is too small to be of importance, for we never know how far-reaching the point we make may be. Circles in the water following the dropping of a pebble eventually widen until they reach the shore. So it is with the public relations of the Woman's Auxiliary, whether it be personal public relations of one doctor's wife in a small community or of a large group in the city.

The small side roads, the byways, are the social activities without which no auxiliary can function in well-balanced form. These are the dinners and picnics with the local medical society, the teas and parties for the Benevolence Fund, and the hundreds of luncheons and gatherings planned for the purpose of knowing each other in a friendly way. It is here that we receive refreshment to prepare us to continue on our busy way toward the goal.

The machines in which we wish to travel I would symbolize as the *wheels* of progress toward the goal. Think if you will of the *hub* of the *wheel*—your county president—she who plans your year's work and guides your activities; then the *spokes* coming out from the hub—these are the officers and chairmen of committees who put the program into action. Each spoke is important, for it has a job to do and none can be missing, for then the wheel would not be perfect. Around them all we place the *rim* of coordination and then the *tire* of cooperation. No part of the wheel can function alone—each is essential to the whole—and so it is with our auxiliaries. We need all of the contributing factors to carry our program toward the goal of education and progress.

To guide us on the way, well-marked maps and tools for repairing our motors are provided. These we will find in the PENNSYLVANIA MEDICAL JOURNAL, the Auxiliary Newsletter, the National Bulletin, the Guide for County Presidents, and letters and instructions from the state officers and chairmen. Way stations are provided in case we need repairs—district meetings, conferences, conventions, and suggested programs and outlines all give aid in time of need to the traveler.

In the event our enthusiasm carries us along too fast for safety, we can always apply the brakes provided in the by-laws and the advisory committee of the medical society.



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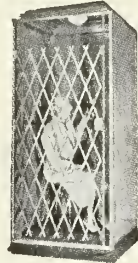
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If we read the directions carefully, follow the maps with care, and obey the rules of the road, we cannot possibly go wrong.

Last but by far the most important items in preparation for our journey are the *fuel* to supply power and the *spark plugs* which ignite it to set our wheels in motion. Unless the tank is full of good gas and the spark plugs clean and dry, we cannot travel very far.

On this, our twenty-fifth birthday, it behooves us to take stock of the *power* provided by our membership. Do you realize that we are expecting fewer than 4000 women to carry the load for some possible 10,000 or more? It is comparable to trying to run a 12-cylinder Cadillac with half of the cylinders "missing." With the mileage we must cover and the huge task we must perform, our goal cannot be reached unless every county auxiliary exerts the effort to contact in a personal way every eligible woman for membership. Potential power is going to waste at a time when our value in the field of public relations is becoming greater and greater.

As the Education Campaign moves forward, we must strive to secure an increase in membership worthy of the task before us and the recognition accorded to us by our medical society. Only two small counties remain in the unorganized field in this state; they would bring in less than one hundred of the needed 6000 still missing. They are not the answer to the problem; that answer lies with every member who feels that the Auxiliary is important, that we have a job to do, and can do, if we but want to do it. The answer will come if we strive to recognize the value of the individual doctor's wife and her influence in her own community; if we give importance to small groups meeting together for study of legislation and similar issues; if we stress the need for speakers' bureaus to train auxiliary members and their lay friends alike to spread the story of the Voluntary Way versus Compulsion and Political Control; and last but not least, if we will but realize that our greatest responsibility to the Auxiliary is not in holding office, but rather in training the new members and above all the young women to take their rightful places in county and state work. To this end I shall recommend this year, on both a state and county level, that as many committees as possible endeavor to have sub-committees and sub-chairmen serve under one leader, giving responsibility to several members in several areas of the county or state rather than hoarding all power in one individual. The idea of decentralization is not foreign to our thinking today—it is worth a try in the Auxiliary.

I believe that the combination of the enthu-

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siasm of the younger with the wisdom of the older member is power for progress in any organization. Training of the young is the only way in which we can provide a source of supply for the future; if we neglect to prepare them to take our places, we have failed miserably in our journey through life, both as citizens and as members of this organization designed for and dedicated to service to the profession.

The *highway* is before us, wide and straight. Let's check our fuel tanks and clean the spark plugs for the journey we must make.

Twenty-five years together have given us the experience so necessary to the success of our journey. The fellowship of these years is a weapon against government medicine that the social planners can never acquire. With *every* doctor's wife an *active* auxiliary member, the future success of the Education Campaign in county, state, and nation will be assured.

The history of these twenty-five years shows that the wheels have been in constant motion—ever increasing in speed and gathering momentum. They have cleared the paths leading up to our highway of the year ahead; their experiences in the past will be our guideposts into the future.

(MRS. DRURY) ELIZABETH MACILROY HINTON.

NATIONAL CONVENTION IN REVIEW

The challenge given to every auxiliary member and doctor's wife at the twenty-sixth annual meeting of the Woman's Auxiliary to the American Medical Association was how great was their interest in American medicine and the American way of life.

The formal opening took place Tuesday, June 7, in the Vernon Room, Haddon Hall, Atlantic City, N. J., with Mrs. Luther H. Kice, president, presiding. The usual procedure was followed and reports of officers were given.

Mrs. Charles L. Shafer, national legislation chairman, of Kingston, Pa., gave such a stirring commentary on legislation and the applause was so great that she was asked to finish her report when the timekeepers called time on her. This was most unusual in the history of auxiliary reports.

Mrs. Robert Flanders, vice-president of the Eastern Region, told how closely New York and Pennsylvania run in memberships. It is interesting to note that the New York State Auxiliary has 3702 members, while Pennsylvania has 3862 members. New York had an increase in membership of 582, while Pennsylvania had an increase of 413; but Pennsylvania added five new



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auxiliaries and New York only one. Hence the cry, "Every doctor's wife an auxiliary member." (Counties organized recently could not be included. As of now, Pennsylvania has increased the above figures by 150 members and three counties.)

The Auxiliary has at last been recognized as a powerful organization at local, county, state, and national levels. In recognition of the great work done by the Woman's Auxiliary, for the first time at an installation meeting of the American Medical Association, Mrs. Luther H. Kice, president of the Woman's Auxiliary, was seated on the platform and introduced.

After the officers' reports and the election of the 1950 nominating committee (of which our state president, Mrs. Paul C. Craig, was elected a member with 181 out of a possible 214 votes, the largest number received), the new national president, Mrs. David B. Allman, of Atlantic City, N. J., and her officers were installed by Mrs. David W. Thomas, of Lock Haven, Pa.

Round table discussions took place Monday and Tuesday. One on legislation was conducted by Mrs. Charles L. Shafer and her guest speakers, a Mr. O'Connor of *Insurance Economics*, who discussed compulsory disability compensation programs and their threat to medicine, and



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GYNECOLOGY—Intensive Course, two weeks, starting September 26, October 24. Vaginal Approach to Pelvic Surgery, one week, starting September 19, November 7.

OBSTETRICS—Intensive Course, two weeks, starting September 12, November 7.

MEDICINE—Intensive General Course, two weeks, starting October 3. Gastroenterology, two weeks, starting October 24. Gastroscopy, two weeks, starting September 26, October 24.

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Joseph Lawrence, M.D., of Washington, D. C., who explained the different bills presented to Congress.

At the public relations conference, Mrs. Paul C. Craig took part in the discussion of "Does Your Medical Society Recognize Your Value?" She told of the working relationship between the Medical Society and the Auxiliary in Pennsylvania. Here we also heard Miss Mary McGinn of Whitaker & Baxter, directors of the A.M.A. National Education Campaign. Miss McGinn drew a clear picture of the American medical system and recommended a twofold program for the use of auxiliary members—one for the lighter weights and one for the more serious-minded. She said that good leaders are necessary; they must know what to say and when to say it, they must keep well-informed and up-to-date. She stressed making this a "grass roots campaign," as we have something that the American people need.

Miss Leona Baxter and Mr. Clem Whitaker spoke at the Tuesday luncheon. Officers of the A.M.A. were guests at the Wednesday luncheon.

The House of Delegates of the Auxiliary passed two important resolutions—one against compulsory health insurance and for voluntary

health insurance, the other to adopt the A.M.A. 12-point program.

Mrs. Jay G. Linn, of Pittsburgh, Pa., was one of the official timekeepers of the convention.

We must merit the confidence that the A.M.A. has put in the Woman's Auxiliary; each member must be an emissary for the Auxiliary and her husband. Also stressed was the importance of writing to Congressmen and the great part it has had in shelving bills because of the protest from the people back home. We women have entree into the various channels that the doctors cannot reach to spread the message of truth regarding maximum health to the millions of people of this country in the American way.

MRS. ROBERT PARKER BANKS,
Juniata County Auxiliary.

COUNTY NEWS

By the time this goes to press, most county auxiliaries will have elected and installed new officers, councilor district meetings will have been held, the national convention will be remembered as a memorable occasion, and members will be vacationing and getting ready to start the 1949-50 auxiliary year with much enthusiasm for the work to be done.

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PHILADELPHIA'S letters to Congressmen totaled 1500 by June 1.

SCHUYLKILL and its BRANCH held a joint supper meeting in June. WARREN had a joint picnic with the medical society.

Mrs. J. Frederic Dreyer, LEHIGH'S retiring president, reported a total of \$848.38 as its contribution to welfare for the year. At its final meeting, Dr. Walter H. Eastwood, pastor of the First Presbyterian Church, spoke on "How Do You Fit into the Picture?"

PHILADELPHIA'S nursing scholarship has been awarded to a girl accepted at Jefferson Hospital. The medical society has granted a \$200 scholarship, with the auxiliary committee selecting the winner. That girl has chosen Frankford Hospital and has been accepted.

Two successful health poster contests have been reported to the editor:

From BUTLER—We feel that the health poster contest is a very worth-while project. It gave a great deal of satisfaction to the members of the auxiliary, teachers, art supervisors, and over one thousand children who participated.

This contest was open to all public and parochial school children. Volunteers from the auxiliary contacted the art supervisors in the various grades and gave them the rules for the contest. They reported that there was a great deal of enthusiasm and originality on the part of the children, particularly in the elementary grades. The contest period was six weeks. At the end of that time volunteers and members of the health poster committee collected the posters from the various schools and took them to the home of our president, Mrs. James O. Donaldson. As there were so many entries, the committee held a meeting to "weed out" the least desirable of them. The posters were then submitted to a committee composed of a physician, a registered nurse, and an

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WILLIAM HARVEY PERKINS, M.D., *Dean.*

artist, who made the final decisions and judged the posters on neatness, originality, and the message conveyed.

In Group I—including children from grades two to six—we gave a first prize of ten dollars, second prize of seven dollars, third prize of three dollars, and ten honorable mention prizes of one dollar each.

In Group II—including children from grades seven to nine—the first prize was ten dollars, second prize seven dollars, and the third prize was a tie with three dollars going to two contestants. We had no honorable mention prizes in this group, as the children were older and the competition not quite so keen.

Mrs. Donaldson sent a letter to each teacher and enclosed award cards with the name of each prize-winner telling him the prize he received and that a check would be in the mail for him. These cards were presented to the children in their own classrooms so that their classmates would know who had won prizes. We felt that there was a more personal contact this way.

From PHILADELPHIA — Twelve Philadelphia school children were given cash awards and twelve others received honorable mention June 15 as winners in the health poster contest sponsored by the Philadelphia County Medical Society.

Presentations were made by Joseph W. Post, M.D., chairman of the committee on public relations, at a reception in the Society Building, before a large group of physicians, laymen, and members of the woman's auxiliary, which arranged the poster exhibit.

The winners were selected from grade, junior high, senior high, and vocational schools. Judges were Gilson Colby Engel, M.D., president of the MSSP, Mrs. James J. Waygood, past president of the Philadelphia Auxiliary, and Mrs. Augusta Peoples.

Mrs. Hugh Robertson and Mrs. Roy W. Mohler were co-chairmen.

"The Free Man vs. The Puppet Man," an article written by Mrs. Norman K. Beals, VENANGO, and published in the April PENNSYLVANIA MEDICAL JOURNAL, was read before the House of Representatives on June 15 by the Honorable Leon H. Gavin and appeared in the Congressional Record. Representative Gavin highly commended Mrs. Beals on her fine article.

FOR THE DOCTOR WHO MAY THINK NATIONALIZED MEDICINE WOULD NOT AFFECT HIM

To propose non-participation in socialized medicine, if it is enacted into law, writes Dr. F. U. Darby, of Baton Rouge, La., is the most dangerous and deceiving type of wishful thinking that so-called intelligent doctors can be guilty of.

Ninety per cent or more of active practicing physicians cannot economically afford non-participation under national socialization. Discontinue the average physician's income for one month and he must invade his savings. Prolong this period six months and he will, of necessity, have to mortgage his home.

To argue that loyal patients will enable a physician to carry on is dangerous thinking. Loyalty wears thin where dollars and cents are involved.

The enrollment of the British doctors in non-participation was originally a majority matter and in less than one year, due to actual economic deprivation, it had faded into insignificance. The proponents of socialized medicine are being well served by the program of non-participation.

In a factual analysis of non-participation we must inevitably consider our moral if not legal responsibility to the patients in our particular private practices.

Many of us possess the deluded idea of turning to other means of gainful employment during the phase of non-participation. The doctor who swears by all that is holy he will do something else is making the statement on a full stomach.

In the final analysis each physician should seriously consider his own personal status in this matter.

We should, to a man, approve, sponsor and advocate the A.M.A.'s twelve-point program on a local and state level.

Non-participation is below the dignity and level of an honorable profession devoted and dedicated to human welfare.—Whitaker & Baxter, Chicago, Ill.



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*Bigler, J.: Chicago M. Soc. Bull. 50:269, 1947 • Coakley, W. A. et al.: Plast. & Reconstruct. Surg. 3:667 (Nov.) 1948 • Curtis, L.: Surg. Clin. N. A. 1466 (Dec.) 1947 • Downing, J. et al.: J. A. M. A. 133:299, 1947 • Johnson, H.: Arch. Dermat. & Syph. 57:348, 1948 • Mays, J.: J. M. A. Georgia 36:263, 1947 • McCollough, N.: Indust. Med. 16:128, 1947 • Mills, J. et al.: Plast. & Reconstruct. Surg. 3:245, 1948 • Ryan, T.: U. S. Nav. M. Bull. 47:991, 1947 • Shipley, E. et al.: Surg., Gynec. & Obst. 84:366, 1947 • Snyder, M. et al.: Mil. Surgeon 97:380, 1945.

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Just leave instructions with the obstetrical supervisor at the hospital. She will be glad to put your bottle-fed babies on Baker's.

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MEDICAL NEWS

Engagements

MISS BETTYE RUTHERFORD, of Crestwood, N. Y., to Mr. Gordon P. McCouch, son of Grayson P. McCouch, M.D., of Media.

MISS MARY WINIFRED SHAFFER, daughter of Dr. and Mrs. Thomas M. Shaffer, of New Castle, to Mr. John Robert Lukacs, of Mercer.

Marriages

MISS NANCY LOUISE TURNER, daughter of Dr. and Mrs. Creighton H. Turner, of Penn Valley, to Mr. Joseph Thomas Reddy, August 20.

MISS MARGARET ELIZABETH ROBERTSON, of Narberth, to Baldwin Longstreth Keyes, M.D., of Philadelphia, August 19, in Mexico City.

MRS. WILLIAM ELLERY BARTON, of Stamford, Conn., to B. B. Vincent Lyon, M.D., of Philadelphia, August 13.

MISS VERDA LEE WALTER, daughter of Dr. and Mrs. Ralph S. Walter, of Harrisburg, to Mr. Edward F. Glacken, of Long Island, N. Y., August 11.

MISS EVELYN CAROLINE HOLDER, of Huntingdon, to Ralph Arnold Bentz, M.D., of Dillsburg, August 20. Dr. Bentz, who was chief resident at the Harrisburg Hospital this past year, is now in the Navy.

Deaths

○ Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

○ **H. Vernon Swick**, Beaver Falls; Temple University School of Medicine, Philadelphia, 1937; aged 36; was drowned in Lake Erie Aug. 1, 1949, when he fell into deep water while throwing out the anchor of his cabin cruiser. After serving in the Navy during World War II, Dr. Swick entered the University of Pennsylvania for a year's specialized study in urology. Then he joined the staff of St. Vincent's Hospital in Erie and was assistant to Dr. Elmer Hess. Dr. Swick had just bought a home in Beaver Falls where he intended to resume his practice. He is survived by his widow, a son, his parents, a brother, and two sisters.

○ **Tempest C. Miller**, Abbottstown; University of Maryland School of Medicine, Baltimore, 1889; aged 84; died Aug. 4, 1949, from a coronary occlusion. Dr. Miller was a charter member of the Adams County Medical Society and was the oldest physician in the county. He retired in 1946. In 1939 he had been presented the testimonial of the State Medical Society for having practiced medicine fifty years. Surviving are a son, two brothers, and three sisters.

○ **Joseph C. Stahlman**, Vandergrift; Western Reserve University School of Medicine, Cleveland, Ohio, 1887; aged 90; died Aug. 14, 1949, following a long illness. He had retired last year. In 1937 he was honored by the State Medical Society when he reached his fiftieth year in the practice of medicine. He is survived by his widow, a daughter, and a brother, Frederick C. Stahlman, M.D., of Charleroi.

Alexander J. P. Conlen, Philadelphia; Medico-Chirurgical College of Philadelphia, 1915; aged 55; died Aug. 16, 1949, at the Veterans' Hospital, Johnson City, Tenn. He was an eye specialist for the Veterans Administration, chief ophthalmologist at the Misericordia Hospital and was on the staff of Wills Eye Hospital. Surviving are his widow and two daughters.

Louis Wolfson, Philadelphia; Medico-Chirurgical College of Philadelphia, 1899; aged 75; died Aug. 10, 1949. A native of Russia, Dr. Wolfson came to this country at the age of ten. He was a former police surgeon. Surviving are his widow, Dr. Blanche F. Kleiner Wolfson, who is also a physician, a son, and three daughters.

○ **William J. Walsh, Jr.**, Philadelphia; Jefferson Medical College of Philadelphia, 1927; aged 46; died Aug. 12, 1949, after an illness of ten weeks. Dr. Walsh was an associate surgeon at St. Mary's Hospital. He is survived by his widow, three sons, his mother, a brother, and four sisters.

○ **Budd Jameson Reaser**, Martins Creek; University of Maryland School of Medicine, Baltimore, 1909; aged 67; died Aug. 7, 1949, of a heart attack. He is survived by his widow.

J. Malcolm Weber, Philadelphia; Jefferson Medical College of Philadelphia, 1917; aged 58; died Aug. 16, 1949. Surviving are his widow, a son, and two sisters.

Edward K. McGill, Wynnewood; Hahnemann Medical College and Hospital of Philadelphia, 1880; aged 89; died Aug. 23, 1949. He retired in 1935. His widow survives.

○ **Abraham Silverman**, Philadelphia; Baltimore Medical College, Maryland, 1907; aged 64; died July 23, 1949.

Miscellaneous

JAMES D. PURVIS, M.D., of Pittsburgh, has been appointed chief of the Environmental Cancer Section of the Bureau of Industrial Hygiene in the State Department of Health.

GOVERNEUR V. EMERSON, M.D., former brigadier general in the U. S. Army Medical Corps, was recently appointed supervising physician in the Bureau of Tuberculosis Control of the State Department of Health. He is a native of Milford.

THE EASTON HOSPITAL, at a recent emergency meeting, decided to erect a quonset hut to care for additional victims of infantile paralysis. The community of Easton has reported a more pronounced outbreak of the disease this year than last, and the hospital was running short of beds in its isolation ward.

THE FALL MEETING OF THE PENNSYLVANIA ALLERGY ASSOCIATION will be held at the Necho-Allen Hotel in Pottsville on Thursday, October 20. The Board of Regents will meet at 10:30 a.m., and the business meeting will follow at 11 a.m., with a luncheon at noon. The scientific session will start at 1:25 p.m., and will be followed by dinner with an outstanding speaker in the evening.

THE AMERICAN COLLEGE OF CHEST PHYSICIANS, through its Council on Postgraduate Medical Education, is sponsoring a postgraduate course on Diseases of the Chest to be held November 14 to 18 at the Hotel New Yorker, New York City. The registration fee for this five-day course is \$50. Further information concerning this course may be obtained by writing to Frank R. Ferlino, M.D., Secretary, Council on Postgraduate Medical Education, American College of Chest Physicians, 580 Park Ave., New York 21, N. Y.

RESTATE AND REVISE PRINCIPLES OF ETHICS

Since raising the moral standard of the medical profession is one of the fundamental aims of the American Medical Association, physicians throughout the country were urged in an editorial in a recent *A.M.A. Journal* to become familiar with the restatement and revision of the Principles of Medical Ethics as approved by the House of Delegates at Atlantic City in June.

The Principles of Ethics, which appeared in the June 25 issue of the *Journal of the American Medical Association*, will become available in booklet form soon.

"Almost unnoticed in the midst of the startling developments of the Atlantic City session," says an editorial in the July 16 issue of *The Journal*, "was the presentation by the Judicial Council to the House of Delegates of a restatement and revision of the Principles of Medical Ethics. The statement was promptly adopted by the House of Delegates.

"Comparison will indicate," the editorial continues, "the additions and changes that have been made in content and in manner of statement. Among the most significant changes are those relating to groups and clinics, including contract practice, the section on educational information, and the section on the purveyal of medical service."

For example, under Chapter I, is a section entitled "Educational Information Not Advertising." The section says:

Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

The medical profession considers it ethical for a

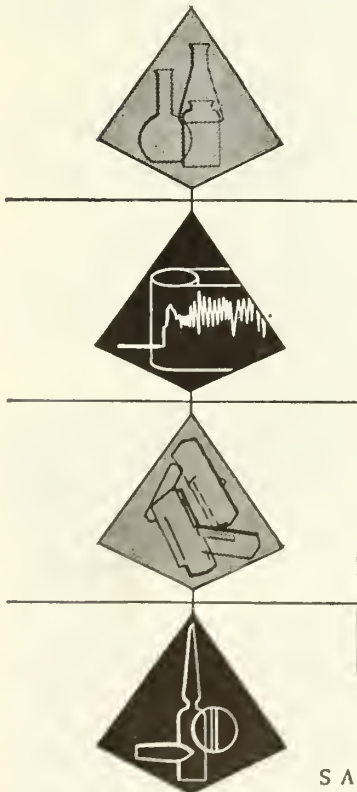
physician to meet the request of a component or constituent medical society to write, act, or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by publishers, motion picture producers, or radio officials. These may offer to the physician opportunity to release to the public some article, exhibit, or drawing. Refusal to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self-seeking or solicitation. In such circumstances the physician should be guided by the decision of official agencies established through component and constituent medical organizations.

A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society.

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

The promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.



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For Sale.—Ideal home and office in eastern Pennsylvania. Near four cities with good hospitals. Oil heat and insulated. Could be paid off with office rent above. Good for G. I. loan. Practice waiting for buyer. Write Dept. 170, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—Modern home with office space and waiting room in busy town. Near schools, churches, stores, and transportation. Contract terms for tryout and proof of 100 per cent location. Consult MRS. P. L. DAVIS, Lake Hopatcong, New Jersey.

Position Wanted.—Anesthesiologist who is diplomate with comprehensive experience including instruction in medical college desires directorship, group or other satisfactory association. Write Dept. 171, PENNSYLVANIA MEDICAL JOURNAL.

For Sale.—Ideal property for convalescent home located at Blue Bell, Montgomery County, one mile from Pennlyn Station, Reading Railroad. Well-built house, 150 feet from road with large lawn and trees, three baths, nine bedrooms, and five porches. Two acres of ground. Asking \$21,500. Write or phone HARRY Z. MAXWELL, Blue Bell, Pa. Telephone Ambler 0941.

For Sale.—Home and office of recently deceased physician. Three-story corner property. Exceptionally large offices attached to home. Two-car garage, large porches, oil heat, all conveniences. Great need for two more doctors in area. Will consider selling furniture, office equipment, and instruments. Will finance. Prompt possession. Inspection arranged. Contact MRS. RUSSELL D. GEARY, 337 Bridgeboro Street, Riverside, N. J. Phone Riverside 4-0389.

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Under Chapter 3, Article 6, is a section entitled "Contract Practice." This section, almost entirely revised, follows:

Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision, or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary, or for a fixed rate per capita.

Contract practice per se is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or

any of its provisions causes deterioration of the quality of the medical services rendered.

Commenting on the Principles of Ethics as approved and adopted by the House of Delegates, *The Journal* editorial says:

In the case of the Government versus the American Medical Association tried in Washington in 1941, the courts took cognizance of the Principles of Medical Ethics as a guide to physicians in relationship to the adoption of any methods of medical practice. The Court recognized that members of the American Medical Association voluntarily subjected themselves to the stipulations of the constitution and by-laws of county and state societies, of the American Medical Association, and also to the Principles of Medical Ethics.

The statements now prevailing permit experimentation with changes in the method of medical practice beyond some restrictions which prevailed formerly. No doubt the Judicial Council will have opportunity to interpret the statements now made in relation to specific incidents as these arise. Ethics as stated in the introduction to the principles "are not laws to govern but are principles to guide to correct conduct." "An upright man instructed in the art of healing" seldom needs to refer to the Principles of Medical Ethics in making his decisions as to the manner in which he conducts his practice and his life.

The fundamental principle that the physician shall not dispose of his professional attainments or services under terms or conditions which permit exploitation of the services for the financial profit of a corporation or lay agency still obtains. The only type of contract practice specifically condemned is that which may result in deterioration of the quality of the medical services rendered.

Instances have occurred in which physicians, for political, commercial, or emotional reasons, have endeavored to utilize the Principles of Medical Ethics as a means of producing embarrassment, distress, or loss of reputation of other physicians whom they envy or whose open competition they fear. The Principles of Medical Ethics were not designed for any such purpose, and the attempt to utilize the principles of medical ethics for such purposes may well be in itself unethical.

EXPERIMENTS ON DOGS AID HIGH BLOOD PRESSURE STUDY

Similarities between experimental high blood pressure produced in dogs and other high blood pressure justify hope that causes of the disease may be found, a Cleveland doctor reports.

Writing in the June 4 *Journal of the American Medical Association*, Irvine H. Page, M.D., of the Research Division of the Cleveland Clinic Foundation and Bunts Institute, says that high blood pressure has been induced in the animals by surgery on certain nerves and by disturbance of the blood supply to the kidneys and brain.

These methods do not produce high blood pressure which exactly simulates most high blood pressure in human beings, he adds. Yet the fact that blood pressure can be elevated by experimental alteration of the nervous system and disturbance of blood supply to the kidneys gives encouragement that ways in which the nervous system and kidneys participate in causing the disease may be explained.

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By ARNOLD GESELL, M.D., and FRANCES L. ILG, M.D.; illus., 399 pp., 1943, \$4.50

THE CHILD FROM FIVE TO TEN

Following the same formula of progressive growth and guidance used so brilliantly in "Infant and Child," this book offers a valuable guide to the critical years when the child first goes to school.

By ARNOLD GESELL, M.D., and FRANCES L. ILG, M.D., in collaboration with LOUISE BATES AMES, Ph.D., and GLENNA E. BULLIS; 475 pp., 1946, \$4.50

HOW A BABY GROWS

A new kind of book about babies—over 800 photographs, each with a simple, explanatory text, of a baby's first years of life.

By ARNOLD GESELL, M.D.; profusely illus., 78 pp., 1945, \$2.00.

THE FIRST FIVE YEARS OF LIFE

The development of mental growth patterns in four major fields: motor characteristics, adaptive behavior, language, personal-social behavior.

By ARNOLD GESELL, M.D., and associates; illus., 393 pp., 1940, \$4.00

THE EMBRYOLOGY OF BEHAVIOR: The Beginnings of the Human Mind

This book portrays the ontogenetic patterning of behavior in embryo, fetus, neonate and infant. A richly illustrated, photographically documented volume which clarifies the earliest stages of human development. ". . . for the medical student, pediatrician and student of behavior . . . one of the best of the many excellent publications by Dr. Gesell."—*J.A.M.A.*

By ARNOLD GESELL, M.D., in collaboration with CATHERINE S. AMATRUDA, M.D.; illustrated, 312 pp., 1945, \$6.00

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BOOK REVIEWS

BLAKISTON'S NEW GOULD MEDICAL DICTIONARY. First edition. Edited by HAROLD WELLINGTON JONES, M.D., Colonel, U. S. Army, Retired; contributing editor, *Encyclopedia Americana*; former director of Army Medical Library, Washington, D. C.; NORMAND L. HOERR, M.D., Ph.D., Professor of Anatomy, School of Medicine, Western Reserve University; ARTHUR OSOL, Ph.D., Professor of Chemistry, Director of Chemistry Departments, Philadelphia College of Pharmacy and Science; Editor-in-Chief, *United States Dispensatory*. With the assistance of an editorial board and over 100 contributors. Philadelphia and Toronto: The Blakiston Company, 1949. Textbook edition, \$8.50; thin paper edition, \$10.75; delux edition, \$13.50.

More than 300 modern texts as well as journals, year-books, and standard indexes in all basic fields were critically examined for new words and changes of usage; all definitions were written by specialists actively at work in the various fields, and each entry was carefully checked and arranged according to modern lexicographic standards demanding brevity, clarity, and accuracy. Hundreds of new words are included that can be found in no other medical dictionary; each new word was examined and analyzed by many experts before being accepted.

This is the first medical dictionary to combine a system of modern phonetic respelling with syllabification, to give alternate pronunciations, and to cross-reference from definitions to illustrations. Special tables of arteries, enzymes, vitamins, monstrosities, etc., are grouped in a special section for easy reference. Bound into the center of the book is an atlas with 252 illustrations, 129 in color.

All branches of medicine and allied sciences are exhaustively covered, including medical physics and chemistry, dentistry, pharmacy, nursing, veterinary medicine, biology and botany, as well as medicolegal terms.

THE ACUTE BACTERIAL DISEASES. Their Diagnosis and Treatment. By HARRY F. DOWLING, M.D., F.A.C.P., Clinical Professor of Medicine, George Washington University; Chief, George Washington Medical Division, Gallinger Municipal Hospital. With the collaboration of LEWIS K. SWEET, M.D., Chief Medical Officer in Pediatrics and Infectious Diseases, Gallinger Municipal Hospital; Adjunct Clinical Professor of Pediatrics, George Washington and Georgetown Universities; and HAROLD L. HIRSH, M.D., Assistant Professor of Medicine, Georgetown University; Director of the Bacteriology and Immunology Laboratory, Georgetown University Hospital. 465 pages with 55 figures. Philadelphia and London: W. B. Saunders Company, 1948. Price, \$6.50.

This book is intended as a practical guide for physicians and students. It is concisely written, complete, and practical. The material is based mainly on work done at the Gallinger Municipal Hospital—an excellent source for authoritative material on the bacterial diseases.

The text is divided into four parts. Part I deals with diagnosis and treatment of acute bacterial diseases—a general section including a discussion of serum, sulfa and antibiotic therapy. The newer antibiotics are not covered, thereby making this new volume antiquated already in this respect. The diagrams summarizing the management of patients being treated by chemotherapy and antibiotics are excellent.

Part II covers the many diseases caused by cocci.

Comparative statistics regarding results of therapy by various methods are included in the chapter on pneumococcal infections. The material is meaty, concise, and good reading. The bibliographies at the end of each chapter are adequate. Rheumatic fever is included in the chapter on beta hemolytic streptococcal infections. Staphylococcal, meningococcal, and gonococcal infections are well summarized in subsequent chapters in logical fashion.

Part III includes the diseases caused by bacilli. The young physician is inclined to wonder why modern medical texts always cover typhoid fever at such great length as it is, for example, in this book. Having seen only one or two cases during internship, one is inclined to minimize this scourge of former years. Salmonella, Shigella infections, and brucellosis are given consideration in separate chapters. Only the acute forms of tuberculosis are covered. The chapters dealing with pertussis and Hemophilus influenzae infections are concise and meaty. There is certainly no excess wordage in this book.

Part IV deals with diphtheria, tetanus, and miscellaneous bacterial diseases in which exotoxins are a major factor.

In summary, this is a practical book for the busy doctor who needs information in a hurry without wading through numberless pages and statistical charts. There are adequate illustrations, some in color. The print is clear and large enough, and the paper and binding are very good.

DIAGNOSIS IN GYNECOLOGY. A Classification of Gynecologic Diseases Based on Etiology and the Clinical Logic for Diagnosis. By JAMES V. RICCI, A.B., M.D., Clinical Professor of Gynecology and Obstetrics, New York Medical College; Director of Gynecology of the City Hospital, New York; Director of Gynecology and Obstetrics, Columbus Hospital; Attending Gynecologist and Obstetrician, Flower and Fifth Avenue Hospitals, New York; Consultant in Gynecology and Obstetrics, Beekman-Downtown Hospital, New York. Philadelphia and Toronto: The Blakiston Company, 1948. Price, \$4.50.

Since the beginning of time, a correct diagnosis has always been predicated upon a careful and precise history followed by a similarly careful and precise examination.

In this book the author has attempted to make clinical demonstrations as given to medical students the basis for its construction. Signs, symptoms, and laboratory data are analyzed, simplified, and evaluated in order to stimulate the student to utilize differential clinical diagnosis as his basis for study. This interesting book of 259 pages is divided into fourteen chapters. These chapters cover the gamut of gynecology, emphasizing embryology and anatomy, female sex hormones, gynecologic examinations and gynecologic symptoms, and a general classification of gynecologic diseases. Also discussed are dermatologic diseases of the genitalia and the perineal areas. The last six chapters classify diseases of the various areas in the pelvis based upon etiology.

The book contains a great deal of factual data and a number of practical hints. Unfortunately, however, it is not illustrated and your reviewer feels that by not using this valuable adjunct in emphasizing the points brought out in his book the author has missed a rare opportunity.

The addition of this volume to any large library on gynecology would offer another valuable source for reference purposes.

DISEASES AFFECTING THE VULVA. By ELIZABETH HUNT, B.A., M.D., Ch.B. (Liverp.), Honorary Consulting Dermatologist, South London Hospital for Women; Honorary Dermatologist, New Sussex Hospital for Women and Children, Brighton; temporarily Honorary Dermatologist, Royal Infirmary, Liverpool; formerly Senior Medical Officer, Radium Institute and Hospital for Skin and Cancer Diseases, Liverpool; Acting Honorary Dermatologist, Royal Sussex County Hospital, Brighton. Third edition, revised, with 36 illustrations and 19 plates in color. St. Louis: The C. V. Mosby Company, 1948. Price, \$7.50.

Although this book was primarily written and intended for the dermatologist, it has tremendous significance in the daily activities of the gynecologist as well

as the general practitioner. Here is a highly specialized book which is enjoying its third edition. The author has brought the volume up to date, particularly in the matter of therapy. The second edition had no information relative to the antibiotic or sulfonamide methods of therapy, but the third is definitely enhanced by this information.

The subject of vitamins in the treatment of avitaminosis which indirectly will cause many vulvar and vaginal pathologic entities is discussed in detail.

The book is made up of 221 pages and is divided into 31 chapters, each chapter dealing with an important phase of gynecologic dermatology. The colored illustrations are all from photographs of the author's private cases. All classifications are based as far as possible on etiology. The chapters are quite obviously short, but they all contain a large amount of good, sound advice.

Your reviewer considers this volume a necessary addition to any well-organized medical library.

PLASTER OF PARIS TECHNIQUE. By EDWIN O. GECKELER, M.D., Professor of Orthopedic Surgery and Chief of the Fracture Service, Hahnemann Medical College and Hospital, Philadelphia; Fellow of the American College of Surgeons, the American Academy of Orthopedic Surgeons, and the American Association for the Surgery of Trauma; diplomate of the American Board of Orthopedic Surgery. Second edition. 220 pages and 236 illustrations. Baltimore: The Williams & Wilkins Company, 1948. Price, \$3.00.

This new edition serves the purpose of adding new material and illustrations to an already splendid handbook. This text also serves as a supplement to another of the author's handiwork, namely, *Fractures and Dislocations for Practitioners*. Both these books should be

WHEN TREATMENT IS INDICATED - RECOMMEND

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Feinberg, S. M.: Postgrad. Med. 3: 92 (1948).

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Levin, L.; Kelly, J. F., and Schwartz, E.: New York State J. Med. 48: 1474 (1948).

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Brown, G. T.: M. Ann. District of Columbia 16:675 (1947).

Pollen desensitization "still remains the treatment of choice in hay fever."

Rosen, F. L.: J. M. Soc. New Jersey 45: 390 (1948).

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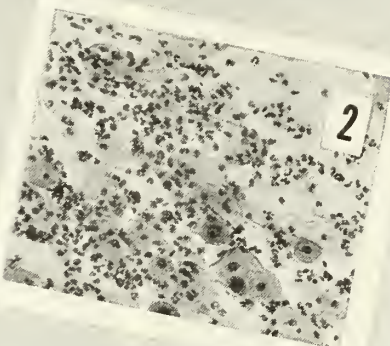
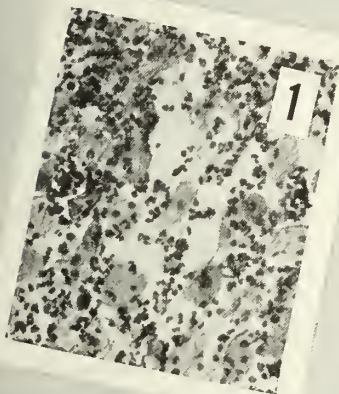
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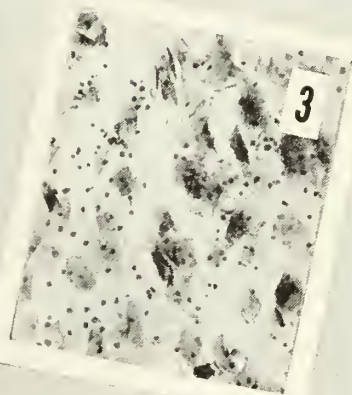
Untreated menopause. Epithelial cells are relatively small, large nuclei predominate; bacteria, leukocytes, free-floating nuclei and other debris cloud the smear picture.

1

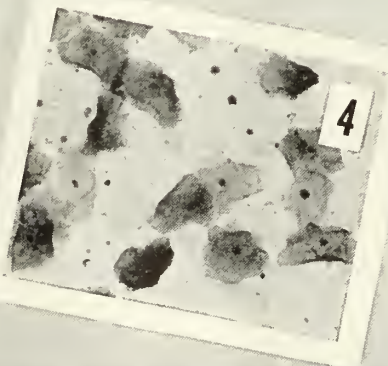


2

2 & 3 Smears showing progressive improvement during estrogen treatment. The picture is beginning to clear. The cells are enlarging and becoming more discrete.



3



4

4 Smear showing effects of full estrogen replacement. The smear is clean and free of leukocytes indicating restoration of a normal vaginal epithelium.



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For action with little or no side action in control of menopause and certain other ovarian disorders.

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readily available to all who are concerned with the instruction of both graduate and undergraduate medical students in the field of orthopedic surgery. The text is arranged in twelve chapters as follows: forms of plaster of paris used in surgery; general technique; application of plaster of paris; errors and difficulties; technique of pattern plaster; spine; shoulder and upper limb; pelvis and lower limb; war surgery; compound fractures and osteomyelitis; plaster for involvement of soft tissues; follow-up care; and references. Within the purposes for which this book was written, it is recommended for both student and practitioner as a working guide in the art of plaster of paris technique.

FRACTURES AND DISLOCATIONS FOR PRACTITIONERS. By EDWIN O. GECKELER, M.D., Fellow of the American College of Surgeons, the American Academy of Orthopedic Surgeons, and the American Association for the Surgery of Trauma; diplomate of the American Board of Orthopedic Surgery. Fourth edition. 371 pages and 344 illustrations. Baltimore: The Williams & Wilkins Company, 1948. Price, \$5.00.

Originally written for the general practitioner and student, the new edition of this book by the inclusion of new methods and developments in the management of severe injuries continues to serve the purpose for which it was written. The author recommends the one method which he considers most favorable for each situation, thereby this book is recommended as a guide but not an exhaustive study. The section on fractures comprises 21 chapters, and the section on dislocations is made up of 10 chapters, each complete within itself. Among the good features noted are the lists of references found at the end of each chapter. The book is well written and the printing and paper are very satisfactory. On the whole, the illustrations throughout the book are excellent.

The author, in this new edition, has continued to offer a book which presents those aspects of the subject which are of interest to the beginner and furnishes a groundwork of knowledge for the surgeon and specialist alike.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

THE PRACTICE OF REFRACTION. By SIR STEWART DUKE-ELDER, K.C.V.O., M.A., D.Sc. (St. And.), Ph.D. (Lond.), M.D., F.R.C.S. (Northwestern), Surgeon-Oculist to H.M. The King; Knight of Grace of the Order of St. John; Consulting Ophthalmic Surgeon to the Army and the Royal Air Force; Director of Research, Institute of Ophthalmology, University of London; Consulting Ophthalmic Surgeon, Moorfields Westminster and Central Eye Hospital; Ophthalmic Surgeon, St. George's Hospital. Fifth edition with 216 illustrations. St. Louis: The C. V. Mosby Company, 1949. Price, \$6.25.

ATLAS OF ROENTGENOGRAPHIC POSITIONS. By VINITA MERRILL while educational director of Picker X-Ray Corporation. In two volumes. St. Louis: The C. V. Mosby Company, 1949. Price, \$30.00

ELECTROCARDIOGRAPHIC TECHNIQUE. A Manual for Physicians, Nurses, and Technicians. By KURT SCHNITZER, R.T., M.D. New York: Grune & Stratton, 1949. Price, \$3.50.

SHEARER'S MANUAL OF HUMAN DISSECTION. Edited by CHARLES E. TOBIN, Ph.D., Associate Professor of Anatomy, University of Rochester School of Medicine and Dentistry. Second edition. Philadelphia: The Blakiston Company, 1949. Price, \$4.50.

TREATMENT IN PROCTOLOGY. By ROBERT TURELL, B.S., M.D., Attending Proctologist, Hillside Hospital; Adjunct Surgeon in Proctology, Montefiore Hospital and Beth Israel Hospital; Senior Clinical Assistant, Rectal Clinic, Mount Sinai Hospital, New York. With a chapter on psychosomatic problems by Louis Linn, M.D. Baltimore: The Williams & Wilkins Company, 1949. Price, \$7.00.

INDUSTRIAL TOXICOLOGY. By LAWRENCE T. FAIRHALL, Scientist Director, Public Health Service, Federal Security Agency; Chief, Industrial Hygiene Laboratory, Industrial Hygiene Division. Baltimore: The Williams & Wilkins Company, 1949. Price, \$6.00.

MEDICAL MAN POWER

The efficiency and integrity of a country's medical profession are influenced by the ratio of doctors to population. If there are too few doctors, medical services are likely to be incomplete, distribution faulty, and the doctors overworked, while if there are too many doctors, the standards of medical practice and conduct tend to deteriorate. The table below suggests that a good medical service requires at least one doctor to every thousand of population. This ratio is found in Canada, Denmark, Great Britain, Iceland, New Zealand, and the United States of America. At the other end of the scale is China, whose teeming population of 450 millions has only .04 doctors to every thousand. The high rate of 3.82 for the Jewish section of Palestine is probably attributable to special temporary circumstances.

Country	Population	Doctor per 1000 Population
Australia	7,500,000.....	.95
Bulgaria	7,022,206.....	.65
Canada	11,489,713.....	1.03
China	450,000,000.....	.04
Czechoslovakia	12,000,000.....	.78
Denmark	4,044,725.....	1.05
Egypt	17,000,000.....	.24
Eire	3,000,000.....	.67
Finland	3,865,000.....	.45
France	40,000,000.....	.75
Great Britain	48,788,000.....	1.14
Iceland	132,000.....	1.13
Luxembourg	281,572.....	.83
Netherlands	9,000,000.....	.89
New Zealand	1,750,000.....	1.03
Norway	3,126,000.....	.93
Palestine (Arab)	1,300,000.....	.22
Palestine (Jewish)	625,000.....	3.82
South Africa	11,391,949.....	.42
Spain	27,000,000.....	.93
Sweden	6,700,000.....	.95
Switzerland	4,000,000.....	.95
United States	141,228,673.....	1.40

—From a report by the World Medical Association.

ANESTHESIA

The attempt to conquer pain associated with surgery goes back to ancient times. Dioscorides used an alcoholic extract of mandrake in Rome shortly after the beginning of the Christian era, and opium, stramonium, and alcohol had their vogue. Even the production of cerebral anemia by compression of the carotid arteries was attempted, but the high death rate from this procedure prevented it from attaining great popularity. In general, surgery in the preanesthetic era was a matter of speed rather than attention to detail, and the most popular surgeons were those like Cheselden, who could do a lithotomy in less than a minute, or Liston, who amputated a leg in twenty-five seconds. When Ephraim McDowell operated on Jane Todd Crawford for her ovarian tumor, the operation was completed in twenty-five minutes, with the patient singing hymns throughout that time.

In 1776 nitrous oxide was isolated by Joseph Priestley, and Sir Humphrey Davy, in studying its properties, stated in 1800: "As nitrous oxide in its extensive operation seems capable of destroying physical pain, it may probably be used with advantage during surgical operations in which no great effusion of blood takes place." Apparently he did not pursue this suggestion further, and it was ether which became the first widely employed anesthetic agent.

In the 1840's "ether frolics" were a popular form of entertainment, particularly among the young folks of the southern states. In these, the participants inhaled ether unto a state of intoxication was reached, and the more observing noted that although they frequently were bruised in staggering or falling during the frolic, they felt no pain until after the effects of the ether had worn off.

This analgesia was noted by Crawford W. Long (1815-1878), who, after studying medicine at the Universities of Transylvania and Pennsylvania, had returned to his native Georgia to practice medicine. He had an acquaintance named James M. Venable, attending the local academy, who frequently inhaled ether and who declared later under oath that he was fond of its use. Mr. Venable had a tumor on the back of his neck which he wanted removed, and after due consideration Dr. Long agreed to do it with the patient under the influence of ether. His ledger for March 30, 1842, shows the item "James Venable, 1842. Ether and excising of tumor, \$2.00." He used the anesthetic on other occasions, but failed to publish any report until 1849, and his work remained relatively unknown until 1877, when James Marion Sims began a long and successful crusade for his recognition—MARGARET E. HAGGAN, M.D., *Jackson County (Mo.) Medical Society Bulletin*.

INTERNATIONAL SURGICAL ASSEMBLY

United States Chapter—International College of Surgeons
Atlantic City, New Jersey—November 7, 8, 9, 10, 11, 12, 1949

President, Dr. Custis Lee Hall, Washington, D. C.; President-elect, Dr. Henry W. Meyerding, Rochester, Minn.; Secretary, Dr. Arnold S. Jackson, Madison, Wis.; Chairman of Assembly, Dr. David B. Allman, Atlantic City, N. J.

All medical men interested in surgery and its advancement are welcome

Intensive clinical and didactic program by world authorities

Special Surgical Clinics—Philadelphia Hospitals—November 7

Special Events—Convocation—November 10—Convention Hall, Atlantic City
Banquet —November 11—Chalfonte Hotel, Atlantic City

Among the speakers listed for the program are:

Herbert Acuff, M.D., Knoxville, Tenn.	John C. McClintock, M.D., Albany, N. Y.
Alfred W. Adson, M.D., Rochester, Minn.	Raymond W. McNealy, M.D., Chicago, Ill.
Roger Anderson, M.D., Seattle, Wash.	Chester B. McVay, M.D., Yankton, S. Dak.
Lyon H. Appleby, M.D., Vancouver, Canada	Karl A. Meyer, M.D., Chicago, Ill.
W. Wayne Babcock, M.D., Philadelphia, Pa.	Henry W. Meyerding, M.D., Rochester, Minn.
Harry E. Bacon, M.D., Philadelphia, Pa.	Theodore R. Miller, M.D., New York, N. Y.
Charles P. Bailey, M.D., Philadelphia, Pa.	Michael K. O'Heeron, M.D., Houston, Texas
Paul Banzet, M.D., Paris, France	Thomas J. O'Neill, M.D., Philadelphia, Pa.
William Bates, M.D., Philadelphia, Pa.	Richard H. Overholt, M.D., Boston, Mass.
M. Leopold Brodny, M.D., Boston, Mass.	George T. Pack, M.D., New York, N. Y.
James J. Callahan, M.D., Chicago, Ill.	J. G. Probst, M.D., St. Louis, Mo.
Meredith Campbell, M.D., New York, N. Y.	Ernest F. Purcell, M.D., Trenton, N. J.
Paul F. Doege, M.D., Marshfield, Wis.	Walter J. Reich, M.D., Chicago, Ill.
John W. Ego, M.D., Philadelphia, Pa.	George P. Rosemond, M.D., Philadelphia, Pa.
George H. Ewell, M.D., Madison, Wis.	Peter Rosi, M.D., Chicago, Ill.
Albert Faulconer, M.D., Rochester, Minn.	Curtice Rosser, M.D., Dallas, Texas
Paul S. Friedman, M.D., Philadelphia, Pa.	Robert L. Schaeffer, M.D., Allentown, Pa.
John Garlock, M.D., New York, N. Y.	Albert P. Seltzer, M.D., Philadelphia, Pa.
Charles F. Geschickter, M.D., Baltimore, Md.	F. A. B. Sheppard, M.D., Winnipeg, Canada
Robert P. Glover, M.D., Philadelphia, Pa.	E. Spiegel, M.D., Philadelphia, Pa.
Custis Lee Hall, M.D., Washington, D. C.	M. E. Steinberg, M.D., Portland, Ore.
N. Frederick Hicken, M.D., Salt Lake City, Utah	Richard W. TeLinde, M.D., Baltimore, Md.
Claude J. Hunt, M.D., Kansas City, Mo.	Max Thorek, M.D., Chicago, Ill.
Chevalier L. Jackson, M.D., Philadelphia, Pa.	Philip Thorek, M.D., Chicago, Ill.
Robert W. Johnson, M.D., Baltimore, Md.	J. E. M. Thomson, M.D., Lincoln, Neb.
Elmer S. A. King, M.D., Pittsburgh, Pa.	Herbert Virgin, Jr., M.D., Miami, Fla.
Ira H. Lockwood, M.D., Kansas City, Mo.	James W. Watts, M.D., Washington, D. C.
W. R. Lovelace, II, M.D., Albuquerque, N. M.	Henry T. Wycis, M.D., Philadelphia, Pa.
Oswald S. Lowsley, M.D., New York, N. Y.	

Hotel Headquarters, Haddon Hall, Atlantic City—For hotel reservations write E. D. Parrish, Haddon Hall, Atlantic City, N. J.

Every doctor of medicine who uses surgery in his practice will find this meeting of great value. A program will be mailed upon request to Secretary Arnold S. Jackson, M.D., 1516 Lake Shore Drive, Chicago, Ill.

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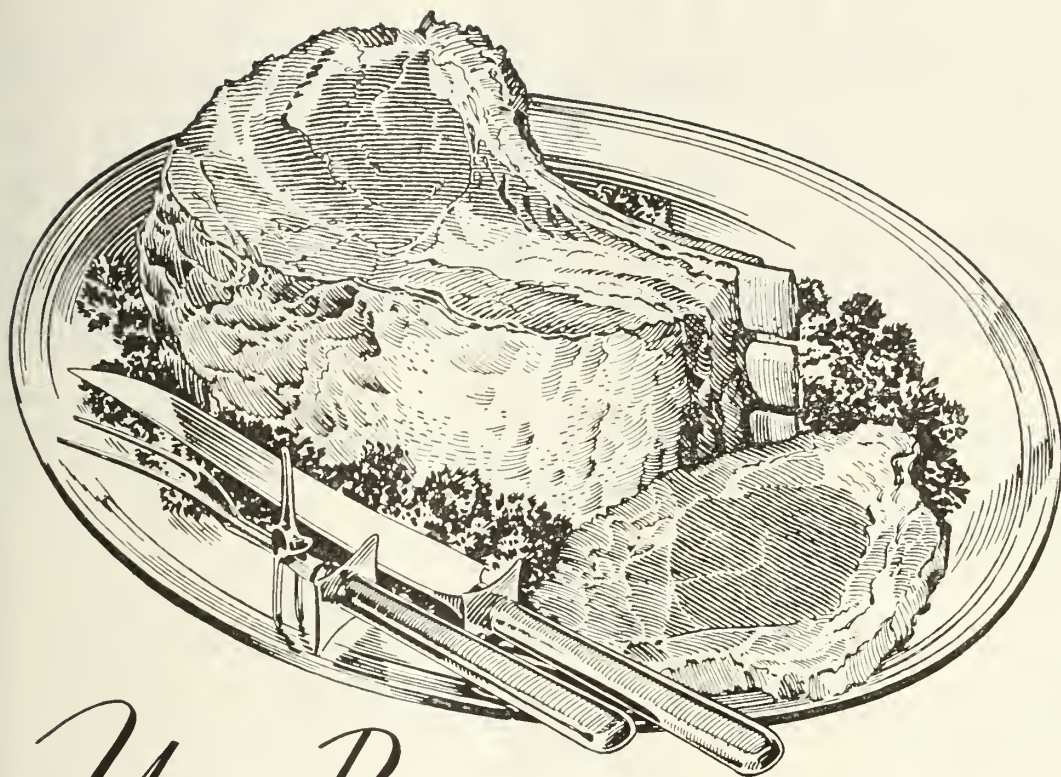
Ordinarily an operation or an autopsy must be performed strictly within the limits of the authority that has been given. Authority may be given, however, for the operating physician to use his own judgment, and this usually should be demanded by the physician.

Consent by word of mouth to an operation or an autopsy is probably the most common form of consent. . . . Oral consent is, however, open to misunderstanding and may be difficult of proof. Whenever it is to be relied on, consent should be given in unequivocal terms, in the presence of one or more disinterested witnesses. Written consent to an operation or to an autopsy is by far the safest, for it permits a clear record of the nature and extent of the operation or autopsy that is authorized. If the patient is a minor, authority for an operation must come from his parent or guardian.—*Board of Trustees, The Medical Society of the State of Pennsylvania.*

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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. 139:897 (April 2) 1949.

American Meat Institute
Main Office, Chicago...Members Throughout the United States

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An Editorial



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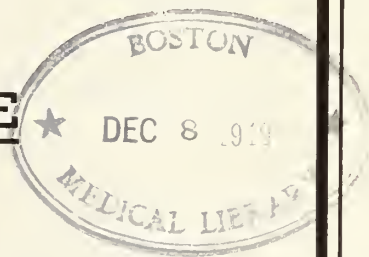
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1950 State Medical Society Dues

Officers' Department

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20

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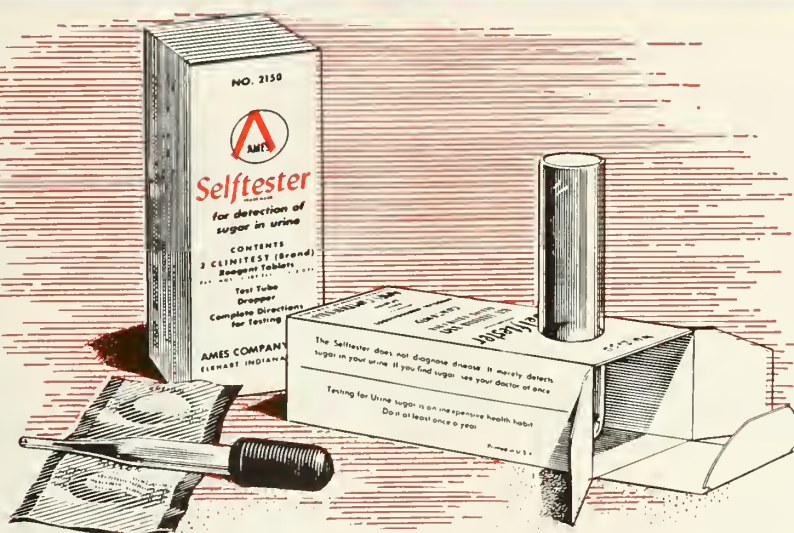
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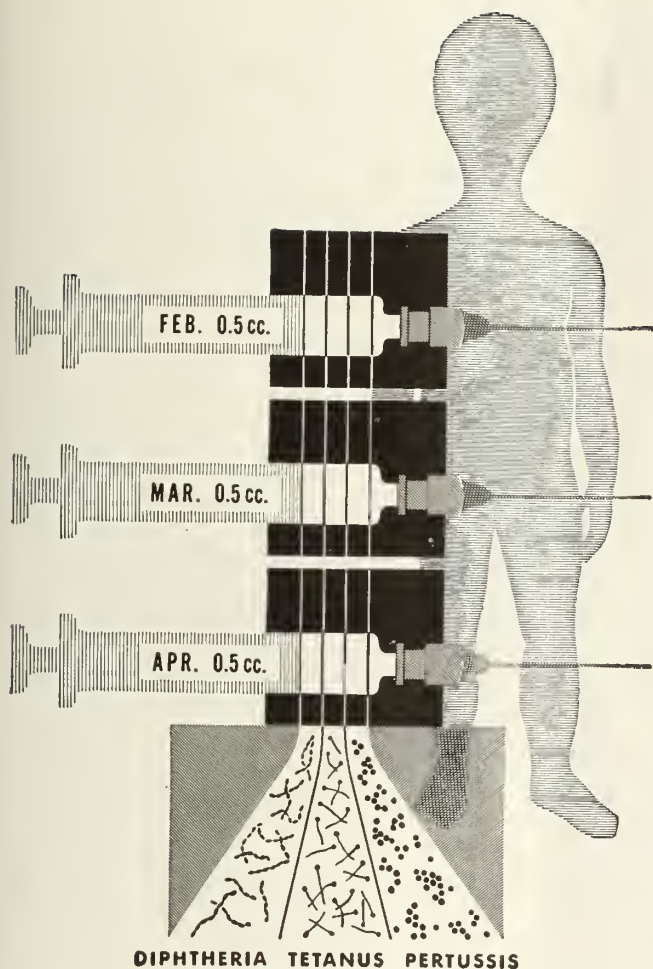
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As Invert.	32.13
As Dextrose	39.13
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So sorry for the delay.

Yours truly,

_____, M.D.
Pennsylvania.

Sept. 19, 1949

GENTLEMEN:

Honestly, this was a gross oversight.

Enclosed find check for \$50 for me and for Dr.

_____, M.D.
Pennsylvania.

Aug. 27, 1949

GENTLEMEN:

I have just received a check for \$25 from the National Physicians Committee covering my contribution made to them in February, 1949. I am enclosing a check to the order of American Medical Association—Assessment in the amount of \$25 to cover my A.M.A. membership assessment.

_____, M.D.,
Pennsylvania.

Sept. 27, 1949



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DETAILS. NO OBLIGATION OF COURSE

PROFESSIONAL SERVICE CO.
25 HUNTINGTON AVE., BOSTON 16, MASS.

Is the Doctor Civic-minded?

GENTLEMEN:

I am very much interested in the booklet which the Commission on Industrial Health and Hygiene of The Medical Society of the State of Pennsylvania mailed to this office titled "Industrial Health Program." I have been mightily interested in the proposed socialized medicine and state health insurance program that has been politically advocated and no doubt will keep on staring us in the face from time to time, even though it seems a rather dead issue at present.

In every one of our monthly bulletins here which go out to 400 of the real people of _____, I have an article on Socialized Medicine. In fact, some of the doctors have told me that I am doing a better job for their cause than they themselves could do. However, there is something that seems unexplainable about the medical profession. Out of more than 50 medical men here in _____, we have a total of 11 who are members of the Chamber of Commerce, and I find that is about the same proportion all over the country. I was interested in knowing whether there was something peculiarly wrong with our Chamber of Commerce that so few of our doctors, who have been enjoying the most lucrative practice in the history of the medical profession, feel obligated civically to do anything for their community that provides a place for them to practice.

It is just as important that the economic conditions are sound so that the doctors can collect their fees as it is to the man who sells shoes and groceries. Yet the latter are the fellows who keep up the Chamber of Commerce and do the things that need to be done in a civic way. However, whether or not the other 40 become members of the Chamber, we expect to do business and I expect to keep up the fight, not exactly for the benefit of the doctors but for those who will suffer under such a setup as they have now in England.

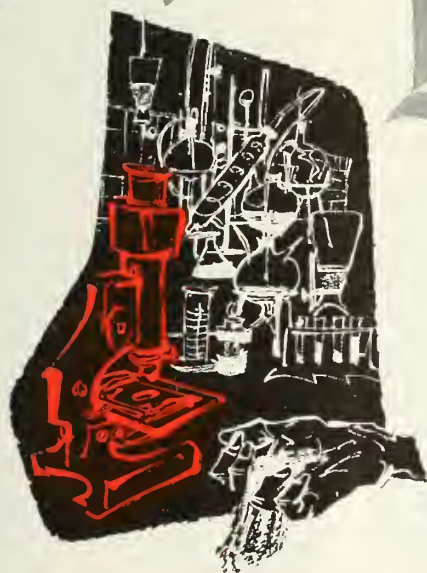
Respectfully yours,

Executive Secretary,

_____, Chamber of Commerce, Inc.

Aug. 25, 1949

AUREO- MYCIN



*The Newest and
Most Broadly Useful
of the Antibiotics*

AUREOMYCIN HYDROCHLORIDE LEDERLE

Aureomycin is now generally accepted as one of the most versatile antibiotics yet isolated. In addition to attacking the Gram-positive cocci with great effectiveness, it is useful against many Gram-negative organisms, particularly those of the coli-aerogenes group. It is also effective against rickettsial infections and certain diseases of unknown etiologies, such as primary atypical pneumonia. Aureomycin in solution with sodium borate has been found highly effective in the eye in a concentration of one-half per cent. Among others it is active against the diplobacillus of Morax-Axenfeld, Friedländer's bacillus, staphylococcus, pneumococcus, and *Hemophilus influenzae*.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY 30 Rockefeller Plaza, New York 20, N. Y.

long lines of black ants



Long lines of black ants attracted to madhumeha, "honey urine," led the ancient Hindu wise men to observe and recognize diabetic urine, which they described as "astringent, sweet, white and sharp." Avid insects became an acknowledged means of diagnosis. Almost equally primitive methods of urine-sugar detection remained in effect for a score or more of centuries, until modern copper reduction tests were perfected, refined and simplified.



Simplest of all today is the reliable *Ames* tablet method, performed in a matter of seconds. Urine-sugar levels are determined by direct, easily-learned steps. The use of *Clinitest* (Brand) reagent tablets has eliminated the inconvenience of external heating. Interpretation of routine urine-sugar testing follows readily from color scale comparison.

CLINITEST, trade mark reg. U.S. and Canada

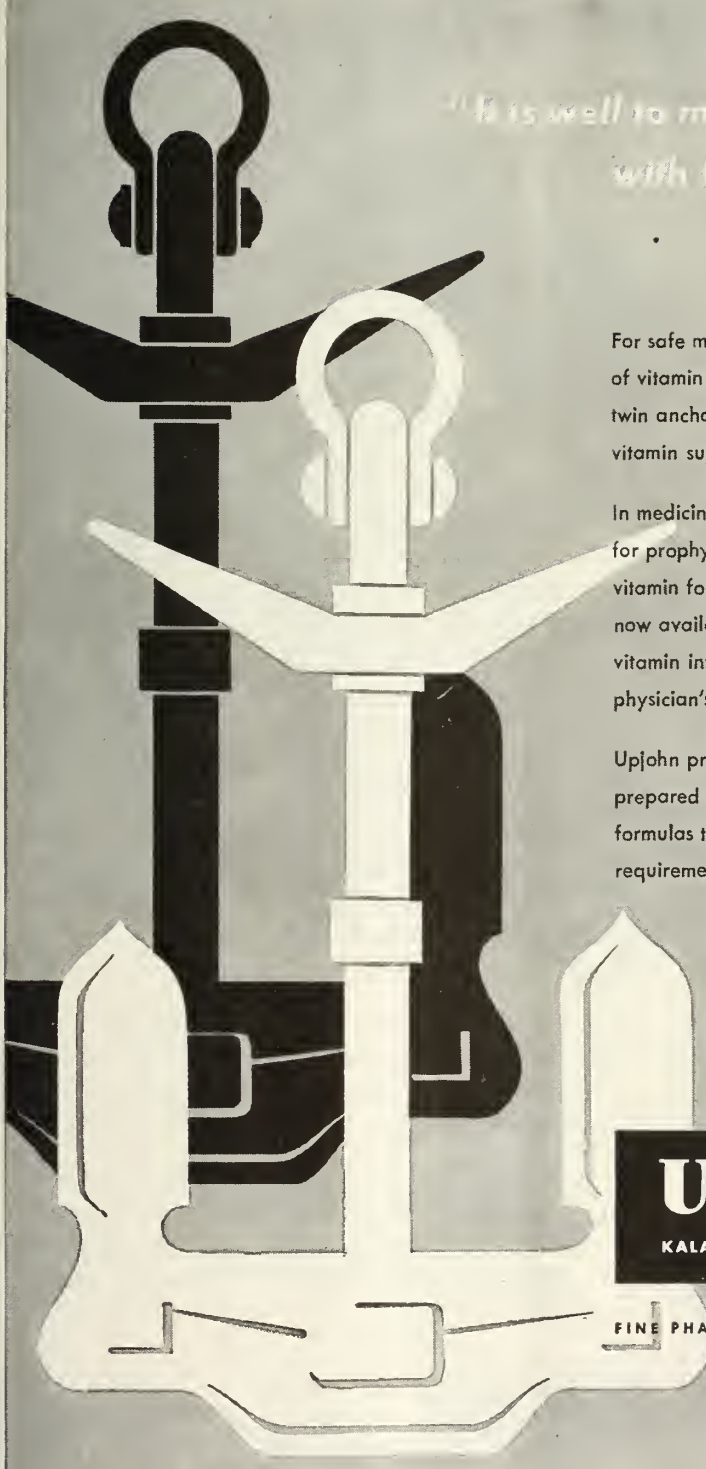
*centuries to perfect
seconds to perform*



Clinitest[®]

for urine-sugar analysis

AMES COMPANY, INC. • ELKHART, INDIANA



*"It is well to moor your bark
with two anchors."*

PUBLILIUS SYRUS, MAXIM 119

For safe mooring in the "snug harbor" of vitamin adequacy, the best twin anchors are balanced diet and vitamin supplementation.

In medicine as in surgery, for prophylaxis as for therapy, the vitamin forms and dosages now available place adequate vitamin intake under the physician's selective control.

Upjohn prescription vitamins are prepared in potencies and formulas that cover the varied requirements of modern practice.

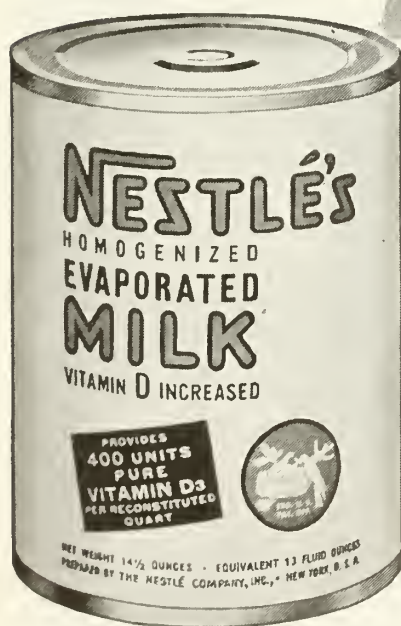
Upjohn

KALAMAZOO, 99, MICHIGAN

FINE PHARMACEUTICALS SINCE 1886

CONSTANT INSPECTION for BABY'S PROTECTION

Our inspectors examine every single ten-gallon can of fresh milk as it comes from the dairy, but this is only the beginning of the tests we apply to Nestlé's Evaporated Milk.



From herd inspection to examination of the filled cans, careful controls at every step of production assure you that Nestlé's milk is of good quality, uniform in composition, safe for even the tiniest baby.

Antirachitic protection is assured by the addition of 400 U.S.P. units of genuine vitamin D₃ to each pint of Nestlé's milk—the first evaporated milk so fortified.



DOCTORS EVERYWHERE KNOW NESTLÉ'S



if she is one of your patients...

...She depends on your help for a speedy return to gainful occupation. Women seeking employment who are nervous, apprehensive and generally distressed by symptoms of the climacteric, may find it difficult to meet competition. "Premarin" offers a solution. Many thousand physicians prescribe this naturally-occurring, oral estrogen because...

1. Prompt symptomatic improvement usually follows therapy.
2. Untoward side-effects are seldom noted.
3. The sense of well-being so frequently reported tends to quickly restore the patient's confidence and normal efficiency.
4. This "Plus" (the sense of well-being enjoyed by the patient) is conducive to a highly satisfactory patient-doctor relationship.
5. Four potencies provide flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg. and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).



While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens...estrodial, equilin, equilinenin, hippulin...are probably also present in varying amounts as water-soluble conjugates.

"PREMARIN"®



ESTROGENIC SUBSTANCES (WATER-SOLUBLE)
also known as CONJUGATED ESTROGENS (equine)

Ayerst, McKenna & Harrison Limited 22 East 40th Street, New York 16, New York

4911

For mixed infections



Chronic, infected, cutaneous ulcers of hypostatic, decubital or diabetic origin, usually respond rapidly to topical Furacin therapy. Of 81 such cases specifically mentioned in the literature, good results were obtained in 65. The infection, odor and discharge usually diminished promptly without delay of healing. Furacin® brand of nitrofurazone, is available as Furacin Solution (N.N.R.) and Furacin Soluble Dressing (N.N.R.) containing Furacin 0.2%. These preparations are indicated for topical application in the prophylaxis or treatment of infections of wounds, second and third degree burns, cutaneous ulcers, pyodermas and skin grafts. Literature on request.

EATON LABORATORIES, INC., NORWICH, N. Y.

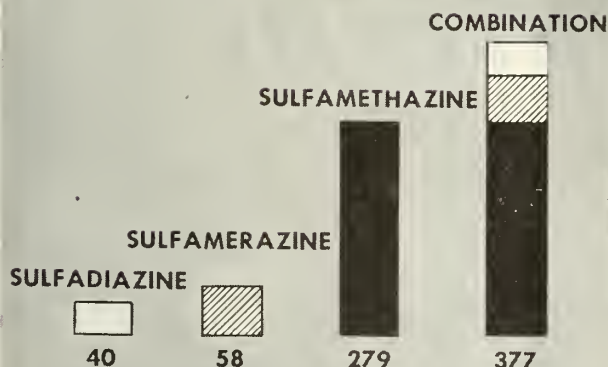
Downing, J. et al.: J. A. M. A. 133:299, 1947 • Johnson, H.: Arch. Dermat. & Syph. 57:348, 1948 • Miller, J. et al.: New York State J. Med. 47:2316, 1947 • Miller, R. et al.: North Carolina M. J. 9:574, 1948 • Shipley, E. et al., Surg., Gynec. & Obst. 84:366, 1947.



INCREASED MARGIN OF SAFETY — A ***NEW***
IMPROVED TRIPLE-SULFA COMBINATION

TRISULFAZINE

TRADEMARK



SOLUBILITY IN URINE AT pH 6.0 (mg. per 100 ml.)

Sulfamethazine plus sulfadiazine plus sulfamerazine provides a new, effective triple-sulfonamide combination that presents a minimal hazard of toxic reactions—particularly crystalluria.

Sulfamethazine "... can be considered to be a real advance, more especially as its therapeutic activity is of the same order as the parent compound, sulphadiazine."¹

¹ Whitby, L.: Practitioner 155: 264 (1945).



FEATURES • *Low toxicity*—reduced danger of crystalluria • *Potency*—intensive dosages feasible • *Simplicity and convenience*—reduced need for adjuvant alkali or fluid administration • *Prolonged action*—because of sustained blood levels • *Rapid effect*—components of the mixture pass quickly into tissue fluids.

Available in three convenient dosage forms: *Tablets:* 0.166 Gm. each sulfonamide per 0.5-Gm. tablet. *Palatabs** (Half Strength): 0.083 Gm. each sulfonamide per 0.25-Gm. peppermint-flavored *Palatab.* *Suspension with Sodium Lactate:* 1 Gm. each sulfonamide (microcrystalline) per fluidounce with 3 Gm. sodium lactate; in stable, agreeably flavored vehicle.

*Trademark of The Central Pharmacal Co.

THE CENTRAL PHARMACAL COMPANY

Pharmaceutical Progress Since 1904

SEYMOUR INDIANA



Quinine

is again available in ample supply

All government restrictions on the use of quinine in general practice have been removed.

The clinical effectiveness of quinine, coupled with its almost complete absence of toxicity, strongly recommend it in the treatment of malaria.

You may again also prescribe quinine whenever its use is indicated, as in:

<i>minor surgery</i>	<i>influenza</i>
<i>hemorrhoids</i>	<i>myotonia</i>
<i>obstetrics</i>	<i>anemia (with iron)</i>
<i>varicose veins</i>	<i>hydrocele</i>
<i>trachoma</i>	

You may also prescribe quinidine whenever its use is indicated, as in:

<i>auricular fibrillation</i>	<i>ventricular tachycardia</i>
-------------------------------	--------------------------------

Cinchona Products Institute, Inc., 10 Rockefeller Plaza, N.Y. 20

Quinine . . . the NATURAL Remedy for Malaria

Publications and abstracts on the uses of cinchona alkaloids are available on request. Please state your special interests in requesting information. Publications of the Cinchona Products Institute, Inc. of general interest include:

The Technique of Blood Examination in Malaria (with 5 colored illustrations of malaria plasmodia)

Quinine Formulary (revised edition) *Quinine and Quinidine in General Practice*



"Nurse, I hope Doctor will prescribe **BAKER'S MODIFIED MILK** for her as he did for my little boy—it's so reliable and easy to prepare."

DOCTOR:

Are you acquainted with Baker's Modified Milk?

Mothers who have brought one baby through the bottle-feeding period on Baker's Modified Milk, are happy when Baker's is prescribed for the second baby. They are thankful for the baby's robustness, regularity and well-being. Particularly pleasing is the ease with which Baker's is prepared for feeding—just dilute liquid Baker's with equal parts of boiled water.

Many doctors have learned from experience that Baker's Modified Milk meets their requirements in most of their bottle-feeding cases, since Baker's is fed either complementary to or entirely in place of mother's milk. No formula change is required as baby grows older—merely increase the quantity of feeding.

To prescribe Baker's Milk at the hospital, just leave instructions with the obstetrical supervisor.



• Individual requirements are easily met with Baker's powder or liquid form, since both may be fed interchangeably.

BAKER'S MODIFIED MILK

THE BAKER LABORATORIES INC., Cleveland, Ohio

Division Offices: San Francisco, Los Angeles, Denver, Seattle and Greensboro, N. C.

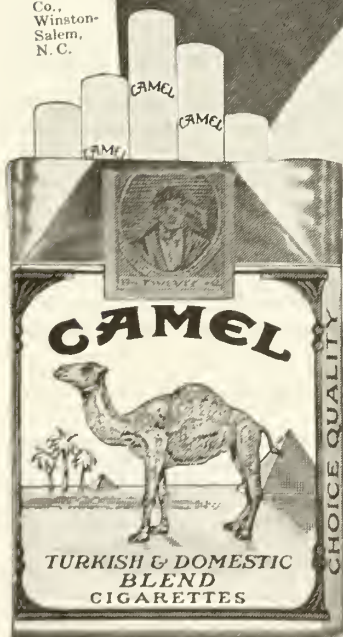


30-DAY TEST REVEALED

*"Not one single case of throat
irritation due to smoking Camels!"*

Yes, that's what throat
specialists reported
after making weekly
examinations of the
throats of hundreds of
men and women from
coast to coast who
smoked Camels, and
only Camels, for 30
consecutive days.

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According to a Nationwide survey:

More Doctors smoke Camels
than any other cigarette

When three leading independent research organizations asked 113,597
doctors what cigarette they smoked, the brand named most was Camel!

maintaining urinary antiseptis without distressing the patient

Comprehensive clinical evidence establishes that MANDELAMINE (methenamine mandelate) is effective against *Escherichia coli*, *Staphylococcus aureus* and *albus*, and certain streptococci. Comparative studies indicate its bacteriostatic and bactericidal effectiveness to be approximately the same as that of the sulfonamides or streptomycin.

Because MANDELAMINE therapy is exceptionally well tolerated, patients willingly adhere to the prescribed regimen.

DOSAGE: Adequate dosage is important; for maximum effect, adults should take 3 or 4 tablets t.i.d.; children in proportion.

Complete literature and samples sent to physicians on request.

6 outstanding features

- Has wide antibacterial range
- No supplementary acidification required (except when urea-splitting organisms occur)
- Little or no danger of drug-fastness
- Is exceptionally well tolerated
- Requires no dietary or fluid regulation
- Simplicity of regimen — 3 or 4 tablets t.i.d.

MANDELAMINE

REG. U. S. PAT. OFF.

BRAND OF METHENAMINE MANDELATE

urinary antiseptic-council accepted



NEPERA CHEMICAL CO., INC.

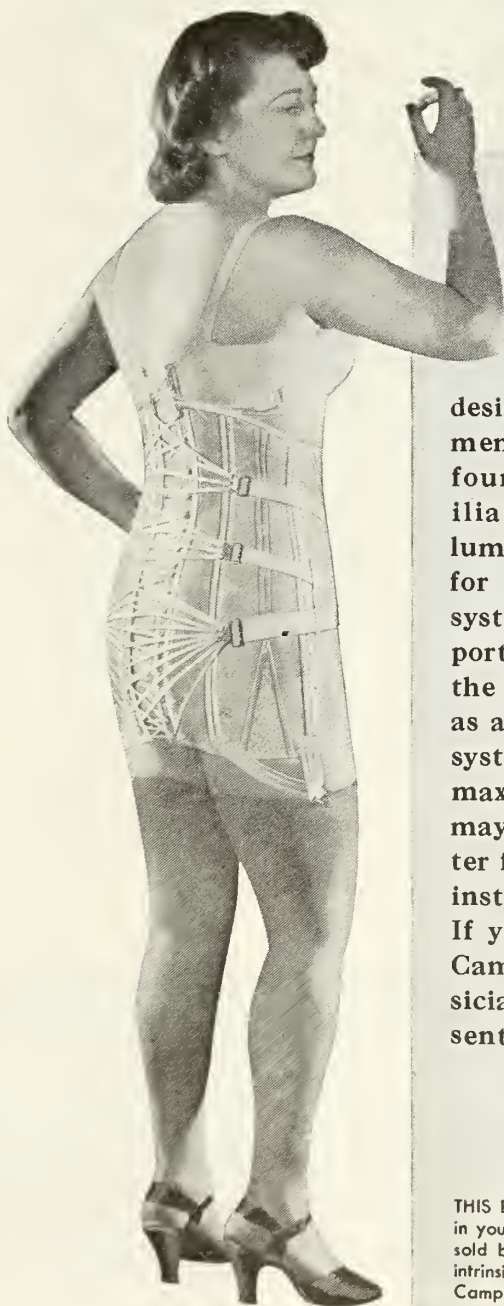
Manufacturing Chemists

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CAMP ANATOMICAL SUPPORTS

for ORTHOPEDIC CONDITIONS



Whether it be relief from lesser degrees of postural or occupational strain, or as an aid in treatment following injury or operation, the Camp group of scientifically designed orthopedic supports for men, women and children will be found "comprehensive." Sacroiliac, Lumbosacral and Dorso-lumbar supports may be prescribed for all types of build. The Camp system of construction fits the support accurately and firmly about the major part of the bony pelvis as a base for support. The unique system of adjustment permits the maximum in comfort. Physicians may rely on the Camp-trained fitter for the precise execution of all instructions.

If you do not have a copy of the Camp "Reference Book for Physicians and Surgeons", it will be sent on request.

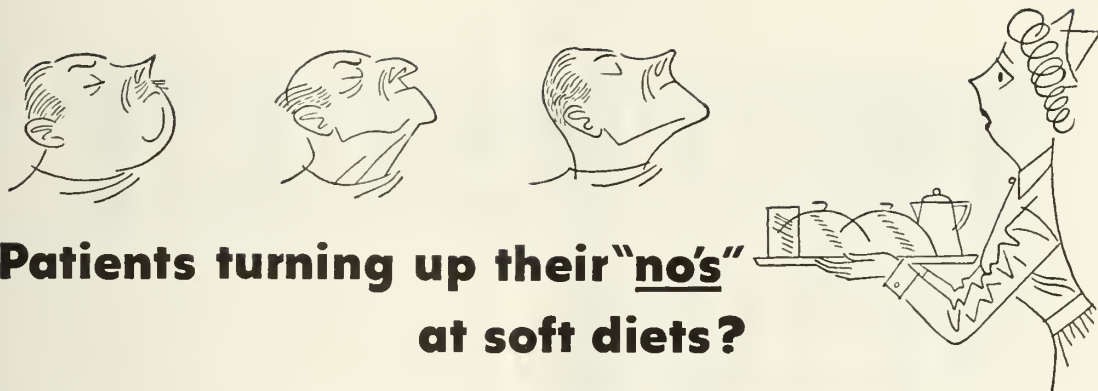


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World's Largest Manufacturers of Scientific Supports

Offices in New York • Chicago • Windsor, Ontario • London, England



Patients turning up their "no's" at soft diets?



Try tasty, protein-rich Swift's Strained Meats!

A palatable, natural source of complete, high-quality proteins

It's not surprising that soft-diet patients develop appetite-apathy. The things they have to eat!

To help overcome this anorexia many doctors now recommend Swift's Strained Meats. Delicious, *real* meat that patients on soft, smooth diets can eat and *enjoy*. Swift's Strained Meats provide an excellent base for high-protein, low-residue diet. Rich in iron, they're chemically and physically non-irritating. They make available *simultaneously* all essential amino

acids for optimum protein synthesis.

Swift's Strained Meats are tasty enough to tempt tired appetites. They supply goodly amounts of B vitamin to help stimulate patients' natural appetite for other foods. Swift's Strained Meats are 100% meat—a variety of six kinds: beef, lamb, pork, veal, liver, heart. Originally prepared for infant feeding, they're exceptionally fine in texture—may easily be used in tube feeding. Convenient—ready to heat and serve.



6 varieties:
Beef, lamb, pork,
veal, liver, heart



For patients who can take foods of less fine consistency—Swift's Diced Meats offer tender morsels of nutritious meats with tempting flavors patients appreciate.

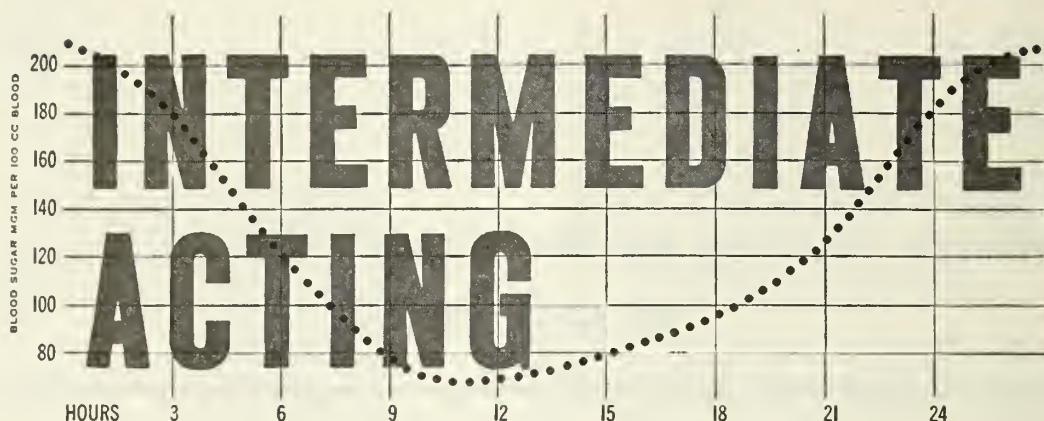
The makers of Swift's Strained Meats invite you to send for your copy of "The Importance of Protein Foods in Health and Disease"—a physicians' handbook of protein feeding, written by a doctor. Send to:

SWIFT & COMPANY

Chicago 9, Illinois



All nutritional statements made in this advertisement are accepted by the Council on Foods and Nutrition of the American Medical Association.



GLOBIN INSULIN

'B.W. & CO.'

*...was developed to fill the
"need for an insulin with
activity intermediate between
that of regular insulin and that
of protamine zinc insulin."¹*

IN 1939, Reiner, Searle and Lang described a new
"intermediate acting" insulin.

IN 1943, after successful clinical testing, the new sub-
stance was released to the profession as 'Wellcome'
brand Globin Insulin with Zinc 'B.W. & Co.'

TODAY, according to Rohr and Colwell, "Fully 80%
of all severe diabetics can be balanced satisfactorily"²
with Globin Insulin 'B.W. & Co.'—or with a 2:1 mixture
of regular insulin: protamine zinc insulin. *Ready-to-use*
Globin Insulin 'B.W. & Co.' provides the desired inter-
mediate action without preliminary mixing in vial or
syringe.

In 10 cc. vials, U-40 and U-80.

1. Rohr, J.H., and Colwell, A.R.: Arch. Int.
Med. 82:54, 1948.

2. ibid Proc. Am. Diabetes Assn. 8:37, 1948.



'B.W. & CO.'—a mark to remember



BURROUGHS WELLCOME & CO. (U.S.A.) INC. Tuckahoe 7, New York

when

M

ilk becomes

a dietary dilemma

Problem: When casein or other animal protein sensitivity renders all natural or processed milks* contraindicated in the pediatric dietary, because of eczematous, gastro-intestinal or other reactions, how can allergy be avoided and proper infant nutrition still be maintained?

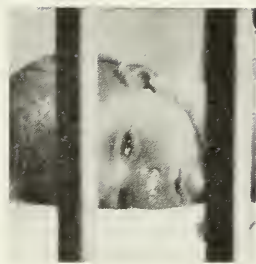
Solution: Replace milk with Mull-Soy, the liquid hypoallergenic soy food—completely free of offending animal proteins. Mull-Soy is a biologically complete vegetable source of all essential amino acids, and closely approximates whole cow's milk in fat, protein, carbohydrate, and mineral content when diluted 1:1 with water. It is quickly prepared, palatable, easily digested and well-tolerated—equally desirable for infants, children or adults.

*Goat's milk and processed cows' milk have unmodified casein factors.

BORDEN'S PRESCRIPTION PRODUCTS DIVISION

350 MADISON AVENUE, NEW YORK 17, N. Y.

In Canada write The Borden Company, Limited, Spadina Crescent, Toronto



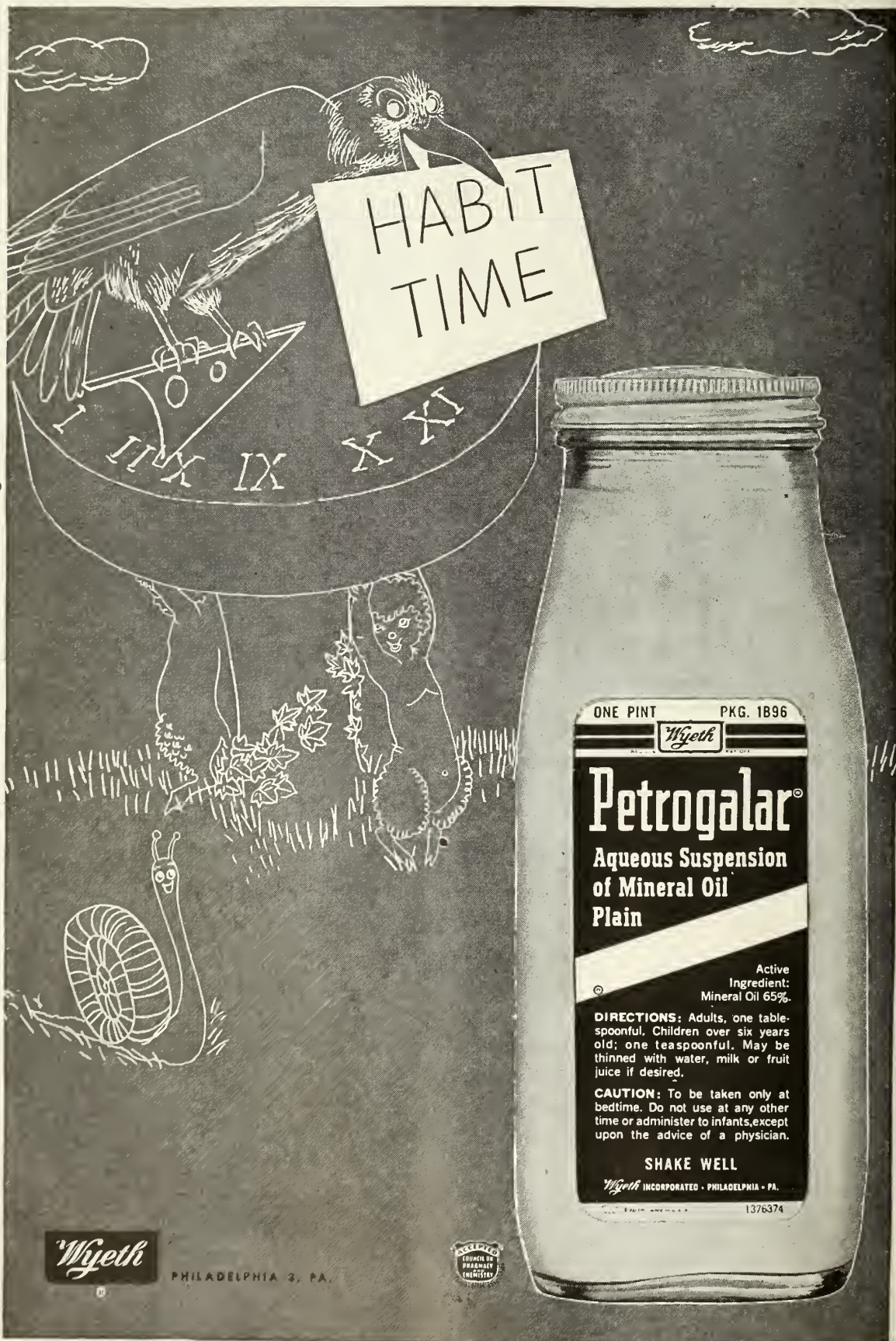
Mull-Soy is a liquid hypoallergenic food prepared from water, soy flour, soy oil, dextrose, sucrose, calcium phosphate, calcium carbonate, salt, and soy lecithin; homogenized and sterilized. Available in 15½ fl. oz. cans at all drugstores.

M



ull-soy

When Milk becomes
"Forbidden Food"



in hay fever...

- ...Nasal Engorgement Reduced
- ...Soreness, Congestion Relieved
- ...Aeration Promoted
- ...Drainage Encouraged

with

NEO-SYNEPHRINE®

HYDROCHLORIDE

Brand of
Phenylephrine Hydrochloride

When Neo-Synephrine comes in contact with the swollen, irritated mucous membrane of the nose, the patient soon experiences relief.

This powerful vasoconstrictor acts quickly to shrink engorged mucous membranes, restoring easy breathing, and promoting free drainage.

The prolonged effect of Neo-Synephrine makes fewer applications necessary for the relief of nasal congestion — permitting longer periods of comfort and rest.

Neo-Synephrine does not lose its effectiveness on repeated application . . . It may be employed with good results throughout the hay fever season . . . It is notable for relative freedom from sting and absence of compensatory congestion . . . Virtually no systemic side effects are produced.

Supplied as:

- ¼% and 1% in isotonic saline solution—1 oz. bottles.
- ¼% in aromatic isotonic solution of three chlorides—1 oz. bottles.
- ½% water soluble jelly—⅝ oz. tubes.

Winthrop-Stearns INC.
NEW YORK 13, N. Y. WINDSOR, ONT.

Neo-Synephrine, trademark reg. U. S. & Canada

*With this
in hand*



*The
Cardiologist*

is assured of

Dependability in Digitalis Administration



Being the powdered leaves made into
physiologically tested pills,
all that Digitalis can do, these pills will do.

Trial package and literature sent to physicians on request.

DAVIES, ROSE & COMPANY, Limited
Manufacturing Chemists

Boston 18, Massachusetts

D14

CHECK LIST

*for choice of
a laxative*

Phospho- Soda (FLEET) TYPE OF ACTION

- ✓ Prompt action
- ✓ Thorough action
- ✓ Gentle action

SIDE EFFECTS

- ✓ Free from Mucosal Irritation
- ✓ Absence of Constipation Rebound
- ✓ No Development of Tolerance
- ✓ Safe from Excessive Dehydration
- ✓ No Disturbance of Absorption of Nutritive Elements
- ✓ Causes no Pelvic Congestion
- ✓ No Patient Discomfort
- ✓ Nonhabituating
- ✓ Free from Cumulative Effects

ADMINIS- TRATION

- ✓ Flexible Dosage
- ✓ Uniform Potency
- ✓ Pleasant Taste

Phospho-Soda (Fleet) is a solution containing in each 100 cc. sodium biphosphate 48 Gm. and sodium phosphate 18 Gm.



Judicious Laxation

**...through freedom from
undesirable side effects**

The clinical preference for Phospho-Soda (Fleet)* stems in large part from its freedom from undesirable side effects. This desideratum, together with its controlled action and ease of administration, assure safe, effective anticonstipative therapy from every prescription of this "tried and true" laxative agent. Clinical samples on request.

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*'PHOSPHO-SODA' and 'FLEET' are registered trade-marks of C. B. Fleet Co., Inc.



**PHOSPHO-SODA
(FLEET)**

®

ACCEPTED FOR ADVERTISING BY THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

Good Nutrition..

A VITAL FACTOR IN THERAPY



The sound and wholesome nutritious diet is an integral part of modern day preventive and definitive therapy. A steady stream of adequate amounts of all the essential nutritional elements is vital for good growth, maintenance of tissue structure and functioning, healing after trauma, and resistance to infection. For maintaining this daily, steady stream of nutrients, however, conditions both in health and illness often make imperative the use of an efficient food supplement along with the diet.

The *multiple dietary food supplement* Ovaltine in milk has wide usefulness for enhancing to full adequacy even nutritionally poor diets. Its rich store of vita-

mins and minerals includes vitamins A and D, ascorbic acid, thiamine, riboflavin and niacin, and calcium, iron and phosphorus. Its nutritionally complete protein has excellent biologic rating.

Since these vital nutritional values along with carbohydrate and easily emulsifiable milk fat are incorporated in liquid suspension or solution, Ovaltine in milk is also especially adapted to liquid diets. The highly satisfying flavor makes for its ready acceptability when foods are often distasteful.

The important overall nutrient contribution of three glassfuls of Ovaltine mixed with milk is presented in the accompanying table.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.



Ovaltine

Three servings of Ovaltine, each made of $\frac{1}{2}$ oz. of Ovaltine and 8 oz. of whole milk,* provide:

CALORIES.....	676	VITAMIN A.....	3000 I.U.
PROTEIN.....	32 Gm.	VITAMIN B1.....	1.16 mg.
FAT.....	32 Gm.	RIBOFLAVIN.....	2.0 mg.
CARBOHYDRATE.....	65 Gm.	NIACIN.....	6.8 mg.
CALCIUM.....	1.12 Gm.	VITAMIN C.....	30.0 mg.
PHOSPHORUS.....	0.94 Gm.	VITAMIN D.....	417 I.U.
IRON.....	12 mg.	COPPER.....	0.5 mg.

*Based on overage reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.



PRESIDENTIAL ADDRESS

E. ROGER SAMUEL, M.D.
Mt. Carmel, Pa.



IN ASSUMING the office of president of The Medical Society of the State of Pennsylvania, I am like the tail of a comet; all of the brilliance has gone before. It is indeed a task to take up the work after such a brilliant array of talent as has preceded me. The honor of

being president is equaled only by the responsibility which it entails. For it has been truly said that he who accepts honors assumes responsibilities.

This month we complete the first year of the second century of organized medicine in the Commonwealth of Pennsylvania. The founders of our Society had three objectives in view when they sought to federate the county societies into one state-wide organization: first, to advance the standards of medical education, both in the medical schools and in the counties by means of graduate education; second, to suggest and to advocate ethical standards of the highest order in the profession; third, to try by legislative enactments and by other means to advance the health and well-being of the public and to give to the public enlightenment in the newer developments in the art and science of our profession.

The first part of the program was accomplished after a great deal of effort and is still being carried out. Our schools have attained the highest standard of any in the world. Graduate education has been brought to the physicians in the past few years to a greater extent than ever before.

The second part of the program was and is a delicate matter. Many developments from the principles of medical ethics have been evolved, but none has yet superseded the Golden Rule.

We have recently been confronted by the fact that we have not made as much progress in the enlightenment of the public as we should have.

Necessity is a hard taskmaster and the current necessity of accomplishing in a few years that in which we should have been more diligent in earlier years now requires us individually and collectively to strive for improved public relations.

In this endeavor we may agree that a close personalized relationship between physician and patient is one essential to success. A second essential to success involves support by every Pennsylvania physician of the Medical Service Association of Pennsylvania, our state society's own freely sponsored form of voluntary non-profit medical and surgical insurance. Introduced originally as insured surgical and obstetric service in hospitals only, and offered only to employed groups, it has progressed on the basis of its own actuarial experience to the point where it is now available on an individual or family subscription basis to individuals, employed or unemployed, who are under 66 years of age.

Time and space will not permit of giving other details, but we do want all to know that after ten years' experience this complete coverage may be had for husband and wife and all their unmarried children under 19 years of age at an annual cost of \$39.60, or the cost of one package of cigarettes purchased every second day throughout the year.

If, in addition to spreading the benefits of voluntary insured medical service, we Pennsylvanians strive successfully for the maintenance of high educational standards for all who practice the healing art and we as practitioners also observe the principles of medical ethics, our task of carrying our story to the people will be much simplified.

Our state society has other organizational responsibilities since it federates 61 component county medical societies and thus becomes a constituent association of the great American Medical Association which is composed of 53 state and territorial medical societies.

This organizational structure embodies a true republic, by means of which the smallest county medical society elects delegates to state society conventions such as ours of this week, which in turn will elect delegates to the American Med-

Delivered at the Installation Meeting of the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania, Carnegie Music Hall, Pittsburgh, Sept. 27, 1949.

ical Association. By this process the House of Delegates of The Medical Society of the State of Pennsylvania will speak for 11,000 Pennsylvania county doctors of medicine in the A.M.A. House of Delegates, which finally forms policies for more than 145,000 American doctors.

At the national level we and the patients we serve are confronted by the ogre of compulsory nationalized medical practice. To combat this, we, the membership throughout the nation, are supporting financially and by personal effort a two-year national education program designed by the American Medical Association. Its only objective is to thoroughly inform the people of the nation of the radically contrasting ideologies, quality of service rendered, and the costs of same—a contrast that may be readily demonstrated between compulsory health insurance, as proposed by the Federal Social Security administration, and voluntary insured medical and hospitalization services, as being offered locally throughout the states of the Union and which have already been subscribed for by more than 60 million Americans.

Fortunately, another speaker on this program, who has had personal experience under socialized medicine in another nation, will bring to us more in detail the disadvantages of governmental compulsion when connected with a personalized professional service such as we have been accustomed to in medical practice in this country.

It has been said that we in Pennsylvania and in the nation are late in starting our educational program for the public. Nevertheless, it is being accelerated to perform in a very few years that which should have been undertaken on a national scale throughout a decade.

I wish to discuss briefly the demands that are being made upon the time of a large proportion of our membership throughout the State in attendance upon various medical society meetings, hospital staff conferences, specialty group meetings, postgraduate instruction, committee meetings connected with all the above-mentioned activities, as well as community meetings that revolve around health activities in which the public is interested and cooperative. These demands in many instances require both day and evening attendance, which naturally results in the neglect of one or more of these multiple sources of demand. Too often, I regret to say, the attendance at the regular meetings of the county medical society suffers. This should not be so. The county medical society, being a basic professional organization of all medical organizations, should be so organized as to be the hub around which should revolve a large percentage of professional activ-

ities whose purpose is to keep the physicians abreast of medical progress and provide the community with the best possible preventive and curative medical service.

The above-mentioned multiple attractions have served also to reduce interest and attendance at councilor district meetings, which are designed to bring together members of adjoining county medical societies.

Such meetings presided over by the trustee and councilor for each district should be made as attractive to these neighboring physicians as possible and might in many instances be preceded by the councilor commission meetings which were formerly in vogue for county society officers and committee chairmen of the county societies in the district. To gather around a luncheon table and discuss health and socio-economic problems peculiar to the district; to discuss nominees for the office of trustee and councilor; to arrange for joint county medical society meetings and for meetings to which the public should be invited might well be the prime purpose of many such meetings.

Closer acquaintanceship through expansion of the social phases of medical organization should be developed. By such means as suggested, we might re-emphasize the message delivered at Harrisburg in 1947 by Dr. H. H. Shoulders, of Tennessee, at that time president of the American Medical Association, in which he stated, "The presence of a soul in an individual or an organization is recognized by its humane attributes, such as charity, courage, lofty ideals and loyalty to them, and a genuine interest in the welfare of fellow human beings. Medicine has never been willing to sell its soul for a mess of pottage."

Let us therefore concern ourselves with advancing the science of medicine, with maintaining the standards of medical education, and with delivering an ever improving quality of medical service, being also mindful that science without a soul may be cruel and inhumane, whereas science possessed of a soul may express the very highest achievement by mankind.

Our Society is about to begin remodeling into one administrative unit its two adjacent headquarters buildings on State Street in Harrisburg. Since 1922, when we first purchased one of these buildings to house the offices of the PENNSYLVANIA MEDICAL JOURNAL, our official publication, and headquarters for the Board of Trustees and three employees, our membership has increased from 7,000 to 11,000; our annual dues from \$5.00 to \$15.00; our assets from \$84,000

to \$640,000 (including headquarters building); and our employees from 3 to 25.

So, today, we need increased office and library capacity and the cost of remodeling will approximate \$100,000. That may suggest a raise in annual dues. But, today, 20 per cent of each member's annual dues is immediately allocated to two non-administrative purposes; namely, \$2.00 to the Educational Fund, or \$22,000 annually to provide advanced education for the needy, capable children of deceased or incapacitated members; and \$1.00 to the Medical Benevolence Fund, or \$11,000 toward the aid of members or their survivors in pecuniary distress.

This latter fund is a pet project of the Woman's Auxiliary to our county and state societies. Their total contributions in 25 years approximate \$100,000. Their record-breaking 1949 contribution was \$9,000. As chairman of the Benevolence Fund Committee, I am acquainted with the numerous cases in which relief and security have come to beneficiaries of this fund although I know the names of none of them, so confidential is the conduct of the preliminary survey and the action on all applications.

The Woman's Auxiliary, celebrating its twenty-fifth anniversary this year, has developed into a splendid ancillary group, meeting the public in connection with health-related problems in a way that members of the profession would never have been able to accomplish. Their assistance in developing better public understanding of socioeconomic and political problems closely related to health and sickness service deserves our highest expression of appreciation.

Our Society is to be congratulated on the personnel of its Board of Trustees. During each year they meet eight days and evenings, exclusive of meetings held during the annual convention. Their interim responsibilities are heavy and admirably discharged, but they might be relieved considerably if the House of Delegates held a short meeting early in the spring of the year in addition to its longer fall session.

Something should be said about the recently completed survey of public health facilities in Pennsylvania, which was made at the request of our Society, as approved by the Governor of the State and its Secretary of Health. There must be many useful and practical suggestions in the 350-page volume recently issued after preparation by the American Public Health Association. The opening sentence in the introduction to the report reads as follows: "Pennsylvania can enter a new era in public health," followed by another sentence which states, "Penn-

sylvania has great strength and resources for its public health."

One of my own measurements of successful approach to the "new era" will be based on the degree of improvement in the ten state-owned and controlled general hospitals, none of which now qualify for the intern training and credit which are required for license to practice medicine in our own state.

A current topic, namely, displaced medical personnel, brings to mind the ghastly records of some Continentals too long and too deeply under Nazi control who participated under war conditions in atrociously inhuman experiments on men and women of their own day and generation. With the hope that all foreign physicians of that inhuman stripe have been eliminated from any consideration as future citizens of the United States, we realize that there is a problem created by unsettled political and economic conditions in many foreign countries which leads many who have received their medical degrees abroad to migrate to this country.

The Council on Medical Education and Hospitals of the American Medical Association has sponsored an unofficial board known as the Committee on Foreign Medical Credentials. The personnel of this committee includes individuals from such organizations as the following: Rockefeller Foundation, U. S. Office of Education, World Medical Association, Pan-American Sanitary Bureau, Association of American Medical Colleges, and all the recognized boards in the United States whose function it is to examine and recommend for license to practice medicine or to be designated as specialists.

Doubtless when governments are better stabilized in some foreign lands, the student records of foreign graduates will then supply indispensable information to the state licensing boards throughout our country whose duty it is, in protection of the public, to permit medical practice by none but the well qualified.

Let us now together commit ourselves to the task of so placing our house in order that we may face the future with a calm and steadfast determination to bring to those who need it everything that the science and art of medicine can offer. Doing this we should count on the public to support us in our efforts to keep the politician out of the personal relationship between patient and physician as depicted in the soulful scene by Sir Luke Fildes in his great painting, "The Doctor."

Almighty God has placed us upon this earth to serve our fellowmen. Let us be about our Father's business.

POLYCYSTIC DISEASE OF THE KIDNEY

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THE most widely accepted theory as to the etiology of polycystic disease of the kidney is that of Hildebrand in 1894: "Cyst formation results from the failure of junction of the nephroblastic elements (glomeruli) and the collecting tubules originating from the Wolffian duct, so that the glomerular secretion results in cyst formation." This is in keeping with the pathology found, which shows numerous small cysts giving a honeycomb effect.

This condition has been found in stillborn infants, but a sufficient amount of normal renal tissue may be present to enable the individual to grow to adult life with no apparent handicap. Obviously, life depends on the amount of uninvolved kidney substance.

Polycystic disease of the kidney has been found, according to different observers, from 1 to 5.6 times in every 1000 deaths coming to autopsy. At the Jewish Hospital there were 16 cases of polycystic disease of the kidney in 63,495 admissions in five years, or one in 3968 cases admitted.

Although this condition may be more marked on one side than the other, it is always bilateral and is different from the unilateral simple cysts occasionally found. From its very nature, it is progressive in character.

Nolan stresses the role of heredity in polycystic kidney disease and quotes the cases of:

- (a) Cairns—who found ten cases in three generations of the same family.
- (b) Shapiro—who cited a mother, four children, and one grandchild with polycystic kidneys.
- (c) Goldstein—who noted polycystic kidneys in a mother and four children, and a father and his two children.

Symptomatology

The extent and character of the symptoms depend on the amount of kidney which has undergone destruction by pressure of the cysts. Ap-

parently the destructive changes may have periods of remission in which little cystic degeneration is undergone and then the degenerative process begins again.

Pain is a frequent symptom, dull and acting in character.

Some patients are conscious of a mass which they can palpate or of an increase in girth.

Painless hematuria is a frequent symptom and, if clots are formed in the pelvis, ureteral colic may occur due to passage of such clots.

Most cases generally have the initial symptoms in the early thirties.

Diagnosis

A polyuria with low specific gravity and containing red blood cells and white blood cells and casts is usually found. The blood urea nitrogen is elevated. Combining these findings of chronic nephritis with the finding of large bilateral kidney masses makes the diagnosis not too difficult. The x-ray confirms the diagnosis on the finding of a bilateral dragon deformity of the kidney pelvis. This may vary in degree in the two kidneys.

Treatment

Lowsley and Curtis present a strong case for medical management of polycystic kidneys and reserve surgical therapy for the complications that arise. Renal tissue destruction is slow unless augmented by infection, calculus formation, or back pressure of urine. The avoidance of infection in any form is stressed. Physical and mental rest and avoidance of cold with the use of a low protein diet are measures which have been found of value.

Dodson stresses the poor results in medical management and the fact that progress is always downhill, even if very gradual. He thinks more consideration should be given to the probability of surgical relief in many of these cases.

Definite surgical treatment first was suggested by Rovsing in 1911. He recommended simple puncture and aspiration of the cysts to relieve pressure on the residual kidney tissue or to relieve the pressure on the intrinsic blood vessels

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in cases of hemorrhage. Many modifications of the above and other operations have been advocated. In 1935 Goldstein proposed "the establishment of a temporary, nephrocuteaneous fistulous tract in a nephrostomized, immobilized kidney." This procedure permits re-aspiration of reformed cysts after the incision has healed.

W. W. Young thought it logical to replace the cyst fluid with sclerosing solution to prevent reformation of the cysts and he cites one case treated thus with good results.

None of these methods prevents progress of the underlying disease. However, most men are conservative and resort to surgery only when there is obstruction, stone, infection, severe hemorrhage, or when pain becomes incapacitating. Even in the case of prolonged hemorrhage, palliative and supportive measures are indicated, since it is usually bilateral. Even when hematuria is limited to one kidney, surgery should still be the relatively rare exception. The hematuria may finally abate or the other kidney may also begin to bleed.

Case Reports

CASE 1.—J. O., male, aged 40, was admitted to the hospital in 1939. His chief complaint was pain on the left side of three days' duration, also hematuria. Study revealed a mass in the left upper quadrant with exquisite tenderness.

Cystoscopy showed that no indigo carmine appeared in 10 minutes from either side. Each ureter was catheterized readily. A bilateral pyelogram showed bilateral polycystic disease. The blood pressure was 110/80, 180/120, and 130/90.

BLOOD COUNT

Date	Blood Urea		Red Blood Cells	White Blood Cells	Poly-morphonuclears	Lymphocytes
	Nitrogen	Hemoglobin				
12/20	31 mg. %	102	5,350,000	14,200	92	8
12/24	43 mg. %	63	3,200,000	9,400	87	23
1/16	28 mg. %	68	2,800,000	7,100	79	21

The urine showed a heavy trace of albumin and occasional hyaline and granular casts. There were 3 to 5 white blood cells per low power field.

Operation, because of falling hemoglobin despite transfusions, revealed a polycystic left kidney with blood clots in the ruptured cysts. As many as possible were opened.

The patient was not seen again until 1943 when he started going downhill rapidly. (At this time it was brought out that another brother had polycystic disease.) The patient was readmitted to the hospital Oct. 23, 1943 because of hematuria of nine days' duration. There were no other urinary symptoms. The blood pressure was 160/100.

BLOOD COUNT

Date	Blood Urea		Red Blood Cells	White Blood Cells
	Nitrogen	Hemoglobin		
10/23/43	192	4.5 Gm. (33%)	1,650,000	6,700
10/30/43	264			

Date	Blood Urea		Red Blood Cells	White Blood Cells
	Nitrogen	Hemoglobin		
11/ 2/43	256	8.0 Gm. (58%)	2,900,000	8,800
11/ 5/43	256			
11/ 8/43	285	9.5 Gm. (69%)	3,500,000	11,800

The patient died of uremic poisoning Nov. 13, 1943.

CASE 2.—S. W., male, age 45, was admitted to the hospital July 9, 1934, with acute pain in the left upper quadrant of one day's duration; he came to the hospital for relief. There were no urinary symptoms. He gave a history of right-sided pain four years before and the passage of a small calculus. The impression was that he had nephrolithiasis of the left kidney.

Cystoscopy revealed a normal bladder. Indigo carmine appeared after 13 minutes from the right side—only fair. There was no dye from the left side until a catheter was passed at 15 minutes.

Retrograde pyelogram revealed bilateral polycystic disease.

Operation was performed July 31, 1934, because of continued pain. The left kidney was enormous with many large cysts of bluish discoloration. When punctured, they revealed serous to purulent contents. The blood urea nitrogen was 28 mg. per cent, and 52 per cent of phenolsulfonphthalein was excreted in two hours.

The patient was readmitted Jan. 16, 1938, complaining of palpitation, nausea, and indigestion. There were no urinary complaints. Cystoscopy revealed no indigo carmine in 15 minutes. An intravenous urogram showed no evidence of function. The blood urea nitrogen was 62 mg. per cent, and the blood pressure 250/150. No urologic treatment was given. The patient could not be traced after this time.

CASE 3.—M. W., female, aged 49, was admitted to the hospital in 1928 as a case of pyelitis after being seen first by a general surgeon. Her chief complaint was pain in the back with fever and nausea of six weeks' duration. There were no urinary symptoms.

Cystoscopy revealed cystitis and there was cloudy urine from each kidney. A catheter was placed in each ureter for drainage. Microscopic examination of the urine revealed the specimen to be loaded with white blood cells, and the culture showed diphtheroids.

The patient was first seen by us in November, 1940, at the age of 62. She had a mass in the right upper quadrant, but no genito-urinary symptoms.

Cystoscopy revealed a normal bladder with indigo carmine appearing in 4½ minutes from the right side and in 5 minutes from the left side.

The intravenous urogram showed bilateral polycystic kidney disease. Her blood pressure was 180/130, and the blood urea nitrogen was 32 mg. per cent.

The patient has been watched and checked every year. Urograms have shown the polycystic disease. The blood urea nitrogen has remained around 20 mg. per cent. The systolic blood pressure has varied from 190 to 210. Her general health and appearance have been good.

CASE 4.—T. F., a male, aged 37, was admitted to the hospital April 29, 1947, with hematuria as his chief complaint. He gave a history of having had "back-ache" for ten years. Two days prior to admission he felt his back "slip" and when he urinated he noticed gross blood. There was terminal dysuria; diuria was three to four hours, and nocturia two times. Hematuria had not recurred. He was under treatment for hypertension for eight years.

Upon examination he voided clear urine, and a size No. 21 cystoscope was passed readily. There was no residual urine. The bladder picture was normal, and there was no new growth. There were four whitish pieces of gravel in the base of the bladder.

Indigo carmine showed no return from either side in 20 minutes, but orifices could be seen contracting and expanding and emitting clear urine.

Retrograde pyelogram revealed advanced polycystic disease, but no evidence of calculi. The blood pressure was 200/120, the blood urea nitrogen 48 mg. per cent, and 35 per cent of phenolsulfonphthalein was excreted in two hours.

The patient was referred back to his family doctor, who reported his death six weeks later due to a cerebral accident.

CASE 5.—W. N., male, age 48, was admitted to the hospital March 14, 1944, with pain in the left loin and hematuria of one week's duration as his chief complaint. There were no other urinary symptoms.

Cystoscopy revealed a normal bladder. Indigo carmine appeared in five minutes from the right side (excellent function) and in seven minutes from the left side (good function). The blood pressure was 180/100. The intravenous urogram showed bilateral polycystic disease.

The patient, who has been watched since, has had recurrent bouts of mild hematuria. His blood pressure has remained high, but he has had no complaints aside from hematuria. Occasional pain in either renal area has never been severe or prolonged enough to require surgical intervention. Cystoscopy at such times has revealed bleeding from the kidney affected.

Urograms have revealed no change in size in the past four years.

CASE 6.—A. G., female, aged 57, when seen June 14, 1947, had dysuria as her chief complaint. Three years before she had been studied at another hospital and a diagnosis of polycystic disease of the kidneys was made.

The systolic blood pressure had been 240, but was 170 at this time. Urgency and dysuria had developed.

Examination disclosed hazy, straw-colored urine. Cystoscopy showed low-grade cystitis, ulcerative trigonitis, and chronic urethritis. There was no return of indigo carmine from either side in 22 minutes. Palpation revealed bilateral kidney masses.

The patient was admitted to Jewish Hospital June 17, 1947. Her blood pressure was 190/100. She had large masses in each quadrant. The blood urea nitrogen was 70, chlorides 513, and hemoglobin 9 Gm. On June 18 the patient went into a peripheral vascular collapse, and her blood pressure was 70/40. Despite supportive measures, she died June 19, 1947. No autopsy was performed.

Conclusions

The routine treatment of polycystic kidney disease is largely a medical problem and consists mainly of regulation of the patient's food, drink, and habits.

Surgical intervention is reserved for relief of pain or the symptoms of pressure, infection, cal-

culus, or severe, uncontrollable hemorrhage. It is a difficult matter to puncture a sufficient number of cysts to do the patient very much good, for many of the cysts are situated in the depths of the organ.

The prognosis in such cases is usually bad. Certain patients have had asymptomatic polycystic kidneys that were found accidentally at autopsy. The greater number, however, are handicapped throughout life by diminished kidney function and usually die rather early.

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ABSTRACT OF DISCUSSION

WILLARD C. MASONHEIMER (Allentown): I have only a few observations to make: (1) It is remarkable how these patients maintain renal function. (2) The disease is always bilateral. (3) Medical management of the uncomplicated disease may be advisable, but one should not hesitate to carry out surgical procedures when complications arise.

I had a patient who was suffering from pain and a palpable right kidney. The fact that the pathology was definitely unilateral ruled out polycystic disease, and operation revealed a multiple cyst type kidney.

Another patient had true polycystic kidneys, and in the lower left ureter a stone was impacted at the ureterovesical junction. She had severe anemia, a blood pressure of 150/100, a urea clearance of 19 per cent, chlorides 700 milligrams, serum protein 8 grams, and a 4-4 albumin-globulin ratio. The urea nitrogen was 18 mg., and the phenolsulfonphthalein elimination was 28 per cent in one hour, but only 8 per cent in the first 15-minute period.

The ureterocele was incised and the stone delivered into the bladder and crushed by a cystoscopic lithotrite. The left kidney was explored and the cysts drained, and the patient left the hospital improved.

She returned to the hospital eight months later because of pain in the right kidney and hematuria. The bleeding stopped following rest in bed.

There was some improvement in this patient's general condition, blood pressure, and urea clearance, but I believe this should be attributed to relief of pain and temperature, which followed the removal of the stone, rather than to the operation on the kidney.

The Use of One-tenth Per Cent Pentothal in Clinical Anesthesia

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Philadelphia, Pa.

THE use of sodium pentothal in clinical anesthesia has grown tremendously since its introduction in 1934 by Dr. John S. Lundy. Since then, many methods of administration have been advanced according to the needs of various anesthesiologists. Our purpose here is to present our experiences with a dilute solution of pentothal which we have found valuable for our needs.

The choice of agent and the technique of administration of anesthesia in a large city hospital are affected by many factors which might not be present in other environments. The average patient who comes to us for surgery is more often than not a living textbook of pathology. Many conditions which are direct contraindications to pentothal, perhaps direct contraindications to surgery, are the rule rather than the exception. After several unfortunate experiences with 2½ per cent pentothal, we made a drastic change and switched to 0.1 per cent concentration for routine use.

The solution is prepared by dissolving a 5.0 gram ampule of pentothal sodium in 50 cc. of sterile distilled water. Ten cubic centimeters (one gram) of the stock solution are mixed with one liter of 2.5 per cent dextrose in 0.62 per cent sodium chloride, which makes a 0.1 per cent solution of pentothal. We use 0.1 per cent pentothal to supplement nitrous oxide-oxygen anesthesia, as the induction agent for nitrous oxide-ether or cyclopropane, as a complement to spinal anesthesia, and to supplement a waning spinal. The recovery is usually pleasant and rapid. As in other pentothal anesthetics, there is very little postoperative nausea, vomiting, or excitement. One basic principle to remember in dealing with dilute pentothal is that it is not an anesthetic per se. It is merely a basal anesthetic which must be supplemented with conventional anesthetic agents in order to insure safety and efficiency. The use of enough pentothal, in this or any other concentration, to obtain the ordinarily required levels of clinical anesthesia demands an amount

which, in the minds of some, is contraindicated for the poor risk patient.

From January 1, 1947 through December 31, 1948, we administered 0.1 per cent sodium pentothal to 1560 patients. Almost half the operative procedures performed were gynecologic. Ten per cent were orthopedic cases, many of which were done in our fluoroscopy room where non-explosive agents are essential. Another 10 per cent were urologic procedures, for the most part on elderly patients. There were 31 simple or radical mastectomies. Head and neck cases made up about 7 per cent of our series, as did skin grafts. There were 62 cases in which the patient was in the prone position. While we do not advocate pentothal for surgery done in the prone position, we feel that where its use is necessary, one is far safer in using the 0.1 per cent solution with an endotracheal tube in situ than one would be with more concentrated mixtures. In cases requiring an endotracheal tube, the nose and throat are carefully sprayed with 10 per cent cocaine before the anesthetic is started. The endotracheal tube is sprayed just prior to intubation. This is done to guard against laryngospasm.

The average dose of pentothal for each type of surgery was in most instances extremely small. The importance of such low dosage as 0.3 Gm. for a cervical dilatation and curettage, 0.8 Gm. for a craniotomy, and 0.7 Gm. for a mastectomy cannot be overstressed in view of the physical status of our patients. We have found the use of 0.1 per cent pentothal to be one way of exercising the caution necessary in the aged group.

At first glance one might be afraid that the use of 0.1 per cent pentothal entails giving so much fluid as to overload the circulation. We have had little actual difficulty along these lines. Discrete regulation of the flow of pentothal is all that is required to prevent over-hydration, since the patients who cannot take a large quantity of fluid are the same poor risk patients who require only a small amount of pentothal.

From the Department of Anesthesiology of the Philadelphia General Hospital.

Most of the advantages of pentothal as a supplementary agent in anesthesia are had with the dilute concentration discussed here. By using a 0.1 per cent solution we are able to give pentothal with comparative safety to patients who might otherwise be denied the benefits of this agent. Our hospital sponsors an intensive intern and resident training program. Consequently, besides trained medical anesthesiologists, we have residents in anesthesia who are in various stages of development and interns who give anesthesia

in a perfunctory manner as part of their rotating internship. These latter two groups are usually unaware that even the simplest of anesthetic procedures may be fraught with danger. We believe that in the hospital where fully trained professional anesthetists are not available, the use of this solution increases the safety of pentothal anesthesia.

The assistance of W. Lyall Howell, Jr., M.D., now serving in the U. S. Army, is gratefully acknowledged.

DISTRIBUTION OF PHYSICIANS' FEES

One of our local surgeon members told us recently of a technique he used to interpret the cost of modern medicine to his patients.

The surgeon had performed a hysterectomy on a woman whose family was of moderate means. The husband called at the doctor's office to pay the bill.

In a personal interview, the doctor explained to the husband that 20 per cent of the total bill went to his surgical assistant. The cost of running the doctor's office for *one* day took another 40 per cent. The surgeon retained 40 per cent as his fee for services rendered.

The patient's husband was amazed at the explanation of distribution. His reaction was:

"Doctor, I wish I could pay *you* more. I never thought about all the expenses you have. I assumed *you* got the whole amount."

And such is the thinking of the average layman. The heavy cost of the doctor's education and training—the great outlay for modern equipment and its upkeep—the expenses of rent, transportation, and personnel—the necessary standard of living in the doctor's own home establishment—these are matters little understood.

We are told that many of our local members take the time and trouble to explain their fees and their distribution to patients. Is this an effective way of building good relations for the profession?

We believe it is. It hits the public in the pocket-book.

One *poorly handled* contact between doctor and patient gets more circulation than ten good impressions developed by an M.D. with his patients.

No profession has as good an opportunity for building good-will as has medicine. But *organized* medicine, so-called, cannot accomplish the job *as a group*.

It rests squarely on the shoulders of each *individual* doctor in the organization—in his *day-to-day* doctor-patient contacts. Each doctor has his own conception of public relations. Some are good; some are bad. The net result is the cumulative effect on the public.

One state is building its entire public education campaign on compulsory health insurance in a grass-roots effort to *teach and improve* the human and public relations of *every member* with his patients.

What is public relations?

In the abstract, it can be termed an inexact science. In a practical analysis can it be called more than treat-

ing patients and public with consideration and honesty—the winning of friends who understand—the building of good-will with each patient and his family?

It sounds simple.

By big business, public relations is considered important enough to budget heavily to insure the *right kind* of relations with the public.

Great efforts and expense are now being put forth to educate the public as to the advantages of a voluntary system of medical protection versus a compulsive system. There are almost as many ideas about how to do it as there are members of the profession.

But the people will decide. And their decision will be based largely on the way they are handled by *individual doctors*, or by their impressions of the strengths and weaknesses of medicine as practiced today.

In other words, the collective public relations of medicine will count. But *above all* the *individual* public relations of each doctor is the final answer to what the public—and the politicians—will think of us.—*Bulletin of the Dade County Medical Association, Inc., Florida.*

ONE SCHOOL CHILD OUT OF FIVE HAS DEFECTIVE EYES

A recent survey indicates that more than 4,500,000 of America's school children cannot see clearly.

These figures on the number of school children with defective eyes were gathered in a survey by the National Society for the Prevention of Blindness. The survey was made during the month beginning September 14.

"Roughly, one-fifth of all children at school are found, when their eyes are tested and medically examined, to have some form of defective vision," the Society reports.

To prevent further impairment of the eyesight of school children, the Society recommends better lighting of classrooms, non-glare surroundings, coloring of walls and floors according to modern illumination standards, light-adjustable desks, and more legible reading material.

State commissioners of education and county and city superintendents of schools, from Maine to California, sent reports to the Society.—*The Diplomat*, May, 1949.

The Bacteriology of Industrially Laundered Baby Diapers

A Three-Year Survey

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THE bacteriologic examination of diapers began in 1941, but remained somewhat limited to a small group of the earliest founders of the diaper service industry.

Toward the end of the war it became possible to establish a more regular routine system than was possible previously. In the meantime a large group had been organized into an association which required a high standard of bacteriologic efficiency for admission to membership, making it essential for them to meet certain laboratory standards that could be maintained only by hygienic plant practice.

During this period, as a result of the war, the diaper laundries were confronted with many difficulties in procuring equipment such as boilers, mechanical apparatus, chlorine for sterilization and bleaching, soap, and even fabrics for the manufacture of diapers.

The studies described in this report were made during 1945 to 1947 inclusive, and cover the methods used and the results obtained from the examination of 1665 processed diapers.

Diapers were picked at random by plant superintendents after all processing had been completed including folding, which is done by hand.

The samples, after being wrapped in new paper, were placed in heavy Manila envelopes and sent by first class or air mail to the laboratory.

A close approximation of the reaction, hydrogen-ion (pH) concentration, of diapers was made by adding one or two drops of a universal indicator to various parts of the dry samples after the sections had been cut for bacteriologic purposes. This enabled us to detect improper rinsing, as evidenced by varying pH values found in different areas of the diapers. A range of pH 4.5 to pH 7.5 was considered satisfactory; however, in view of the change of reaction, becoming alkaline due to the bacteriologic decomposition of urea in the urine, particularly when soiled diapers are allowed to remain on infants

for any length of time, it would seem that a pH of 5.0 might be preferred.

In our earlier studies of diapers, it became evident that bacteriologic examinations must be directed to skin, intestinal, and other organisms and not to *B. coli* alone, as the indicator of fecal contamination.

Cultural Methods

Two patches of double-thickness diaper, approximately two inches square, were cut from different parts of each diaper under aseptic conditions. This represented sixteen square inches of diaper, since cuts are made through two layers of material. Two patches were placed in Smith fermentation tubes containing approximately 50 ml. of F. D. A. lactose broth. The remaining patches were placed in sterile Petri dishes into which was poured sterile nutrient agar at a temperature of 45° C. sufficient in amount to cover the patches.

The fermentation tubes and agar plates were incubated for 48 hours, after which the tubes



Fig. 1. Sterile diaper.

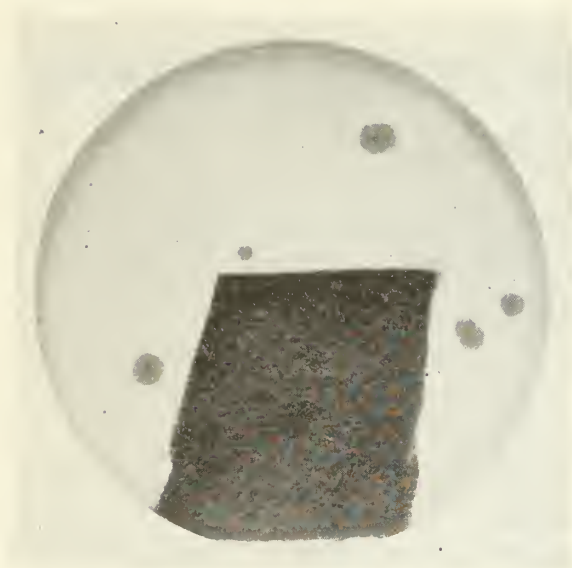


Fig. 2. Diaper revealing few colonies (saprophytes).

were examined for the presence of gas and the plates for pathogenic organisms. Subcultures were made to agar plates from all fermentation tubes showing growth and, wherever gas was present, additional subcultures were made to "S. S." agar plates for the isolation of possible members of the Salmonella group. The subcultures were incubated from 24 to 48 hours and all suspicious colonies were fished to blood agar and other differential media depending upon the types of organisms isolated.

Staphylococcus albus was found most frequently during each year. Since it was isolated only by subcultures in 71.1 per cent of the sixty-five samples in which it was found, one may conclude that it was present in very small numbers in this group of samples.

Streptococcus faecalis was next highest in in-

cidence during the three-year period. However, in 25 per cent of the forty-nine samples in which this organism was found, it was isolated from the fermentation tubes by subculture only.

As greater heat or an increased concentration of a germicide such as chlorine is necessary for the destruction of this organism, it is not altogether surprising to find it more frequently than other organisms more easily killed.

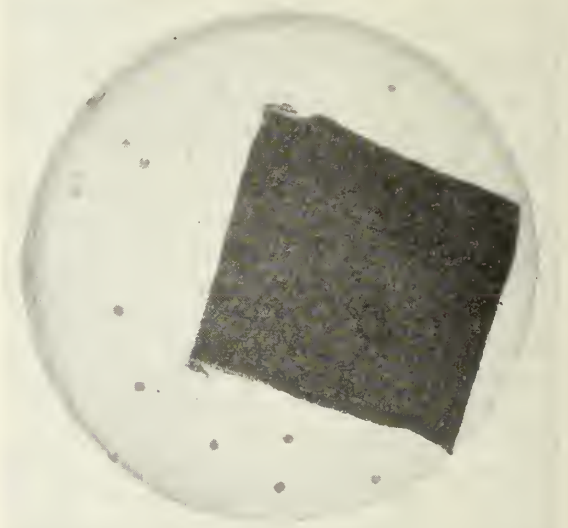


Fig. 3. Diaper which revealed moderate number of colonies.

It will be appreciated that on some occasions several types of organisms were isolated from a single sample and different combinations of organisms were encountered throughout the study. For this reason all organisms are listed under a separate heading. At first glance this may give the impression of a high incidence for certain of them. However, the true picture becomes appar-

TABLE I
COMPARISON OF THREE-YEAR STUDY

Organisms	1945		1946		1947	
	Incidence	Per cent per total number of examinations	Incidence	Per cent per total number of examinations	Incidence	Per cent per total number of examinations
<i>Staphylococcus albus</i>	25 }	15.5%	20 }	15.0%	18 }	10.2%
* <i>Staphylococcus albus</i>	40 }		60 }		55 }	
<i>Streptococcus faecalis</i>	36 }	11.7%	16 }	4.5%	25 }	4.2%
* <i>Streptococcus faecalis</i>	13 }		8 }		5 }	
<i>Escherichia coli</i>	18	4.3%	5	0.9%	8	1.1%
<i>Alcaligenes faecalis</i>	15	3.6%	16	3.0%	9	1.7%
* <i>Staphylococcus aureus</i>	1	7.9%	0 }	1.1%	0 }	0.56%
* <i>Staphylococcus aureus</i>	0		6 }		4 }	
<i>Bacillus proteus</i>	0		2		0	
<i>Pseudomonas aeruginosa</i> ..	0		0		1	

* Subculture from fermentation tubes only.



Fig. 4. Diaper revealing many colonies.

ent if one compares the different organisms isolated with the number of samples from which they were obtained.

The incidence of the coliform group was much lower than the organisms previously mentioned, and it is of interest to note that when this group was present, other organisms were also isolated. During the whole three-year period *B. proteus* was present on but two occasions and *Pseudomonas aeruginosa* on one.

*Staphylococcus aureus** was found on eleven occasions during the three-year period from the 1665 samples examined. It was present in only one instance by direct culture, and then only in small numbers.

A scoring system was adopted. Sterile diapers earned 100; those revealing occasional or few saprophytic bacteria only received scores ranging from 95 to 80 depending upon the number of

colonies found; however, those with excessive numbers of saprophytes were scored as failures (see Fig. 4).

The presence of any pathogen, even when obtained by subculture only, was considered a failure, including the non-hemolytic *Staphylococcus albus* not infrequently found on the normal skin, and about which there is some question of pathogenicity.

TABLE II
DIAPER EXAMINATIONS

	1945	1946	1947
Members	38	60	69
Total examinations	418	534	713
Sterile samples .	66-14.8%	115-21.5%	202-28.5%
Passing scores	305-73.2%	428-80.2%	622-88.5%
Failures	113-26.8%	106-19.8%	91-11.5%

The saprophytic non-pathogenic spore-bearing bacteria isolated have not been discussed here, but they are of interest since many of them require considerable heat for their destruction and for this reason, depending upon the number which may be found in a diaper, their presence in a measure determines whether or not adequate water temperature has been maintained during the washing processes, also the exposure to dust in the folding and finishing rooms.

Conclusion

The report covers a complete bacteriologic study of laundered diapers during a three-year period. The improvement in processing is shown in Table II, the percentage of members submitting sterile diapers 14.8 per cent (1945) to 28.5 per cent (1947) and those receiving passing scores increased from 73.2 per cent (1945) to 88.5 per cent (1947).

The maintenance of rigid standards in plant practice by plant superintendents and other personnel during the process of handling, in some instances, millions of diapers weekly makes it possible to place diapers of hygienic quality in the home.

We wish to thank the members of The National Institute of Diaper Services for the grant which made this study possible.

We are indebted to the plant owners and superintendents for their fine cooperation and to Mr. Clifford Reichenbach for his assistance in the bacteriologic studies.

*During the period of this study, both soiled and "wet" diapers have, in some fifteen instances, been submitted from babies having so-called diaper rash. We have invariably found *Staphylococcus aureus* and occasionally hemolytic streptococci in such diapers. However, in no instance were these organisms found in unused (control) diapers obtained from the home of the child.

Staphylococcus aureus and hemolytic streptococci have not been found in the regular routine examination of laundered diapers submitted by a member who had on any occasion submitted diapers taken from patients with a rash.

The bacteriologic findings of diapers from babies having a rash indicate that the skin of babies becomes irritated due to the ammonia produced as a result of decomposition of urea in the urine by fecal organisms. The irritation becomes further aggravated by *Staphylococcus aureus* and/or hemolytic streptococci, resulting in an infection.

Combined One-Stage Pharyngeal Diverticulectomy

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IN PREVIOUS reports^{1, 2, 3} the author has advocated the combined one-stage method of operation for the removal of pulsion pharyngeal diverticulum. The term "combined" refers to the simultaneous collaboration of surgeon and esophagoscopist throughout the entire operation as well as during the preoperative and postoperative periods. Experience gained in 204 consecutive personal cases has proved that this method is safe and effective, regardless of the age of the patient or the size of the sac. It is the purpose of this paper to analyze this series and describe the present operative technique.

Incidence

The age extremes were 37 and 84, the average age being 60 years. Eighty-two per cent of patients were past 50 years. Males predominated almost four to one. None of the patients were Negroes. At Jefferson Hospital, the approximate incidence of these diverticula among total admissions is 1 in 1400, among total operations 1 in 800, and among total esophagoscopic examinations 1 in 30. Responsibility for this unusually high incidence began with Dr. W. Joseph Hearn,⁴ who in 1896 at Jefferson Hospital performed the first deliberate extirpation of one of these sacs in the United States. In 1915 Gaub and Jackson⁵ first advocated the use of the esophagoscope during the operation. Since then the writer has devised his present operative procedure.

Etiology

Although the exact cause for the development of a pulsion pharyngeal diverticulum is not known, it is generally accepted that intrapharyngeal pressure acting, during deglutition, from within outward upon a vulnerable area in the muscular wall is a definite factor. It is debatable whether the vulnerability is due to the normal penetration by nerves, blood vessels and lymphatics, congenital muscular defect, neuromuscular incoordination, or a combination of these.

Pathogenesis

Almost all pharyngeal diverticula arise from the left lateral wall of the pharynx between the lowermost fibers of the inferior constrictor muscle and the upper border of the cricopharyngeus. Descent of the enlarging sac in the retropharyngeal space produces a torsion of the lower pharynx and upper esophagus in a counterclockwise direction. This causes a rotation of the sac orifice from a left lateral to a posterior position. This explains why the orifice of the sac as viewed through the esophagoscope was approximately in the mid-line posteriorly in 60 per cent of the cases in this series. The surgeon, however, makes his observation when the torsion defect has been corrected by his dissection.

Pathology

The diverticula varied in size from 1 to 8 cm. in their greatest diameter, but the majority measured 2.5 to 5 cm. Inflammation of the mucosal lining of the sac was noted by the esophagoscopist in 77 per cent of the cases, and in 16 per cent it was severe. This explains the adherence to surrounding tissues so commonly noted at operation.

Although the largest pharyngeal opening en-

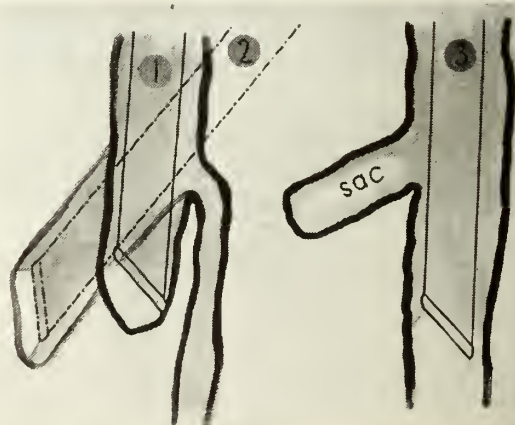


Fig. 1. Esophagoscopic technique: (1) esophagoscope is introduced into diverticulum, and sac is cleansed from within; (2) diverticulum transilluminated and rotated to aid surgeon in identification of sac; (3) esophagoscope passed beyond mouth of sac preparatory to amputation. (This step will prevent postoperative stricture and rotation of the lower pharynx and upper esophagus.)

Read before the Section on Surgery at the Centennial Celebration Session of The Medical Society of the State of Pennsylvania in Philadelphia, Oct. 5, 1948.

From the Samuel D. Gross Surgical Division of the Jefferson Medical College Hospital.

TABLE I
CONCOMITANT DISEASES AND COMPLICATIONS IN LAST 100 CASES

<i>Preoperative</i>	<i>Number or Per Cent</i>	<i>Postoperative</i>	<i>Number or Per Cent</i>
Cardiovascular (auricular fibrillation, heart block, hypertension)	6	Temporary vocal cord paralysis	9
Pulmonary (tuberculosis, fibrosis, asthma)	3	Wound infection	5
Urinary retention	3	Simple	4
Traction esophageal diverticula	3	With fistula	1
Miscellaneous (duodenal ulcer and diverticulum, papilloma of larynx, diabetes, arthritis, severe inanition requiring gastrostomy)	6	Parotitis	2
		With recovery	1
		With uremia and death	1
		Atelectasis	2
		Auricular fibrillation	1
		Pneumonia and death	1
		Recurrence	1

countered was 4 cm. in diameter, a sac neck larger than 1.5 cm. in diameter usually indicates incomplete dissection. In two instances the fundus of the sac was bilocular, but there was only one opening into the pharynx. In many instances the fundus of the sac extended well into the superior mediastinum. Multiple pharyngeal diverticula were not encountered, but three cases were associated with traction esophageal diverticula and one with a duodenal diverticulum.

Microscopically, the diverticulum consists of a fibrous tissue wall lined by stratified squamous epithelium. In the wall there are usually dilated blood vessels, small foci of inflammatory cells, and occasionally a few scattered striated muscle fibers.

Malignant change was not encountered in this series.

Symptoms and Signs

The duration of symptoms varied from a few weeks to forty years, the average being four and one-half years. Those commonly encountered were dysphagia (86 per cent), regurgitation (83 per cent), noisy deglutition (64 per cent), weight loss (44 per cent), and cough (35 per cent). Those less commonly encountered were expectoration of mucus (11 per cent), fullness in the throat (10 per cent), choking sensation (10 per cent), soreness in the neck (7 per cent), and hoarseness (2 per cent). Only one of these, namely, noisy deglutition, deserves special mention, since it is seldom encountered in other lesions producing dysphagia. It occurs during swallowing when the sac contains fluid and air, and is usually accompanied by a gurgling sen-



Fig. 2. Steps in excision of pharyngeal diverticulum: (a) identification of sac by esophagoscopy transillumination; (b) freeing of sac neck to submucous coat; (c) ligation of sac neck, with esophagoscope in place; (d) ligation completed; (e) severance of sac neck between ligature and clamp; (f) sterilization of stump.

sation palpable at the site of the sac. Pressure on the neck over the sac will sometimes express its contents into the patient's mouth. In other cases physical signs may be altogether lacking.

Diagnosis and Differential Diagnosis

Although the clinical picture of pharyngeal diverticulum is as a rule typical, it is always necessary to differentiate it from cicatricial stenosis and carcinoma of the cervical esophagus. While this can be accomplished by the roentgenologist alone in the majority of cases, it is often necessary to have the esophagoscopist make the final conclusive study. Therefore, in all lesions of the pharynx and esophagus both roentgenologic and esophagoscopy studies should be performed.

Treatment

Preoperative.—In this series, the average length of time required to prepare patients for operation was five days. During this period, therapy is directed toward correction of nutritional deficiencies such as secondary anemia, hypoproteinemia, and avitaminosis by dietary and parenteral methods. In a few instances tube feeding was necessary and in 10 cases preliminary gastrostomy. Concomitant diseases (Table I) require special attention and often prolong the preoperative period. The day before operation, the patient swallows several feet of thread to aid passing the esophagoscope into the subdiverticular esophagus at operation.

Operative.—The salient features of the combined one-stage procedure, previously described,¹ are as follows: first, cleansing and emptying of the sac through the esophagoscope; second,

maintenance of the normal anatomic position of pharynx and upper esophagus by keeping the esophagoscope in the esophagus during ligation of the sac neck and transplantation of its stump, as well as during the entire period of pharyngeal repair. The restoration of normal anatomic alignment, which is assured by this method, favors normal function after healing has occurred. Open drop ether anesthesia has proved to be most satisfactory for this operation.

Esophagoscopic Technique (Fig. 1).—It is important to empty the contents of the pouch, since it is common to find secretion and not infrequently masses of food. These should be removed to prevent overflow into the trachea when the pouch is manipulated.

Identification of the diverticulum by the surgeon can be accomplished promptly if the tip of the esophagoscope is introduced into the pouch so that it can be palpated through the incision and the sac transilluminated. After it is clearly identified and partially separated, further esophagoscopic assistance is unnecessary until ligation of the neck of the pouch. The esophagoscope is then introduced into the subdiverticular esophagus, guided by an olive-tipped bougie passed over the thread swallowed the day prior to operation. This avoids the occurrence of esophageal stenosis which might ensue if too much of the pharyngeal and upper esophageal walls is removed. In addition, it also aids the surgeon in removing the entire pouch.

At the conclusion of operation, a feeding tube is inserted through the esophagoscope into the lower esophagus. The esophagoscope is then removed without disturbing the feeding tube, the



Fig. 3. Steps in repair of pharyngeal wall following excision of diverticulum: (a) transplantation of stump beneath inferior constrictor muscle; (b) approximation of cricopharyngeus to inferior constrictor muscle; (c, d, and e) anchoring of posterior suture to prevertebral fascia; (f) pharyngeal repair completed.

proximal end of which is withdrawn through the nose.

Surgical Technique.—An incision is made along the anterior border of the left sternocleidomastoid muscle from one inch above the sternum to the level of the hyoid bone (Fig. 2), passing through the skin, platysma, and deep fascia, exposing the anterior belly of the omohyoid muscle. The latter may be severed or retracted. The diverticulum is then approached in incising the pretracheal fascia near its lateral margin, retracting the contents of the carotid sheath laterally and the thyroid gland and trachea medially. It is sometimes necessary to divide the inferior thyroid vessels for better exposure.

The fundus of the sac, which is now rotated into the wound and transilluminated by the esophagoscopist (Fig. 2a), is grasped with intestinal forceps and drawn upward and outward, after which the esophagoscope is withdrawn from the sac. The diverticulum is then entirely freed to its junction point with the pharynx (Fig. 2b). Care must be exercised to free all muscle fibers from its neck, exposing the submucous coat. This will assure stability of the ligature to be placed subsequently by minimizing the amount of tissue included in it.

A moist sponge is packed in the lower pole of the wound to safeguard the mediastinum from contamination. Then, with the esophagoscope in the esophagus, a transfixion suture of No. 1 chromic catgut is placed in the sac neck at its junction with the pharynx and the ends left long (Fig. 2, c and d). An additional braided silk tie is used for reinforcement when the sac neck is edematous or unusually large. After clamping a hemostat across the sac neck just distal to the ligature, the sac is severed between the ligature and hemostat (Fig. 2e). Phenol and alcohol are applied to the stump (Fig. 2f), following which the protective sponge previously placed is removed. The long ends of the transfixion suture are used, and the stump is transplanted upward beneath the inferior constrictor muscle (Fig. 3a). The muscular defect in the pharyngeal wall is now corrected by approximating the upper margin of the cricopharyngeus to the lower margin of the inferior constrictor with interrupted No. 1 chromic sutures spaced about 1 centimeter apart (Fig. 3, b and c). The posterior portion of the suture line which overlies the retropharyngeal space is anchored to the prevertebral fascia (Fig. 3, d, e, and f). This important stitch obliterates the retropharyngeal space at this point, erects a barrier against descending infection into the mediastinum by way of the retropharyngeal

space, and reinforces the posterior portion of the suture line. The incision is closed in layers around a small Penrose drain placed in the lower pole of the wound. The average operating time for this procedure is forty-five minutes.

Postoperative.—The usual hospital stay after operation is three weeks, but only during the first day or two is the patient confined to bed. Penicillin is administered hypodermically during the first six days. The wound is treated as in any clean case and the Penrose drain is removed on the seventh day. A concentrated liquid diet is administered through the indwelling nasal tube in increasing amounts. In order to maintain nutritional and fluid balance during the first few days, additional fluids and vitamins are administered parenterally. The nasal tube is left in place for eighteen days, acting as a splint during the healing process. A day or two after its removal, roentgenologic examination of the swallowing function is done. By this time the operative site is healed and a soft diet readily tolerated.

Complications

Complications occurring in the author's earlier series have been described in previous reports.^{1, 2, 3} Those occurring in the last 100 cases are listed in Table I. The most frequently observed complication was unilateral vocal cord paralysis, which was temporary in all instances. The normal location of the recurrent nerve at the lower border of the inferior constrictor muscle is a vulnerable one. In one instance paralysis of the left vocal cord was present before operation. Injury to this nerve can be minimized only by exercising care during retraction of the thyroid gland and trachea, freeing of the sac, and repair of the pharyngeal wall.

Only one of the wound infections did not respond readily to chemotherapy and local conservative measures. In this instance a fistula persisted for ten weeks, but then remained healed. Mediastinitis was not encountered in the entire series of 204 cases.

In several instances postoperative roentgenologic examination revealed retention of a speck of barium at the operative site. These dimples were not associated with symptoms and the patients were considered cured. One patient, however, was well for six months, then had a mild recurrence of symptoms. Roentgenologic and esophagoscopy examinations revealed a pharyngeal sac which was deemed too small to warrant reoperation at that time. She was advised to return for follow-up six months later, but failed to do so.

Mortality

In the entire series of 204 cases there were 5 deaths, or a mortality of approximately 2.5 per cent. The causes were pneumonia in two instances, uremia in one, uremia with parotitis in one, and coronary occlusion in one. It is therefore apparent that the mortality of one-stage pharyngeal diverticulectomy is not greater than would be expected for any other major operation in this age group.

Conclusions

1. The combined one-stage method of pharyngeal diverticulectomy has proved its safety and effectiveness in this series of 204 consecutive cases because of the absence of mediastinitis, a mortality of 2.5 per cent in an age group averaging 60 years, and only one recurrence.

2. Meticulous repair of the pharyngeal wall is essential. Anchoring the posterior portion of the suture line to the prevertebral fascia is advocated because it strengthens the repair, obliterates the retropharyngeal space at this point, and erects a barrier against descending infection into the mediastinum.

3. Esophagoscopy assistance during the operation is also essential, since it provides for cleansing of the sac from within, allows easy identification of the sac by the surgeon, and insures against stenosis or angulation at the site of the repair.

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ABSTRACT OF DISCUSSION

W. WAYNE BARCOCK (Philadelphia): The early experiences with these diverticula evidently were associated with a mortality that was frightening, because the early papers of the Mayo Clinic emphasized strongly the danger of a secondary mediastinitis and death, and this danger, I believe, continues even today with a two-stage operation. In Boston, at the Lahey Clinic, I do not think Dr. Lahey would consider any one-stage operation, yet the patients are subjected to a great deal more trouble and a scar in the neck that may be quite unsightly, and the results are not as good as would be obtained by an operation such as Dr. Shallow has described.

Dr. Shallow mentioned that we owe a great deal to Dr. Chevalier Jackson, who upon developing his very useful esophagoscope soon began to find these diverticula. While working in Pittsburgh he interested a

local surgeon, Dr. Gaub, who developed a satisfactory operation for closing them, and when Dr. Jackson came to this city, first at Jefferson Hospital, he had the advantage of working with Dr. Shallow. Again a group of patients was brought to the hospital such as, I dare say, had not been seen before, and so it was when he came to Temple University. I had never seen what we call a diverticulum of the esophagus. Dr. Jackson went along with us before he asked if I would care to operate on these patients. I didn't know how to do the operation and I didn't want to get advice from Dr. Jackson, but in his coy way he led me on and gave guidance which was very helpful. He reduced the hundreds of cases performed in Philadelphia and elsewhere with a one-stage operation.

In the two-stage operation, after the incision is made, the sac is usually fastened so that its mouth will be dependent in the neck, and then when adhesions have formed after some days, the sac is cut away and usually the neck is left completely open so that the esophagus drains through this wound. When adhesions have been formed, and the wound is more or less clean, either it is permitted to close spontaneously or sutures may be put in to aid the process, but in many cases the treatment of the wound consists of simply permitting it to heal spontaneously, and the patient has weeks of disability and a scarred neck.

I have been much interested in Dr. Shallow's simple procedure, because I had thought it was necessary to sew the necks of these sacs very carefully with a delicate intestinal type of suture in two layers, and feared that if I transfixed and ligated the sac the ligature would cut through and there would be spilling. However, Dr. Shallow has shown that that does not occur, which greatly simplifies the operation, because the fine suture, deep in the neck, is rather difficult and, as we have used the transverse incision, which does not give as much room, it has made it even more difficult.

In our series we had one case with slight leakage in the mediastinum, as shown by the presence of barium given by mouth. There were no serious symptoms and, by drainage, the patient made a satisfactory recovery. On Dr. Jackson's service, from time to time, we saw perforations of the esophagus caused by people swallowing dentures with sharp hooks on them, or bones, or other things that perforate the esophagus—we saw what are supposedly very dangerous peri-esophageal abscesses from perforation, and yet these patients never died. Even if the perforation were low in the esophagus, by separating the esophagus and going down low in the neck, and getting the cellular space about it, even these abscesses would drain through the neck.

We saw one death from a diffused phlegmon involving the entire neck as well as the mediastinum. That, of course, was a different procedure.

The tendency still to do these operations in the old open way in Boston and in Rochester, Minn., is surprising. However, in recent years one of the Boston surgeons has had the temerity to try to find a single-stage operation. Having tried five and not having satisfactory results, he said that possibly it was equally safe with the open operation, and he was going to try more, because he needed experience to tell whether an operation was safe or not. If he had simply called upon Dr. Shallow, he would have found that the operation had been done on large numbers of people and the mortality was really trifling.

Experiences with Retropubic Prostatectomy

Report of 25 Cases

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THREE principal operative approaches to the prostate gland have been recognized and all have their proponents. The results obtained by the master surgeons in each approach have been good, but the morbidity generally obtained leaves much to be desired. I do not intend to enter into any controversy with the proponents of the three various routes used today in prostatic surgery or to try and influence them in any way to change their approach. My only purpose is to report my experiences with 25 cases of benign prostatic hypertrophy cured by the retropubic approach.

At the annual meeting of the American Urological Association in Buffalo in 1947, Millin¹ reported 1503 cases of retropubic prostatectomy performed in Europe; 402 he did personally, with an average mortality of 5.3 per cent. At that time he visited several large clinics in the East and demonstrated his operative technique.

Bacon,² Austin and Quinby,³ Stratte,⁴ and Lowsley and Gentile,⁵ to name a few American urologists who have reported small series of cases, are all quite enthusiastic about the retropubic approach to the prostatic problem.

In March, 1948, Moore reported 46 cases before this society at Hot Springs, Va. He used no special instruments, but as a complication he reported 8 cases of osteitis pubis. This report did not stimulate me to do the operation.

Nelson in his discussion of Millin's paper said: "We must keep in mind that he possesses a degree of surgical dexterity which is obtainable by only a few. If we try to follow him without adequate study and preparation, we will likely find ourselves in an embarrassing situation." This statement gave me the impression that only a master surgeon should attempt the operation. I assure you that I am not a master surgeon, but just average. This again was a deterring factor in not performing retropubic prostatectomy but to stick to my suprapubic route for the larger glands.

After seeing the marvelous drawings by Didusch in Lowsley and Gentile's article in the *Journal of Urology*, I became impressed with the simplicity of the operation and anatomical approach to the prostate. In May of last year I found the first case which I thought was suitable. The man was thin and the operation went quite smoothly. There was some suprapubic leakage of urine on the third day after a blood clot was expelled through the lower angle of the wound. This cleared up the next day. The urethral catheter was removed on the ninth day and the patient was discharged on the twelfth postoperative day, voiding normally every two to three hours. All of us, including the nurses, were surprised at the minimum amount of care required and the smooth recovery. This case stimulated our interest in the operation.

Retropubic prostatectomy is in truth a perineal prostatectomy upside down, having all the advantages of that procedure without the possibility of rectal injury and the disturbances of the pelvic floor which at times cause incontinence and sexual impotency.

The same meticulous preoperative care is used, no matter which approach is finally decided upon. The final decision as to the operative approach is still made at the time of cystoscopy. All our cases have preliminary catheter drainage. The other details of the preoperative care will not be repeated, as all are familiar with them.

No special instruments are used. Single shot spinal anesthesia is the anesthetic of choice. The inlying catheter is removed after emptying the bladder. A mid-line incision is made about 3 to 4 inches long, starting over the symphysis pubis. We have never used the transverse incision. The rectus muscles are separated in the mid-line exposing the prevesical space. A Randall self-retaining retractor is then introduced and the prevesical space is incised, exposing the bladder and prostatic capsule at its junction. The prevesical fat and peritoneum are pushed backwards and upwards. The self-retaining retractor is removed

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and a Balfour retractor is inserted into the wound.

For posterior retraction we have been using a malleable two-inch retractor which we have made to fit on the sliding bar of the Balfour. If the patient is quite obese, a large mop is folded and placed beneath the malleable retractor over the bladder. The index and middle fingers are then introduced on either side of the prostatic capsule. This maneuver is very essential as it serves in helping to outline the true size of the gland and brings the prostate more into view. The fatty tissue between the symphysis and the anterior surface of the capsule is then pushed off exposing the bare prostatic capsule. If any large veins are seen, they are clamped and coagulated. In exposing this area we prefer small mops on a sponge holder.

Two gauze packs are next introduced deep into the lateral recesses, one on either side of the prostatic capsule. These packs fix and elevate the prostate and should be introduced well under the pubic arch. At no time has it been necessary to introduce a finger in the rectum, even in adipose individuals. Beneath the endopelvic fascia, in the majority of cases, a single vein can be seen running down the middle of the anterior capsule of the prostate. At times two veins are seen in close approximation.

An area about one centimeter below the vesicoprostatic junction is selected as the point of entrance into the prostatic capsule. Below and above this point the veins are transfixed, care being taken to penetrate deep into the prostatic capsule. If bleeding is encountered, the needle is withdrawn and placed deeper into the prostatic capsule. These sutures are left long for traction. A transverse incision is made into the prostatic capsule exposing the hypertrophied gland which is easily recognized by its greyish-white appearance. Several smaller veins can now be seen that have been cut. These are grasped and coagulated.

Enucleation is begun by blunt dissection, using a long scissors, and continued with the finger until the entire hypertrophied mass has been separated. The urethra is also separated from the apex of the prostate by blunt dissection. The urethra frees easily and does not have to be cut as recommended by some authors. The entire prostate is then turned upwards through the capsular incision. The remaining attachments of the prostate at the vesical neck are next separated by blunt dissection until the entire adenoma is held by a cuff of mucosa which is incised. A temporary pack is placed in the prostatic cavity for

a few minutes in order to control bleeding. Most of the bleeding usually stops at this time. When the pack is removed the remaining bleeding points are coagulated after careful visualization.

On several occasions it has been necessary to place a suture ligature through the prostatic capsule in order to control large bleeders. We feel that this careful attention to hemostasis will prevent early postoperative bleeding with blocking of the urethral catheter due to clots. The vesical neck is examined and if the floor is elevated a section is removed. This again we consider an essential procedure in preventing postoperative strictures. A 24 Fr. Foley catheter is introduced through the urethra and into the bladder. We use the 30 cc. bag routinely in case the bleeding at the vesical neck is excessive and traction has to be applied. On several occasions in the earlier cases, it has been necessary to introduce two pieces of oxycel gauze in order to obtain complete hemostasis. The capsule is closed with interrupted sutures of 0 chromic catgut. This at times was reinforced with a second layer of sutures. This second layer of sutures is not essential and at times causes new capsular bleeding.

The bag portion of the catheter is next filled with water and the bladder irrigated with sterile water in order to be sure of a watertight joint. The first irrigation contains a few blood clots. In the first few cases, due to incomplete hemostasis, there was some oozing from the capsular incision and a piece of oxycel gauze was placed over the line of incision. This I would not recommend, as it is not absorbed from the prevesical space and usually sloughs out through the lower angle of the wound even though there is no urinary leakage. We have now found, if bleeding appears to be excessive from the capsule, that pressure with a gauze sponge for a few minutes will usually suffice.

The original packs of gauze which were placed in the lateral regions are now removed. A small Penrose drain is inserted down to the capsular incision. The wound is anatomically closed. The bladder is again irrigated and, if bleeding is excessive, traction is made with a Hamer splint. I have not performed bilateral vasectomy and have depended on chemotherapy and the antibiotics to prevent epididymitis.

As soon as the patient is returned to bed, the catheter is irrigated every 10 to 15 minutes and then according as circumstances may require. Fluids are given as tolerated, a soft diet at night and full the next day. The patient is allowed out of bed on the second postoperative day. At

first there is some slight suprapubic leakage which is serosanguineous and the dressings are changed the next day. The drain is removed on the third day. We have tried removing the catheter on the third to fifth day as recommended, even leaving it in nine or ten days. Now we feel that the optimum time to remove it is on the seventh day. If some urine leaks suprapubically, the catheter can be reinserted until it stops. In one case the catheter became blocked with clots on the second day and had to be removed. There was no difficulty in reintroducing it. In the average case the catheter drainage was bloody the first day, but was clear by the third day.

Complications

It has been stated, if enough case reports of a type of operation are studied, that all types of complications will be seen. My series is quite small at this time, but from all indications retro-pubic prostatectomy should be relatively free of complications if the technique is meticulous.

The catheter should drain freely after return from the operating room. There should be no clot retention, and if it does occur, there has been faulty hemostasis. In the earlier cases it was the resident staff who stayed up all night and I have them to thank for a successful operation. Usually the bleeding stops in 12 to 24 hours. We had one case of secondary hemorrhage which occurred on the fifth day and the bladder became full of blood clots. A McCarthy resectoscope was introduced, the clots evacuated, and the bleeding point coagulated.

There have been no cases of urosepsis. The preoperative use of the sulfonamides and the postoperative use of penicillin plus the sulfonamides have been a great advance. It has been our experience that the urine clears more rapidly than in either the suprapubic or transurethral route.

We have had no cases of wound sepsis and have never seen the need for sulfonamide dusting powders as recommended by Millin. There have been no cases of persistent fistula in this series, due we feel to accurate approximation of the capsule. In a few cases there was suprapubic leakage of urine following too early removal of the catheter. All healed up after reinsertion of the catheter for a few days.

Incontinence of urine has not been a problem following retropubic prostatectomy, but there has been some urgency of urination amounting to almost incontinence. This persisted for only a few days. There has also been no post-prostatectomy obstruction, we having had the benefit of Millin's

experience. He reported 5 cases in his first 75 and since then has been removing a wedge of tissue from the posterior lip of the vesical neck. This we have adopted as a routine measure.

The complication of osteitis pubis has not been seen in our series. This, we feel, is due to respect for the periosteum of the pubis and care of the point of the needle to be sure the periosteum is not injured. This injury plus the presence of an acid urine is the cause for osteitis pubis, we believe.

Discussion

Our first case stimulated us to continue the procedure so as to completely acquire the operative technique. As in any type of surgery, practice makes perfect. Our operative time has been shortened to the patient's benefit. The smallest gland weighed 20 grams, the largest 165 grams, with an average of 71. The best results are obtained when no oxycel gauze has been used to control bleeding. Five out of the last 7 cases were out of the hospital in ten days following surgery. This is an example of what the retro-pubic approach has done for the patient with the large gland.

Recently we had some difficulty with capsular sloughing in the largest gland removed, which weighed 165 grams with marked intravesical protrusion. This patient was finally cystoscoped. The verumontanum was still intact with a normal appearing pouch. He was discharged on the twenty-eighth postoperative day with good urinary control. This was the longest postoperative stay in our series. In our entire series of 25 cases the mean postoperative stay was 14.8 days. We have learned to be meticulous in stopping all bleeding and not to depend on oxycel gauze. This I cannot overemphasize. The operation requires no trained assistants. At no time has it been necessary to open the bladder to complete the operation.

We had a cardiac arrest in one case which was quite interesting. This occurred while closing the abdomen. His chest was opened and cardiac massage performed. The catheter was removed on the ninth day and the patient was discharged on the fourteenth day.

After reviewing the published reports, and as a result of the experience gained in our small series, we believe that the operation of retropubic prostatectomy has the following definite features to recommend it: The approach is simple, direct, and presents no important structures to be injured or sacrificed. The exposure of the prostate is excellent and the entire prostate gland from the apex to the vesical neck can be clearly visual-

ized and palpated. Following enucleation the entire cavity can be visualized and all bleeding accurately controlled. The vesical neck is easily visualized and any plastic procedure that is necessary can easily be performed. Since the vesical neck is not unduly traumatized or torn, as inevitably occurs in the suprapubic operation, the intact outlet with its sphincter action intact prevents to a major degree the post operative occurrence of vesical spasms. If watertight closure of the capsule is obtained, suprapubic leakage of urine is rarely encountered.

In our experience, as in that of others, the most striking feature of the operation is the easy postoperative course for the patient and hospital staff. The patient is up and about the second day with little discomfort.

We have performed one second-stage retropubic prostatectomy in our desire to see if the operation is feasible. We were amazed at the ease with which it could be done. This gland weighed 65 grams. An acute epididymitis developed in this patient, which was the only one in our series.

The operation is not indicated for the treatment of patients with obstruction due to vesical neck sclerosis and prostatic fibrosis. In such cases transurethral prostatic resection is still the preferred procedure, as is the gland of 35 grams or less. Likewise in cases of prostatic obstruction associated with disease of the bladder in which surgical therapy of both lesions is required, we feel that the retropubic approach is contraindicated. In this group may be included bladder tumors, large vesical calculi, and large poorly draining diverticuli. For the treatment of prostatic calculi or abscess of the prostate, the perineal approach is preferable. For the surgical

treatment of early carcinoma of the prostate, the perineal approach is still the ideal method.

Summary

A report of 25 cases of retropubic prostatectomy for benign prostatic hypertrophy from ward and private service has been given. We believe that the operation has great merit and should be worthy of consideration, primarily because of its direct approach to the prostate, avoidance of trauma to the bladder and vesical neck, easy postoperative course with good functional result, and early discharge from the hospital. In these days of expensive hospitalization early discharge from the hospital is a definite economic factor. We firmly believe that the operation is not applicable to vesical neck contracture, prostatic fibrosis, and the prostate of 35 grams or less. They are removed much easier by transurethral methods. In the treatment of early carcinoma of the prostate, a total perineal operation is still the method of choice. As Millin stated, the retropubic operation is not the crazy idea of a mad Irishman. Our results have been so uniformly good that we plan to continue using the retropubic approach to the prostatic problem when the indications are present. The number of cases reported is small, but is presented to emphasize the soundness of the operation in the hope that greater experience will be accumulated among urologists so that its true place in prostatic surgery can soon be decided.

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IS GOVERNMENTAL PROPAGANDA EVER TRUSTWORTHY?

Of late we have had "shoddy propaganda" (so termed by a respectable source) concerning Federal aid to schools. Here's how the boys get themselves all lathered up over a phony set of figures: The Senate Committee on Labor and Public Welfare issued this nifty, "According to U. S. census estimates for 1947, about 4,000,000 children between the ages of five and seventeen attend no school whatever."

This "shocking, appalling" state of affairs was exploded (by Dr. Lawrence M. Gould, president of Carleton College) as follows: "In many states, compulsory education does not start until six or seven years of age

and some end compulsion at sixteen. Of the 4,000,000 referred to, 2,063,000 were only five years old, 156,000 were six, and 1,406,000 were sixteen and seventeen."

Anyone can figure this one out! 3,625,000 kids were "either too young or too old," according to their respective state laws. Thus, slightly over a quarter-million children—from the originally estimated 4,000,000—"attend no school." In their miscalculations, the bleeding-hearts even ignored the unavoidable increment of mental or physical defectives among children. And again, the propagandists offered only one solution: more Federal taxes and spending, more Federal job-holders and bureaucrats, more Federal steps toward statism and totalitarianism.—*Jackson County (Mo.) Medical Society Bulletin*.

THE PENNSYLVANIA MEDICAL JOURNAL

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EDITORIALS

ANTI-TRUST PROBE OF A.M.A. STARTED

These words summarize headlines appearing in leading newspapers throughout Pennsylvania and probably throughout the nation on October 6 and 7, 1949, and were followed by a news story of considerable length sent out by both the United Press and Associated Press from Chicago. We quote:

"Dr. George F. Lull, secretary and general manager of the American Medical Association, said 'no accusations are made against the Department of Justice.' But he added the robbery incident is one of 'real significance in the chronology of events' since the A.M.A. decided to oppose compulsory health insurance.

"The trustees said the office was broken into in the early hours of the morning during the board's February session. Their statement said that records were thoroughly searched and brief cases of the trustees, left in the room, also were searched.

Occurrences Listed

"The facts indicate this was a search for information rather than an ordinary burglary,' they said. 'Certainly no friends of medicine would take this means of obtaining medical data.'

"The trustees listed this chronology of events:

"1. In November, 1948, the A.M.A. voted to

collect funds from doctors to finance a campaign against compulsory health insurance.

"2. One month later, Department of Justice agents called on the Chicago Medical Society seeking information in connection with 'an alleged anti-trust investigation.'

"3. The trustees' office was rifled February 10.

"4. Near the end of that month 'administration leaders began threatening medical societies and medical men with investigation, as part of their campaign to discredit and intimidate the medical profession.'

Political Implications

"The statement added:

"We would be naive indeed if we ignored the political implications of this sudden rash of investigations of medical societies at a time when the administration is doing its utmost to stifle opposition to its proposed system of government-controlled medical care.'"

The news story appearing in the papers on October 7 quoted Attorney General J. Howard McGrath as stating:

"The Justice Department has received numerous complaints from doctors and the general public charging the American Medical Association and certain other medical associations with con-

spiring to restrain and monopolize the prepaid medical care plans not conducted under their sponsorship and operated in competition with plans controlled by them."

The medical profession as early as last spring had what may have been a preliminary introduction to this movement in the form of a publication captioned "Restrictions on Free Enterprise in Medicine" issued in April by the Committee on Research in Medical Economics, of which Michael M. Davis, Ph.D., is chairman, and Channing Frothingham, M.D., a member. Interestingly, misleading statements from that publication appeared and were discussed on pages 985 and 986 of the June, 1949 PENNSYLVANIA MEDICAL JOURNAL.

It is said that representatives of the Department of Justice in communicating with medical organizations whose records they desire to investigate present a list of fifteen items ranging from lists of officers, committees, boards, and bureaus to correspondence with other national or local medical societies, references to the practice of medicine by hospitals, all these in addition to the details of prepaid medical care plans.

The threat to the constitutional right of free speech and free press and to securing the blessings of liberty for ourselves and for our posterity that is reflected in the above has undoubtedly come as a greater shock to good citizens outside the ranks of the medical profession than it has to members of the profession. Most of the latter are informed about the snooping tactics and the self-contained Disciplinary Tribunals such as have been long prevalent with compulsory sickness insurance in other nations of the world under the yoke of a police state, and which have so tragically developed recently in England where "the Minister of Health is his own prosecutor, his own judge and jury, and he approves of his own findings" (see page 1494, this issue).

WE WILL LOSE ONLY BY DEFAULT

The fundamental philosophy of the practice of medicine of today must be viewed as a part of the whole pattern of present-day living and thinking. For the past ten years the problem of compulsory health insurance has occupied a prominent place in discussion and debate on the health of the nation. Within the past year it has become a real menace and threat. Organized medicine has been severely criticized, not only by its own membership but also by many groups

outside of the circle, because of its negativistic, pedantic and, on occasion, uncompromising attitude. The chief protagonist of compulsory health insurance is the Federal Security Bureau. Mr. Ewing, the Federal Security Administrator, will push this program vigorously and stubbornly. He has convinced the President of the necessity for the Federal Government to intervene and take over the practice of medicine, because of the dissatisfaction among the majority of our people with the cost of medical care.

It is essential that the physicians recognize the tremendous and constantly changing social trends with every economic disruption in the lives of the people. It is futile to employ the arguments of yesterday in answer to the present problems of the day. We must prepare ourselves to live and serve in this day and not yesterday. These facts must develop an awareness of our precarious position in the social economic scheme which apparently is very gradually evolving in our midst. Morris Sayre, chairman of the board of the National Association of Manufacturers, says: "There is no room in any nation for both 'dynamic movement' of American individualism and 'stalling socialism.'"

The growing socialism in the political thought of the people was reflected in the 1948 presidential election. It was apparent that a bare majority of the American people obviously had come to embrace the philosophy and policies of the powerful centralized type of government. Theoretically, the majority of American people believe in our free institutions as opposed to any form of "statism." Practically, entrenched and selfish interests both inside and outside of the Federal Government condition mass thinking in order to perpetuate themselves. It is evident that these same bureaucracies will strive to maintain and extend their power by presenting to the politicians legislation under the guise of social and economic advancements. It is within this pitfall that the physicians find themselves. Forest A. Harness, ex-Congressman from Indiana, says: "Medicine's problems are not going to be solved at the academic level. If you hope to survive as practitioners of a free and untrammelled science, you must, in my opinion, become practicing politicians. If you continue as academicians, I frankly fear that you will soon practice as a medical bureau in Washington directs you."

Change is inherent in the colleges and medical schools. The curriculum of the medical college must be vital, not static. There must be alterations in its methods and progress in its work. The same teachers should not teach the same

subjects in the same way forever, though there are those who seem to approach this ideal. The curriculum that was good enough for the fathers is hardly good enough for the sons, though it is hard for the fathers to accept this. It is likewise true that change in any institution is influenced by factors without. We do know that there has been an economic inflation from which we may never recover. It is obvious that medical students are caught within this whirlpool of change, and when they become Doctors of Medicine their thinking on the practice of medicine will be more deeply influenced by social and economic factors than was that of their fathers.

The progress of scientific medicine is, in essence, responsible for the changing order of medical service. The mounting costs in medical practice confront the public in the form of fees charged by physicians, hospitals, laboratories, and other special services. The problem is how can we best provide the public with adequate medical service embracing all the advantages of scientific medicine and yet remain free agents. The majority of people want to know why good medical care has become so expensive. They do not separate the charges of the physicians and the cost of hospitalization. To the majority this represents the cost of one illness and the physician and the hospital are one in the minds of the public. The proponents of compulsory health insurance capitalize on this type of thinking. One of our biggest jobs is combating the people's impression that Federal medicine will give them something for nothing.

There is no doubt that we as physicians would prefer to practice medicine and let others deal with political and economic questions. Whether we like it or not, medicine is so intricately associated with social change and economics that we are finally compelled to study and analyze these trends and to properly interpret and evaluate the underlying reasons in terms of service to the public. Many plans and suggestions have been made by the American Medical Association and others interested in maintaining medical care on a private enterprise basis. The twelve-point medical and public health program of the American Medical Association has been presented to the public. The proponents of compulsory health insurance say that they are "too little and too late." Dr. Engel, president of The Medical Society of the State of Pennsylvania, has presented a ten-point program for Federal aid to improve medical care.

Dr. Hawley urges enactment of legislation setting up federal grants-in-aid to the states for health insurance to be administered by voluntary groups such as Blue Cross and Blue Shield. Under this system the states would reimburse the voluntary agencies for care extended to the needy or other persons lacking adequate medical assistance.

Benjamin Disraeli, in 1867, said: "Change is inevitable in a progressive country, change is constant." The medical profession is confronted today with proposals for a complete change in our system of medical care. The question that is asked most frequently is: What are the physicians doing to inform themselves and their patients about the implications of compulsory health insurance? Organized medicine, the American Medical Association, has done a tremendous amount of work in preparing and furnishing the members with data on this subject. It is a fact that too few doctors are interested in organizational work for medicine. If each doctor is well briefed, his opinion will be a potent force in his community. In addition to his professional duties, the physician finds comparatively little time for something in which he has no direct interest. If the change is apt to affect his own economy, self-interest rather than any altruistic motive may compel him to inquire what is happening to the practice of medicine. It is incumbent on all physicians to be informed and aware of what is transpiring around them. At present, the leadership is ours. The medical profession must direct and control any change in medical service. Just as surely as we fail to recognize this fact, socialization is the only logical sequence, and the politicians and the bureaucrats will be among the first to appreciate our failure. Our loss can only be by default.

It is necessary to arouse and alert the American public to a great crusade and basic struggle for freedom by proving to every American that medicine is fighting unselfishly for the American way of life against the forces of bureaucratic regimentation.

It appears that some time fairly soon there will be a showdown on compulsory health insurance legislation and an alternate program. When that day arrives, it will be essential for the medical profession to be solidly behind a measure that members of Congress can accept, support in debate, and offer to the constituents back home.

THEODORE R. FETTER, M.D.

DISPLACED PERSONS (DOCTORS OF MEDICINE)

As very pertinent to the subject of housing displaced persons (Doctors of Medicine) discussed fully in an editorial appearing in the June, 1949 PENNSYLVANIA MEDICAL JOURNAL, we quote from an editorial appearing in the September 1 issue of the *New England Medical Journal*:

"... the period of great influx of graduates of foreign schools is over and, in fact, the recent graduates of most foreign schools are not now permitted even to take the examination for registration in Massachusetts. This condition will probably prevail at least until the Council on Medical Education and Hospitals of the American Medical Association has made the investigation that it is sponsoring of foreign schools and issued its report."

KEYSTONES OF PUBLIC HEALTH IN PENNSYLVANIA

The health of the public has and always will be the direct concern of the medical profession of this country. To permit any voluntary or official health agency to assume the major responsibility for providing essential health services to any community without the active participation of the medical profession is to invite control of medicine and allied professions by governmental bureaucrats at the municipal, county, state or federal level.

The American Medical Association recognized this responsibility when its House of Delegates adopted the following resolution on June 10, 1942:

"WHEREAS, A major inadequacy in the civilian health protection in war as in peacetime exists consequent upon the failure of many states and of not less than half the counties in the states to provide even minimum necessary sanitary and other preventive services for health by full-time professionally trained medical and auxiliary personnel on a merit system basis, supported by adequate tax funds from local and state and, where necessary, from federal sources, therefore, be it

Resolved, That the trustees of the American Medical Association be urged to use all appropriate resources and influences of the association to the end that at the earliest possible date complete coverage of the nation's area and population by local, county, district or regional full-time modern health services will be achieved."

These principles were reaffirmed on December 8, 1948.

World War II prevented the A.M.A. and its component state societies from taking immediate

action to bring to fruition the principles embodied in the above-mentioned resolution. But, as soon as World War II terminated, The Medical Society of the State of Pennsylvania took the initial steps to insure action in the field of public health by creating a Commission and a Section on Public Health and Preventive Medicine in October, 1946. The following year, this newborn commission, in order to determine the true public health picture as it exists in this state, introduced a resolution in the House of Delegates which suggested that His Excellency, the Governor, and the Honorable Secretary of Health initiate a public health survey of the Commonwealth. The request was for a survey of all health resources, official and non-official, and not for an investigation of any governmental health unit. It was the feeling of the members of the commission that they could not recommend a well-balanced public health program unless the deficiencies as well as the many fine accomplishments of all health agencies be made known, not only to members of the commission but also to the people of the Commonwealth. Subsequent action taken by the House of Delegates stimulated His Excellency, the Governor, and the Secretary of Health to promptly request the American Public Health Association to conduct this survey. Some financial aid was given by the Commonwealth Fund, and liberal contributions, both financial and technical, were supplied by the State Health Department. The American Public Health Association assigned a most competent director and several associates. The survey was completed and released on April 27, 1949, by Governor Duff in laudatory terms. He said in part, "When I first took office, at the suggestion of the State Medical Society and the Secretary of Health, it was determined to have a survey of our public health services made as a kind of inventory on which we can now base future operations."

This volume contains 338 pages of factual data and recommendations. Dr. Norris W. Vaux, Secretary of Health, provided the State Society with a few more than 500 copies of this report for distribution. The requests received from physicians and public health workers over the entire state more than double the available copies, demonstrating an interest far in excess of the expectations of the commission. The staff of the magazine "Commonwealth" prepared an excellent digest of this comprehensive report in its February issue. About 10,000 copies of this digest are available for distribution.

It would be impossible in this brief article to discuss the many recommendations made by

these experts, but, strange as it may seem, they appear very similar to the recommendations of the A.M.A. and those submitted by Dr. Gilson Colby Engel, president of the Society, to leaders in the Congress of the United States as a substitute for the government's proposed compulsory insurance bill.

Permit me to list the eight essential recommendations in this report, so that you may compare them with the resolution of June 10, 1942, of the A.M.A.

1. The establishment in the Department of Health of a unit of Local Health Services under a Deputy Secretary of Health.

2. The development of minimum standards of performance for all phases of public health, and the application of these standards to the services provided by the State and to the public health activities of each municipality.

3. Decentralization of the Department of Health services through the establishment of district offices, with full-time, qualified district medical directors to administer all direct state services.

4. A merit system applied to all public health personnel which will include the best modern practices in recruitment, methods of selection, permanence of employment, equality and adequacy of pay, impartial treatment, and provisions for economic security upon retirement.

5. Extension of professional training opportunities to all the public health workers of the State.

6. The establishment of local health units in counties, cities, or other municipalities or in combinations thereof.

7. Simplification, revision, and codification of the laws relating to public health.

8. Reorganization of the structure of the Department of Health to achieve a clear direct line of service from the Governor, through the department, to the people.

These eight essential recommendations are discussed more fully in the report. The majority of them can be put into effect immediately by executive order. The seventh recommendation will require legislative action.

The importance of this survey to the citizens of this state cannot be too strongly emphasized. Never before in the history of this Commonwealth has such a blueprint of public health resources been available. Dr. Norris W. Vaux, speaking before the fifty-seventh annual meeting of the Pennsylvania Tuberculosis Society in Pittsburgh on May 26, 1949, said, "As a guide for future planning, the survey report should prove to be an invaluable aid. It will help chart the course for expansion of health services in the fields of tuberculosis, crippled children, cancer, rheumatic fever, medical and dental examinations of school children, and other health activities. Extension and improvement of these services was urged in the platform on which Governor Duff was elected. They have been steadily advanced since then."

The medical profession has a large stake in the responsibility to carry out the important recommendations of this report. Men and women of industry, business, labor, politics, and allied medical groups are looking to us for leadership in this field. We must tell them what is needed for good public health practices. We know what is needed. We must not wait for them to tell us what should be done. I feel certain that the medical profession of this state, led by its many medical statesmen and properly supported by its able Governor and Secretary of Health will not fail the people of this Commonwealth in the most important of all services—public health. The famous statesman, Disraeli, speaking on health once said, "The health of the people is really the foundation upon which all their happiness and all the power of state depend."

PASCAL F. LUCCHESI, M.D., *Chairman,*
Commission on Public Health and
Preventive Medicine,
The Medical Society of the State of
Pennsylvania.

MULTIPLE EXAMINATIONS IN PATIENTS WHO SUSPECT THAT THEY HAVE CANCER

After decades of intensive research, we still lack a blood or urine test for the presence of cancer. The Huggins test stands as the most recent and possibly the best of a considerable series of such tests, but it too gives false positive results in certain patients who do not have cancer. Whether these false positives will fall into a narrow enough group to be excluded by other tests, we do not yet know.

Until we have a universally applicable test that has been proved worthy to rely upon for the diagnosis of malignancy, patients will continue to look to clinicians to discover by clinical methods whether they have cancer. The seriousness of the responsibility thus placed on the physician is emphasized by the recent study of C. D. Haagen-^{*} on the causes of delay in treatment for cancer of the breast. Those patients who had consulted a physician about a lump in the breast and were reassured delayed, on the average, an additional 59.6 weeks before correct treatment was begun. In an analysis of who was responsible for delay in instituting proper treatment for can-

^{*} HAAGENSEN, C. D.: Recent Advances in Cancer Therapy, *Bulletin of the New York Academy of Medicine*, 23: 123, March, 1947.

cer of the breast, it was shown that the fault lay with the patient in only 63 per cent of instances and with a physician in 27 per cent.

From this, it would appear to be a dangerous practice to give a patient complete reassurance, on the basis of a single examination, that he does not have cancer. The effects of error in evaluating the early symptoms of cancer are not only devastating for the individual patient, if it results in a long delay in starting treatment, but it has a very deleterious effect on the relation between the public and the medical profession as a whole. Not infrequently it leads to a loss of confidence that keeps patients away from doctors at times when they urgently need medical care.

If it is difficult to recognize cancer in the patient with early symptoms, it may be much more difficult to recognize it on routine examination of asymptomatic individuals. This is the special problem of the cancer prevention clinic. It would seem that the best protection for the public and the medical profession lies in stressing the limitations of the examination and emphasizing that new symptoms should be investigated promptly even though a cancer detection examination has been carried out recently. Most cancer detection clinics do instruct their patients to report symptoms that develop between examinations but, in spite of this, many patients seem to place more reliance on the examination than is really justified.

Physicians are under great pressure to reassure patients who come to be examined for cancer because so many of them have a phobia or abnormally intense anxiety regarding the disease.

With such persons, it is very difficult to have them keep on the alert for symptoms of neoplastic disease without having them develop great mental anguish and the behavior difficulties that result from it. Unfortunately, however, cancerophobia gives no immunity to cancer and it would seem that the first responsibility of the physician in the management of a patient who consults him for fear of cancer is to avoid missing the early case. If the effort to do so causes mental disease, it is very probable that the patient has a marked tendency toward anxiety states and that sooner or later he will develop psychiatric difficulty in connection with one or another of life's stresses. The aid of a psychiatrist may be necessary for some of these patients.

It is not always possible to recognize the presence of early malignant lesions. Many regrets and much misunderstanding can be avoided if these precautions will be observed: (1) When in doubt about having a biopsy or other special examination done on a suspicion of cancer, have it done. (2) Always examine the patient who consults you for symptoms which might be due to cancer a second time within three to six weeks, even though the first examination is negative. (3) In doing routine examinations for cancer detection in asymptomatic persons, impress upon them the fact that our present techniques are limited in their sensitivity and that new symptoms, or an increase in the severity of old symptoms, should be brought to the attention of a physician promptly.

JONATHAN E. RHOADS, M.D.

TAKING STOCK

The editor of *The Stethoscope* for October indicts members of the Erie County Medical Society in the following words for rudeness toward a gracious host.

"A delightful occasion for thirty-eight members of the Erie County Medical Society is seen by your county society officers and by your editor as an occasion of discredit to the society and as an example of the causes for the poor esteem in which physicians are held by so many of their fellow citizens. . . ."

"We are engaged in a great nationwide campaign to improve our relationships with that public to whose service we are dedicated. 'Public relations' is the keynote of practically all our activities except the purely professional ones and it tinges even those. We have even been assessed a sum of money by the American Medical Association for the purpose of bringing the

excellence of our accomplishments to the public attention, that is, to give us good 'public relations.'

"But what do we do when the time comes to do something practical . . . ? We achieve something like our showing at this luncheon. Seventy-four of our members accepted, in writing, the generous invitation of the General Electric Company. When the guests at the table were counted, they numbered thirty-eight. That is a situation which requires some stock-taking. When almost half of the physicians who agreed to accept hospitality failed to do so, the mere waste of food becomes an item worthy of editorializing.

"But it is not food but 'public relations' which engages our attention. I leave to your meditations the impressions which this mass defection must have made.

"The physician sets himself up as the finest product of our civilization. On him is lavished years of costly education. Can this be the same man who fails to keep an appointment which he has made in writing?"

THE OBLIGATION TO A NEW MEMBER

During the past few years there have come to Lancaster city and county a number of new physicians. Many of these men were total strangers to the community in which they settled, yet were welcomed most heartily, in most instances, by those people whose medical service was inadequate during the doctor shortage of the war years. Without any known exception, these men all promptly applied for and received membership in the society—probably because somewhere they had been told it was the proper thing to do.

During this same period of time, the most frequent question asked by members after a meeting has been, "Who was that so-and-so fellow, wearing a so-and-so suit, who was sitting next to so-and-so?" And how often have we seen the assistant secretary approach an unfamiliar gentleman in the audience, apparently exchanging friendly greetings? What he was actually doing was learning the name of a recently elected member to give him attendance credit!

Has our society been fulfilling its obligations to its new members? We believe that it has not! We further believe that in order to strengthen our organization it does have certain obligations which it should fulfill. By this we mean a sincere effort should be made to fully *orientate our new members* and not let them flounder in the sea of inexperience and inadvertently become the victims of undeserved criticism. The recent proposal of having "name badges" for all our members is a good one and has much merit. It will certainly help the *society in learning to know its members*—but will it help the *new member to know his society*? We believe not!

In order to correct this deficiency, we propose the following points for consideration. They consist of those items pertaining to the society and the practice of medicine which we individually had to ferret out for ourselves over a long period of time.

I. Have the sponsor invite the new candidate as a guest to the meeting at which the application for membership is submitted. Let the sponsor introduce his candidate to the society from the floor, following which the secretary would read to the society the credentials as submitted on the prepared form.

II. Have the board of censors actually meet and become acquainted with the candidate before they signify their approval.

III. After the candidate has been elected, furnish him with the following necessary items and information:

1. A.M.A. handbook. This explains the medical organization from county to national levels—the details of its structure, its aims, its ethics, and its operation.
2. The privileges and advantages of being a society member, including the legal protection, its malpractice and health and accident insurance benefits.
3. An explanation of the hospital facilities, and his rights and privileges extended by those institutions. The available laboratory facilities.
4. The specific names of health officers and coroners for the area concerned. The ways and means of reporting communicable diseases.
5. The availability of special clinics and services, both state and lay sponsored, to help care for the indigent. An explanation of the D. P. A. and its adopted fee schedule and necessary forms.
6. Information concerning the VA and other procedures for veterans' care.
7. Information on MSAP.

These, we believe, are the main items a physician is expected to know in a strange community. You may have more to add after thinking over your own early experience.

If a plan as it is here proposed should be put into effect, we are confident that a stronger organization will arise. With a well-informed membership, there will be a greater understanding and more interest in both the scientific and the business phases of the society. This concerted effort can have but one result—a better, a stronger Lancaster City and County Medical Society; this is our constant aim.—*Lancaster City and County Medical Society Bulletin*.

"YOU RUN THE COUNTY SOCIETY?"

What kind of a doctor are you?

Providing an answer to that question, an answer which will serve your own purposes only, will furnish material for considerable thought. The result is guaranteed by the writer to be a sort of "poor man's self-improvement course." It will provide a method of making you a better doctor which will be inexpensive, but not easy. In fact, this sort of reflection leads to the conclusion that there is no easy road to becoming a good doctor, let alone a better one.

Mowing a lawn happened to be the background for the writer's introduction to this type of analysis, and it is recommended as a suitable background for such mighty cogitation. But your wife's favorite radio program or the hum of your car motor might furnish just as suitable incidental music. Consider the amazing (and refreshing) kinds of doctors who join you in making up our county society. Men of varied shapes and sizes, men of firm convictions, men more easily swayed, men who think like you and men who don't (and some women). You can go on and on from there and, indeed, that is the point of these words—to get you to go on from there.

You see, this is the lazy editor's editorial. You supply it yourself. What is wanted is to lead you to consider your qualifications with a view to improving them by strengthening the good and repressing the undesirable. Then, when you have made suitable corrections in your character (all in the mind's eye, so far), we urge you to go on. We want you to meditate further on your position in the county society and in the organization of medicine and fit yourself into the spot where you can be more effective. Do all parts of your job at peak efficiency—the part that has to do with care of your patient as well as the part that you owe the medical profession.

Don't let "them" run the county, or state, or national society—get in there and be one of them.—*The Stethoscope*, Erie, Pa.

“. . . The trap was most cunningly baited in half a dozen different ways. Some of us were attracted by one illusory lure, others by another. More of us probably were moved by fear, fear for our children, our wives, and for ourselves. How many of us already wish that we might awake and find that it had all been a nightmare!"—Excerpt from a letter of DR. DONALD M. O'CONNOR, Launceston, Cornwall, England, to *The British Medical Journal*.

PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division of the American Cancer Society in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

The Tumor Clinics and Detection Centers

Facilities for detecting and treating cancer have been expanded virtually twofold throughout the Commonwealth during the past two years—one of the accomplishments of the State Cancer Coordinating Committee and the increased efforts of its three agencies, the Pennsylvania Division of the American Cancer Society, The Medical Society of the State of Pennsylvania, and the Division of Cancer, State Department of Health.

Tumor Clinics, or commonly termed Cancer Clinics, now are being conducted in 92 hospitals located in 51 Pennsylvania communities, and there is every indication that the facilities will increase steadily. The Division of Cancer, while promoting and in some instances giving financial assistance to these clinics, has no operating or approving function. The clinics are operated by the hospitals and many have been approved by the American College of Surgeons.

The American Cancer Society also has given financial assistance to the clinics, particularly in Beaver, Butler, Erie, Franklin, Lancaster, Luzerne, and Lycoming counties. Aid is being planned for additional clinics.

A Tumor Clinic is where a well-trained staff and all the facilities for the adequate treatment of cancer are located. Physicians may refer patients to these clinics which are located as follows:

Gettysburg—Annie M. Warner Hospital.
Pittsburgh—Elizabeth Steel Magee, Montefiore, Pittsburgh Skin and Cancer, Presbyterian, St. Francis, St. Margaret Memorial, Shadyside, Western, Woman's, Sewickley, and University of Pittsburgh Hospitals.
Rochester—Rochester General Hospital.
New Brighton—Beaver Valley Hospital.
Beaver Valley—Providence Hospital.
Reading—Community, Reading General, and St. Joseph's Hospitals.
Altoona—Mercy Hospital.
Roaring Springs—Nason Hospital.
Sayre—Robert Packer Hospital.
Johnstown—Conemaugh Valley Hospital.
Palmerton—Palmerton Hospital.
Belleville—Centre County Hospital.
Coatesville—Coatesville Hospital.
Clearfield—Clearfield Hospital.
Carlisle—Carlisle Hospital.
Harrisburg—Harrisburg Hospital and Harrisburg Polyclinic Hospital.
Drexel Hill—Delaware County Hospital.
Darby—Fitzgerald-Mercy Hospital.
Erie—Hamot Hospital and St. Vincent's Hospital.
Chambersburg—Chambersburg Hospital.
Scranton—Scranton State Hospital.
Lancaster—Lancaster Hospital and St. Joseph's Hospital.
New Castle—Jameson Memorial Hospital.
Lebanon—Good Samaritan Hospital.
Allentown—Allentown General, Sacred Heart, and St. Luke's Hospitals.
Hazleton—Hazleton Hospital.
Nanticoke—Nanticoke State Hospital.
Wilkes-Barre—Mercy Hospital and Wilkes-Barre General Hospital.
Williamsport—Williamsport Hospital.
Bradford—Bradford Hospital.
Mercer—Mercer Cottage Hospital.
Grove City—Bashline-Mercer Hospital.
Sharon—Christian H. Buhl Hospital.
Lewistown—Lewistown Hospital.
Abington—Abington Memorial Hospital.
Norristown—Montgomery Hospital.
Danville—George F. Geisinger Hospital.

Easton—Easton Hospital.
Sunbury—Community Hospital.
Philadelphia—American Oncologic, Chestnut Hill, Doctors', Episcopal, Frankford, Germantown Dispensary and Hospital, Graduate Hospital, University of Pennsylvania, Hahnemann, Jeanes, Jefferson, Jewish, Lankenau, Mercy-Douglass, Northern Liberties, Osteopathic, Pennsylvania, Philadelphia General, Presbyterian, Skin and Cancer, Stetson, Temple University, University of Pennsylvania, U. S. Naval, Woman's Homeopathic, Woman's, and Woman's Medical Hospitals.
Coaldale—Coaldale State Hospital.
Pottsville—Pottsville Hospital.
Windber—Windber Hospital.
Wellsboro—Soldiers and Sailors Hospital.
Oil City—Oil City Hospital.
Greensburg—Westmoreland Hospital.
Latrobe—Latrobe Hospital.
New Kensington—Citizens General Hospital.
York—York Hospital.

In an effort to help individuals find cancers in the early and curable stages, the American Cancer Society and its affiliated county units have extended their efforts in opening Detection Centers, 55 of which are being operated now in 33 Pennsylvania communities, many of which also have been approved by the American College of Surgeons.

Set up with the cooperation of county medical societies, Cancer Detection Centers offer facilities where a thorough general physical examination may be given to apparently well persons so they may be certain that no danger signals of cancer exist. Their purpose is to detect, sooner than would otherwise be discovered, early cancer, precancerous lesions, or areas of chronic irritation which might lead to cancer. These clinics are located in:

Tarentum—Allegheny Valley Hospital.
Pittsburgh—Falk Clinic, St. John's, Suburban, and University of Pittsburgh Hospitals.
Rochester—500 Pinney Street.
Reading—Reading, St. Joseph's, and Community Hospitals.
Altoona—Altoona and Mercy Hospitals.
Roaring Springs—Nason Hospital.
Butler—Butler County Hospital.
West Chester—Chester County Hospital.
Bloomsburg—Bloomsburg Hospital.
Harrisburg—Harrisburg Polyclinic Hospital.
Chester—Chester Hospital.
Drexel Hill—Delaware County Hospital.
Darby—Fitzgerald-Mercy Hospital.
Erie—St. Vincent's Hospital.
Uniontown—44 West Church Street.
Chambersburg—Chambersburg Hospital.
Scranton—Scranton State Hospital.
Carbondale—St. Joseph's Hospital.
Taylor—Taylor Hospital.
Scranton—West Side Hospital.
Lancaster—Lancaster and St. Joseph's Hospitals.
New Castle—22 East North Street.
Ellwood City—Ellwood City Hospital.
Hazleton—Hazleton Hospital.
Williamsport—Williamsport Hospital.
Sharon—1 Sharpsville Avenue.
Bryn Mawr—Bryn Mawr Hospital.
Pottstown—Pottstown Hospital.
Philadelphia—American Oncologic, Frankford, Hahnemann, Jeanes, Jefferson, Jewish, Lankenau, Mercy-Douglass, Methodist, Mt. Sinai, Northern Liberties, Pennsylvania, Temple University, University of Pennsylvania, and Woman's Medical Hospitals.
Coaldale—Coaldale Hospital.
Pottsville—Pottsville Hospital.
Oil City—Oil City Hospital.
Charleroi—Charleroi-Monessen Hospital.
Washington—Washington Hospital.

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*

8104 Jenkins Arcade

Pittsburgh 22, Pa.

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

1950 STATE MEDICAL SOCIETY DUES

Confusion Clarified

Before this is read in the October issue of the PENNSYLVANIA MEDICAL JOURNAL, the secretary of each county medical society and its entire membership will have received communications explanatory of the disturbance of a routine in the office of the secretary-treasurer of The Medical Society of the State of Pennsylvania.

For more than thirty years each county medical society secretary has been provided early in November with the printed triplicate receipts by means of which he acknowledges his members' payment of county and state medical society membership dues in a single transaction. This year these may not be mailed out until after the Interim Session of the A.M.A. House of Delegates, Dec. 6 to 9, 1949, and will quite likely include the collection of 1950 American Medical Association dues as well as county and state society dues.

For details read carefully from the minutes of the Sept. 28, 1949 meeting of the House of Delegates of The Medical Society of the State of Pennsylvania as follows:

(Quote) The chair recognizes Dr. James L. Whitehill, of the Board of Trustees.

DR. WHITEHILL: The Board of Trustees recommends to the House of Delegates that the dues of The Medical Society of the State of Pennsylvania for the year 1950 be \$23, of which \$1.00 will be allotted to the Medical Benevolence Fund and \$2.00 to the Educational Fund.

SPEAKER BUCKMAN: Do I hear a motion from the floor that the report from the Board of Trustees be adopted?

DR. ROY W. MOHLER (Philadelphia): I so move, Mr. Chairman.

The motion was seconded by Dr. Constantine P. Faller, Harrisburg.

DR. WILLIAM BATES (Philadelphia): Mr. Speaker, I would like to offer an amendment to this recommendation of the Board of Trustees. In this House, on the first day of the session, we were alerted to the possibility of A.M.A.

membership dues. As a result, your delegates to the American Medical Association, who will represent you at the Interim Session in Washington, in December, met in caucus at 7:30 a.m. the second day of the session. They desire the expression of this House on how they should vote on this question when the A.M.A. Board of Trustees recommends to the A.M.A. House of Delegates that membership dues (probably \$12) be levied for the first time in the history of the A.M.A. This expression has been obtained. Necessary implementation will be expedited by amending this present recommendation of your Board of Trustees by adding:

If and when the House of Delegates of the American Medical Association decides on membership dues, and establishes the amount of such dues, that the secretary-treasurer of this organization be authorized to add the equivalent amount to the state society dues, now established, on the bills for 1950 rendered by him to the secretary of each component county society.

The amendment was seconded by Dr. Henry L. Gowens, Jr., Philadelphia.

SPEAKER BUCKMAN: The question is on the amendment to the recommendation of the Board of Trustees which provides, if and when the A.M.A. dues are established, the billing will be on the county society level through the secretary-treasurer's office in Pittsburgh. Are you ready for the question?

The amendment was put to a vote and carried.

SPEAKER BUCKMAN: The amendment is adopted.

The question is now on the recommendation, as amended, providing state society dues of \$23 annually, \$1.00 to be allotted to the Medical Benevolence Fund and \$2.00 to the Educational Fund.

Are you ready for the question?

(After questions from the floor and answers by Dr. Whitehill)—

SPEAKER BUCKMAN: The question is on the adoption of the amended recommendation of the Board of Trustees. Are you ready for the question?

The motion, as amended, was put to a vote and carried. (Unquote)

The 1950 dues recommendation from the Board of Trustees, *as amended* and without a dissenting vote adopted, reads as follows:

"The Board of Trustees recommends to the House of Delegates that the dues of The Medical Society of the State of Pennsylvania for the year 1950 be \$23.00, of which \$1.00 shall be allotted to the Medical Benevolence Fund, and \$2.00 to the Educational Fund; and, if and when the House of Delegates of the American Medical Association decides on membership dues, and establishes the amount of such dues, the secretary-treasurer of The Medical Society of the State of Pennsylvania be authorized to add the equivalent amount to the state society dues, now established, on the membership bills for 1950 rendered by him to the secretary of each component county medical society."

JOURNAL reader members are urged to read the foregoing action in connection with the printed letter mailed earlier in October to the entire membership dealing with the increased state society dues and signed by four state medical society officers.

SECRETARIES AND EDITORS TAKE NOTE

The 1950 Conference of County Medical Society Secretaries and Editors will be held in the Penn-Harris Hotel, Harrisburg, on Thursday and Friday, March 2 and 3, 1950.

Suggestions for subjects to be discussed will be welcomed by the chairman of the Program Committee, Wilbur E. Flannery, M.D., 24 E. Grant St., New Castle, Pa.

ABSTRACTS FROM ADDRESS BY FORMER ENGLISH DOCTOR SPEAKING AT OUR 1949 CONVENTION IN PITTSBURGH

. . . Socialized medicine reached its full English flowering in 1948, but the seed sprouted way back in 1911 when a government panel system was first introduced to care for manual workers in the lowest income groups. But, as these schemes so often do, politicians wanting more power, the income level was slowly raised and the panel scheme slowly grew until in 1948, with one stroke of the legislative pen, in came the entire population, all blanketed in as one conglomerate whole.

No question of income, no question of need. Now how did it work out, this panacea for all the Nation's ills?

As a general practitioner, I had registered with me (because of course in socialized medicine, we must have registration) some 3200 souls, and this, believe it or not, was not the maximum. I could have had 4000 and even more in certain exceptional circumstances. I challenge any of you listening to me to have even a conception of what is entailed in being responsible for the health of that number of people.

In America there is one doctor for substantially less than a thousand persons. I used to do three one-hour office periods each day. And I could expect 20 people and more in one of these periods; that is an average of three minutes per patient. And I have made as many as 36 house calls in one working day in addition to my work in the office. You will, I am sure, appreciate what sort of medicine this is.

. . . As long as he is in possession of the right form, there is virtually nothing that the energetic patient cannot obtain—drugs, dentures, toupees, surgical corsets, elastic hose, spectacles, hearing aids, all to be had for the asking—and how they do ask.

The Disciplinary Tribunal

. . . I should like to talk of the baffling bureaucratic red tape and of the records available at all times for official checking and snooping; but most of all, I should like to talk about the disciplinary tribunal.

In England, we always prided ourselves on the excellent medical discipline preserved by our General Medical Council—vigilant indeed in all cases of malpractice and unprofessional conduct. And yet, despite the existence of this body, it was felt necessary by the Minister of Health to set up a tribunal with minority medical membership to judge the action of doctors in the National Health Service. I cannot emphasize this too strongly: From the decisions of this tribunal there is no appeal to the judiciary, even though its sentence can remove a man from the medical list of the government's scheme and so take away his livelihood. The Minister, in fact, is his own prosecutor, his own judge and jury, and the approver of his own findings. It is difficult to imagine anything which has in it the seeds of more vicious injustice than this—a far cry indeed from the English tradition of justice, but illustrating well the fundamental rottenness of political medicine.

No, I felt that I had had enough of this sort of government medicine and I made my decision to

make a clean break, and I would make the same decision tomorrow. But I would urge you all to consider the implications for you and for all the people of this country in what I have said. The physicians of this country have the same hopes and the same ambitions that I have, the same hopes and ambitions which forced me to take the action that I took. Let us hope that none of them here are ever forced to make the same decision.

A REPORT FROM PRESIDENT ENGEL

The membership of The Medical Society of the State of Pennsylvania and of the United States must become politically active if it wishes to preserve a free system of medicine in America.

Recently in Washington, Mr. Truman's recommendation for the creation of a Department of Welfare was under consideration. In this department was to be placed Health, Education, and Welfare. The secretary of this Department of Welfare, it was widely reported, was to be Mr. Oscar Ewing. This recommendation was known as Reorganization Plan No. 1.

Your president wired the members of the Senate Executive Expenditure Committee under Senator John L. McClellan (D. Ark.) objecting to Reorganization Plan No. 1, as did many others in American medicine. This committee voted 7 to 3 against the plan. The debate and vote on the plan were scheduled for the Senate not later than August 17.

On August 8 the following telegram was sent to Senators Edward Martin and Francis J. Myers of Pennsylvania:

"The Medical Society of the State of Pennsylvania, having a membership of 11,000, are opposed to the President's Reorganization Plan One. We ask that you oppose this measure when it comes to a vote in the Senate." (signed) GILSON COLBY ENGEL, President.

On August 12 the following telegrams were received by your president:

"Retel intend to oppose Reorganization Plans One and Two." (signed) EDWARD MARTIN, U.S.S.

"Inreurecom Reorganization Plan One will undoubtedly be debated fully in the Senate due to controversial nature of proposal. Appreciate your interest." (signed) FRANCIS J. MYERS, U.S.S.

Following receipt of these telegrams on August 13 your president again wired the two senators as follows:

"U.S.S. Edward Martin—

"Thanks for your telegram reference to your position Reorganization Plans One and Two. We

are deeply grateful for your stand. The 11,000 doctors of Pennsylvania will be acquainted with your position. Gratefully." (signed) GILSON COLBY ENGEL, President.

"U.S.S. Francis J. Myers—

"Thanks for telegram reference Reorganization Plan One. We realize there will be debate. Our request is for your opposition to this plan. Will you oppose it? Senator Martin has wired he will oppose Plans One and Two. Your answer, like Senator Martin's, will be published to the 11,000 members of the medical profession of the Commonwealth." (signed) GILSON COLBY ENGEL, President.

The result of the vote in the Senate on August 16 was 60 to 32 in opposition to Plan One. The Pennsylvania senators voted as follows:

U.S.S. Edward Martin AGAINST the Plan
U.S.S. Francis J. Myers FOR the Plan

Both the senators from Pennsylvania have been made aware that our membership would be reminded of their votes on this and other health legislation.

Your president feels that every doctor in Pennsylvania should stop and think. Senator Martin has backed the medical profession in its efforts to develop and maintain better health standards for all the people, while Senator Myers has opposed. Think it over.

ADDRESS YOUR CONGRESSMAN "IN PLAIN TERMS"

We quote briefly from the speech that Clarence J. Brown, member of Congress from Ohio and a member of the Hoover Commission, delivered at our society's second annual state dinner in Pittsburgh, September 26:

"The socialistic schemers and bureaucrats in Washington have become so cocksure that America as we have known it is gone, and that their battle has been won, that they no longer bother to give Congress estimates of what their schemes will cost. President Truman, Secretary Brannan, and Mr. Oscar Ewing all refuse to say or duck and dodge. They know that most Americans would be aghast at the price they would have to pay. The Congress can still call in outside experts and it has been estimated that this staggering burden, added to present governmental cost, would eventually bring the annual cost of Federal government alone to the frightening figure of 84 billion dollars.

"Back in 1913, the cost of all governments—Federal, state, and local—was only two and one-half billions. Twenty-six per cent of this two and

one-half billions was expended by the Federal government, 14 per cent by state government, and—get this—60 per cent by local government.

"By 1948 the total cost of government had risen to approximately 60 billion dollars, with the Federal government spending 71 per cent, state governments 15 per cent, and local governments only 14 per cent.

"If the spenders have their way, the annual cost will not only go to 84 billions but socialization of America through taxation will have become an accomplished fact. The appalling truth is that unless the present trend is stopped and reversed, the cost to the government will probably be 50 per cent or higher of our national income. That, my friends, is what we actually face.

"The idea of something for nothing is deliberately fostered by the refusal of the bureaucrats in Washington to make any estimate of the cost of their projected programs. They want it that way; they are planning it that way.

"I know of no greater contribution that you members of the medical profession can make to your neighbors and your country than to join in the task of exposing the dangers which lie ahead in these fantastic schemes, which are now openly advocated by the demagogues of Washington. You have already taken up arms against the threat of socialized medicine. You were among the first to see the danger of that proposal to our American way of life. When the medals are struck for the heroes in this fight to preserve human freedom, yours will be among the first. And, if all thinking Americans can become as alert as you have been, we will win this struggle to save our beloved country from this form of state socialism.

"Tonight there is one thin wall standing between the American people and statism, and that is the Congress. There are not twenty men in the Congress, regardless of what they may say publicly, who do not know that if they vote for the White House program to socialize America, this land of ours is gone. Congress alone cannot hold out forever. The entire American public must be aroused to the dangers which confront our beloved country, and to a mighty united action in its defense.

"In the next twelve months the entire legislative program of the socialistic schemers is scheduled to be voted upon by the Congress. Every true American should let his Congressman know in plain terms that he wants no part of socialism, or any other ism. Our citizens still have a voice in their government. But even that right is now threatened."

CHANGES IN MEMBERSHIP OF COUNTY SOCIETIES

New (13) and Reinstated (7) Members

BEAVER COUNTY: (Reinstated) George A. McCloskey, Rochester.

CHESTER COUNTY: Theodore C. Orlik, Coatesville. (R) Lawrence C. Moore, Avondale.

CLARION COUNTY: Paul K. Wellman, St. Petersburg.

LACKAWANNA COUNTY: Harold L. Casey, Carbondale.

LYCOMING COUNTY: Robert Shu Yasui, Williamsport.

NORTHAMPTON COUNTY: (R) Leslie M. Freeman, Somerville, N. J.

PHILADELPHIA COUNTY: Edwin R. Cornish, Jr., Rodney A. Farmer, H. Keith Fischer, Ralph Jones, Harry N. G. Kline, Victor Kremens, Joseph L. Platt, Philadelphia; Morris W. Yarrow, Elkins Park. (R) Mary H. Raytkwich, Norwood; Arthur Raymond Thomas, Philadelphia.

SCHUYLKILL COUNTY: Richard E. Miller, Tamaqua.

WESTMORELAND COUNTY: (R) Roy C. Monsour, Jeannette; Harry J. Stockberger, Slickville.

Resignations (10), Transfers (2), Deaths (10)

ALLEGHENY: *Transfer*—Benjamin R. Mooney, York, to York County Society.

ARMSTRONG: *Death*—John S. McCafferty, Freeport (Univ. Pgh. '33), July 3, aged 40.

BEAVER: *Death*—Harry Vernon Swick, Beaver Falls (Temple Univ. '37), August 1, aged 36.

BERKS: *Resignations*—Robert F. Branch and Howard Reber, Reading.

BUTLER: *Death*—Willis A. McCall, Butler (Univ. Pgh. '04), July 29, aged 71.

LACKAWANNA: *Resignations*—Clara Raven, Dayton, Ohio; Leonard W. Ramey, Van Nuys, Calif.

LANCASTER: *Death*—Walter F. Mylin, Willow Street (Jeff. Med. Coll. '03), August 2, aged 71.

LEHIGH: *Death*—Harry A. D. Baer, Allentown (Jeff. Med. Coll. '17), July 14, aged 61.

NORTHAMPTON: *Transfer*—John P. Manges, Chambersburg, to Franklin County Society. *Death*—Budd J. Reaser, Martins Creek (Univ. Md. '09), August 7, aged 67.

PHILADELPHIA: *Resignations*—John Wm. Frost, Indianapolis, Ind.; Salvatore L. Lombardi, Philadelphia; Charles S. Rosenfield, Miami, Fla.; John A. Sterner, Alderwood Manor, Wash.; Daniel Willner, Atlantic City, N. J.; Russell K. Williams, Shelby, N. C. *Deaths*—Virginia M. Alexander, Philadelphia (Woman's Med. Coll. '25), July 24, aged 50; Abraham Silverman, Philadelphia (Balt. Med. Coll. '07), July 23, aged 64; William J. Walsh, Jr., Philadelphia (Jeff. Med. Coll. '27), August 12, aged 64.

WESTMORELAND: *Death*—Joseph C. Stahlman, Vandergrift (West. Res. Univ. '87), August 9, aged 91.



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The following payment of per capita assessment has been received since July 31. Figures in first column denote county society numbers; second column, State Society numbers.

Aug. 10	Schuylkill	164	10575	\$15.00
	Lackawanna	287	10576	15.00
	Beaver	137	10577	15.00
	Philadelphia	3159-3178	10578-10598	300.00
	Chester	120	10599	15.00
	Clarion	25	10600	7.50
25	Westmoreland	211-212	10601-10602	30.00
	Lycoming	145	10603	7.50
29	Chester	118	10604	7.50

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Requests filled during the month of August were:

Diabetes mellitus (2)	Blood types
Cadmium toxicity	Treatment of asthma
Manganese poisoning	Multiple sclerosis
Beryllium toxicity	Treatment of diabetes
Zinc poisoning	Medical jurisprudence
Arsenic toxicity	Blood sugar
Undulant fever	Poliomyelitis
Pemphigus vulgaris	Water supply
Eclampsia	Treatment of acne
Aneurysm	Psychiatry
Pudendal nerve block	Blepharitis
Medical aptitude tests	Whooping cough
Air conditioning	Acne vulgaris
Trichobezoar	Retrolbulbar neuritis
Retrolbulbar neuritis	Vision conservation
Riedel's struma	Eye diseases
Unexplained fever	Blindness
Electroshock therapy	Glaucoma
Electronarcosis	Cataract extraction
Scleroderma	Medical specialties
Intranasal surgery	Obesity
Colic in infants	The anemias
Splenic anemia	Physical therapists
Portal vein	Gangrene
Banti's disease	Cough therapy
State-aided hospitals	Acne therapy
Experimental diabetes	Plastic surgery
Alloxan and diabetes	Nose deformities
Kaposi's sarcoma	Socialized medicine
Muscle cramps	Cancer of the breast
Thymol turbidity test	Coronary occlusion
Diabetes	Use of dicumarol
Carcinoma of the uterus	
Carcinoma of the pancreas	
Diseases and poisonings in industry and occupation	
Nitrogen mustard in Hodgkin's disease	
Rh factor in obstetrics	
Occupational therapists	
Instructions for colostomy patients	
Intracranial calcification	
Rehabilitation in tuberculosis	
Pathology of lung cancer	
Photomicrographs of the lung	
Rocky Mountain spotted fever	
Blood sugar determination test	
Guillain-Barré syndrome (2)	
Spinal fluid in poliomyelitis	
Giant follicular lymphoma	

NOTICE OF A.M.A. MEMBERSHIP ASSESSMENT

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The American Medical Association has requested each state medical society to collect the 1949 A.M.A. \$25 assessment from active members. Please make check in favor of *American Medical Association—Assessment* and mail to The Medical Society of the State of Pennsylvania, 8104 Jenkins Arcade, Pittsburgh 22, Pa.

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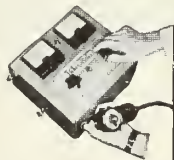


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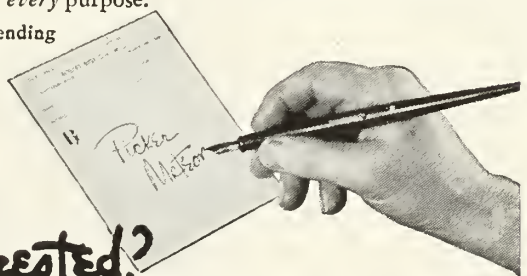
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TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the co-operation of the Pennsylvania Tuberculosis Society
and The Medical Society of the State of Pennsylvania

EVERYONE concerned with tuberculosis control depends upon mortality figures as the mariner does upon the sun and stars. They show how far we have come and what remains to be done before tuberculosis finally disappears. The current figures show progress, but they also bring to our attention the importance of more intensive work with older age groups in planning the attack upon tuberculosis.

TUBERCULOSIS MORTALITY IN THE UNITED STATES, 1947

In 1947 there were 48,064 deaths from tuberculosis in the United States. The death rate was 33.5 per 100,000 population, which was 8 per cent below the rate for 1946.

This decrease in the tuberculosis death rate continued the downward trend which has prevailed with few interruptions since 1910. Of the total deaths from tuberculosis in 1947, more than 90 per cent were attributed to respiratory tuberculosis. For both respiratory and non-respiratory infections, mortality was much greater for non-whites than for whites and greater for males than for females.

Death rates for tuberculosis in the white population and for non-white males were lower in the young adult years than in the older age groups, while for non-white females the highest rates occurred in the young adult group. Among

all young adults, the rates were higher for females than for males; among older persons, the rates were much higher for males. The rates for non-whites were far above those for whites in all age groups except 75 years and over.

Death rates for tuberculosis were lower in 1947 than in 1939-41 for almost all population groups. In general, greater gains were made by females than by males, and by younger than by older persons. The only increases in rates were for males in the age groups over 55 years and for non-white females 65 to 74 years of age. Tuberculosis death rates in 1947 by state of residence ranged from 11.8 for Iowa to 100.0 for Arizona.

Tuberculosis Mortality in the United States, 1947, Sara A. Lewis, Public Health Reports, April 1, 1949.

TUBERCULOSIS MORTALITY IN OLDER AGE GROUPS

Mortality statistics compiled for 1947 show that tuberculosis death rates have again declined in the United States. In 1947 the rate was 33.5 per 100,000, as compared to 36.4 in 1946. These gratifying figures show that progress is still being made toward the goal—the disappearance of tuberculosis from the United States.

An analysis of the 1947 mortality data brings out a fact which is very significant. The proportion of deaths from tuberculosis among people over 45 years of age is steadily increasing.

For many years tuberculosis was a disease primarily of young adults between the ages of 15

and 44—people in the prime of life, wage earners, parents of small children, young people just starting their life work. In 1900, for example, almost two out of three of all the reported tuberculosis deaths were in this age group. Only one out of four of those who died was 45 or over. By 1940, over half of the tuberculosis deaths reported still took place among people between the ages of 15 and 44, but deaths of those 45 and older had risen to 42 per cent of the total.

An important factor in this shift has been the fact that mortality rates have declined more slowly in the older age groups than in the young-

er, and the greater number of older people in the country's population further accentuates the degree of change.

The shift toward older ages at death has great significance for tuberculosis case-finding activities. A study of a recent mass x-ray survey made in a Georgia county contains one of the few available tabulations of the ages of those x-rayed. It was disappointing to see the small percentage of older people who took part in that survey. Although 62 per cent of the population of the county in the age group 45 to 54 were x-rayed, the percentage fell rapidly in older age groups; only 17 per cent of those 75 and over participated.

Obviously there are many reasons why people do not take part in mass surveys. Many of the very old people could not participate because of illness or incapacity. Many others not so old, however, failed to be examined because they

think tuberculosis is a disease they have "outgrown." They must be cautioned that those over 45 are subject to tuberculosis just as younger people are.

Control workers should be reminded that older people form a major source of infection in the population. Special efforts are needed to discover the disease among those over 45 for the protection both of individuals and of the community. All men and women, young and old, should be urged to have periodic x-ray examinations either in mass surveys or as part of their annual physical examination by private physicians. Only by special emphasis and special efforts can all cases of tuberculosis be discovered, isolated, and brought under treatment.

Tuberculosis Mortality in Older Age Groups.
Robert J. Anderson, M.D., Public Health Reports, April 1, 1949.

INTERNATIONAL COLLEGE OF SURGEONS TO MEET

The International College of Surgeons, United States Chapter, will hold its fourteenth annual assembly and convocation in Atlantic City, N. J., Nov. 8, 9, 10, 11, 12, 1949, according to Custis Lee Hall, M.D., Washington, D. C., president of the Chapter.

Some sixty eminent surgeons from the United States and abroad will present papers in the scientific sessions at Atlantic City, covering subjects in the fields of general surgery; eye, ear, nose and throat surgery; gynecology and obstetrics; urology; orthopedic, thoracic, plastic, and neurologic surgery. Extensive technical and scientific exhibits will be presented throughout the assembly by leading manufacturers of surgical instruments, x-ray apparatus, operating room and hospital equipment, pharmaceuticals, and others, Dr. Hall said.

Arnold S. Jackson, M.D., secretary of the United States Chapter, has reported from the College headquarters in Chicago that over 500 surgeons will be received as Associate Fellows and Fellows of the International College at the colorful convocation ceremonies to be held in Convention Hall, Atlantic City, on November 10.

Among the famous surgeons who will participate in the program are: Alfred Adson, M.D., Rochester, Minn.; W. Wayne Babcock, M.D., Philadelphia; Paul Banzet, M.D., Paris, France; John Garlock, M.D., New York, N. Y.; Raymond McNealy, M.D., Chicago, Ill.; Henry Meyering, M.D., Rochester, Minn.; Richard W. Telinde, M.D., Baltimore, Md.; and Max Thorck, M.D., Chicago, Ill.

Special surgical clinics will be held on Monday, November 7, in Philadelphia hospitals.

All doctors of medicine interested in surgery and its advancement are invited to attend, and can obtain a program upon request to Arnold S. Jackson, M.D., Secretary, 1516 Lake Shore Drive, Chicago, Ill. For hotel

reservations, contact David B. Allman, M.D., general chairman of the Assembly, c/o Haddon Hall, Atlantic City, N. J.

HAY FEVER DRUG MAY CAUSE URINARY OBSTRUCTION

Pyribenzamine hydrochloride, an antihistaminic drug that has been used for hay fever and to relieve symptoms of colds, may cause urinary obstruction, says Samuel A. Wolfson, M.D., Los Angeles, in the July 16 *Journal of the American Medical Association*.

The antihistaminic drugs inhibit the action of histamine, a chemical released from body tissues during allergic reactions.

Dr. Wolfson reports a case in which urinary obstruction was attributed to pyribenzamine hydrochloride.

"Various side reactions from the use of pyribenzamine hydrochloride have been observed," he points out. "Drowsiness, dizziness, gastric disturbances, and headache have been the responses most commonly evoked. Less frequent in occurrence have been urinary burning and urinary frequency.

"I recently saw a patient whose reaction to the drug involved the urinary tract. To prove the validity of the assumption that the distress was due to the antihistaminic agent, it was planned to reproduce the condition at a later date.

"The patient was observed for two months, during which urinary function remained normal. On May 3, 1949, the patient received pyribenzamine hydrochloride at 7 a.m. and again at noon. About 4 p.m. the urinary difficulty reappeared. No more of the drug was administered. The symptoms rapidly subsided and have not returned to date."

THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

547 Water Street

Indiana, Pa.

HEART-WARMING PUBLIC RELATIONS

Public relations is a cold phrase for what can be a heart-warming relationship with others in our communities. It gives to each doctor's wife a chance to spread information and to influence the thoughts and actions of Mr. and Mrs. John Q. Public. Even Congress in Washington and the Assembly in Harrisburg, we hope, will feel the effects!

These thoughts—written in the sweltering heat of summer—are designed for the most important link in the medical auxiliary chain, *you*, the individual member. Your understanding of current social and economic problems, your belief in medicine's ability to continue the progress made against disease (if left unhampered by political controls), and your actions as auxiliary members and as "Any Doctor's Wife" may be the deciding factors to preserve for all children the kind of America you have enjoyed.

Of course, it means first a willingness for self-education! However, the American Medical Association and The Medical Society of the State of Pennsylvania certainly give us plenty of learning in easy capsules, if we will but swallow. *Hygeia* in August translates from principles into practice the 12-point program of the A.M.A., the most comprehensive answer to health needs. Then the chairman of our State Auxiliary Advisory Committee, Howard K. Petry, M.D., in his page in the PENNSYLVANIA MEDICAL JOURNAL, as chairman of the Society's Committee on Public Relations, gives those of us who read a philosophy which pricks our consciences and inspires us all to sacrifice if need be to return the doctor to his pedestal in the hearts of the public. The *Bulletin* of the A.M.A. Auxiliary—a quarterly for the price of a good movie—is full of hearty food for mentally lazy leaders. Certainly the 1948-49 articles in this column written by your present national chairman of public relations, Mrs. Paul C. Craig, are frosted delights to whet any appetite. To see where *you* fit into the picture, just read again her diet for "Any Doctor's Wife" in the June issue of the PENNSYLVANIA MEDICAL JOURNAL, page 1008.

To be sure you have the answers to tell the world the facts, and to have fun in the learning of them, why not join or *organize a study group* in your auxiliary? Invite other friends to join also, and pick for a leader someone who will help turn the difficult into easy lessons—(your legislative chairman, a past auxiliary president, or an ex-school teacher, perhaps). Meet once a week for discussions instead of bridge, and you'll unconsciously find yourself telling the world what you have learned. One such group covered the variety of medical care laws presented to this Congress, comparing, evaluating, and noting good features and bad ones. They read Oscar Ewing's "The Nation's Health" and interjected their own reactions. They avidly clipped articles telling of European and English attempts to solve health problems by government magic. They put themselves in the places of their husbands' patients—the clerk, the factory girl, the miner, the teacher—and used their arguments for letting the government handle financial worries for health needs. Then they found the answers—down-to-earth, convincing—to appeal to the temperaments and experiences of the average mother and worker. The first thing they knew, they had worked out a *panel* discussion and were giving a thirty-minute to an hour story to church groups. They have just started, but have been delighted with their reception. Yes, they are doctors' wives, *but* they are proving, too, that they are students who can bring the opinion of true experts to bear on health needs and economic and social problems of American neighbors. They gain *respect*. . . .

Just a few words about the *requested projects* facing every auxiliary in Pennsylvania for 1949-50, urged by the State Medical Society and enthusiastically endorsed, we trust, by your county medical society. Never have your auxiliary officers depended on *you* more for the success of the public relations job. First, the *personal education plan*, of which you will hear more and more—a system whereby auxiliary members agree to inform from five to twenty-five friends of the dangers of compulsory health insurance plans, to provide them with effective literature,



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GYNECOLOGY—Intensive Course, two weeks, starting October 24. Vaginal Approach to Pelvic Surgery, one week, starting November 7.

OBSTETRICS—Intensive Course, two weeks, starting November 7.

MEDICINE—Intensive General Course, two weeks, starting October 3. Gastroenterology, two weeks, starting October 24. Gastroscopy, two weeks, starting October 24.

DERMATOLOGY—Formal Course, two weeks, starting October 24. Informal Clinical Course every two weeks.

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and to alert them to write letters to law-makers at strategic times—not like puppets pulled by a string, but like sincere, well-informed citizens who believe in the rights of all Americans to the best kind of health and medical care.

Second, the *health poster contests*—to make school children more aware of good personal health habits, the role of public health and sanitation, and the part that organized medicine plays in making these things possible for them. Private and parochial schools will welcome the chance. If you remember to ask for cooperation well in advance of the dead-line date, the art supervisors of the public school can plan the work without upsetting their whole course. Our Mrs. John V. Foster is the person to ask.

Third, the *National Education Campaign*—assisting your county medical society in the specific ways suggested to the county committee in that cleverly prepared plan book from 230 State Street, Harrisburg. They will welcome volunteer help, these busy doctors of ours. Anyone can be a delivery girl for pamphlets and an F.B.I. agent to ferret out county meetings of clubs and organizations and especially church groups where speakers may be used and endorsements secured against the compulsory health insurance schemes of government planners.

Fourth, *offering materials, speakers, and movies* to other groups for their health programs. Ease yourself onto a program committee; accept the chairmanship of health committees in your clubs and church societies and skillfully suggest the speakers who reflect right knowledge on health matters. Movies are easily obtained from the MSSP, you know. "Medical Research," "Why Protect the Public by Licensure Laws," and "Newest in Would-Be Laws" are some of the subjects your state legislative chairman wants your help in getting across to your neighbors.

Of course, there are other projects that your auxiliary may choose to sponsor, either alone or in cooperation with other groups, that may challenge your interest: a Health Day; speeding up Blue Shield insurance coverage by starting in your own professional group; supplying kits of study materials on the Voluntary Way in Medical Care to high schools, colleges, and public libraries; or helping to launch a local public health project (based on the A.M.A. famous 12 points) such as nurse recruitment, school health services, or local public health units. Why not be the unusual member and shock your auxiliary officers and public relations chairman by letting them know what appeals to you? The choice each auxiliary makes will reflect on the local

medical society, leave its mark on the auxiliary, and be a real help or hindrance to the cause of "better health for all." So please carefully select projects in the light of present-day needs, consult *in advance* with your local medical society advisory committee, and then carry through!

This public relations challenge need not be too difficult for any auxiliary, as you can readily appreciate, if we as doctors' wives put our hearts and minds into it and study and work together. We will find its results are like those of the "quality of Mercy, which droppeth as the gentle rain from heaven. It blesseth him that gives and him that takes. 'Tis mightiest in the mightiest." It is truly heart-warming, too; let's try it!

(MRS. CHARLES L.) GLADYS HALL SHAFER,
Public Relations Chairman.

REPORT ON 1949 COUNCILOR DISTRICT MEETINGS

Having served four years as an Auxiliary district councilor, I approached with eager anticipation my assigned duty as state chairman of 1949 councilor district meetings.

Each auxiliary district councilor undertaking her full share in the planning and preparation for the Auxiliary's part in the annual meeting of the twelve councilor districts into which the state medical society is divided deserves great credit. Much correspondence, many telephone calls and personal contacts by each councilor are essential if these meetings are to prove profitable.

This report is submitted with the understanding that suggestions and comments are made from the point of view of the Auxiliary in its proper capacity as ancillary to the various medical societies it is pledged to serve.

The report is divided under three headings: first, the purpose of such meetings; second, report of 1949 meetings; third, suggested plans for the membership in future district meetings.

Purpose

To provide an opportunity for social contacts among families of physicians in neighboring counties; to inform the members of community problems of the profession in respective counties and districts; to provide opportunity for study and discussion of auxiliary problems and programs with exchange of helpful ideas; to permit the president-elect of the State Auxiliary as chairman of councilors to gain an insight of the State as a whole from the example set by local

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leadership and to discuss informally with individuals mutual opportunities for service.

Progress Report for 1949

At the State Auxiliary conference held in Harrisburg in March, your chairman met with councilors in discussions that brought forth new ideas, among which was a plan for holding auxiliary meetings on a councilor district basis in some districts apart from the annual councilor district meeting of the county medical societies comprising the district.

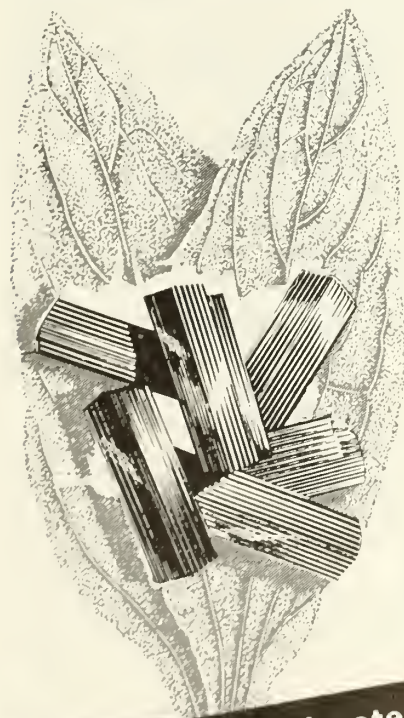
Plans were discussed for these separate meetings including instruction periods, round table discussions, informal talks between county auxiliary officers and chairmen of committees, to be followed by luncheon and a meeting with the auxiliary membership of the district.

Speakers at such meetings might include medical society officers, state and county; representatives of public relations committees, state and county, and representatives of Blue Shield and Blue Cross—every such meeting to provide the women in attendance with suggestions for their personal and individual service to the medical profession in terms of improved public relations.

I was keenly interested in observing the attendance at the meetings which was said to have

waned in recent years. The chief cause attributed was popularity of the graduate education courses, which in the year 1949 enrolled nearly 1100 Pennsylvania doctors and required their absence from their practices for ten days, five days each, in a fall and spring course. Various methods of notifying members regarding meetings in their district were employed. Where combined meetings of medical society and auxiliary were held, auxiliary members received a separate notice from that sent to the county medical society membership. At these combined meetings the attendance of women averaged between 30 and 40. At meetings of the district auxiliaries alone the attendance was about the same with an increase in the number of auxiliary officers and committee chairmen present.

Your chairman attended all councilor district meetings except that of the First District, the combined meeting of the Third-Fourth-Twelfth districts, and the meeting of the Eleventh District. However, I attended other meetings in these latter districts discussing problems and plans with many women who will serve with the incoming president. The tri-county meeting in the Fourth Councilor District was attended by a large percentage of the auxiliary membership for that district, whereas none of these women have



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been able to attend the regular district meeting. I attended a reciprocity meeting in Luzerne County where I spoke to 70 women who would not otherwise have been reached. Therefore, with the exception of the Eleventh Councilor District meeting, which was held in July, I feel that I have gained a good general idea of state needs from the councilor point of view.

Suggestions for the Future

Reading reports of meetings has little value unless they provide a comparison between past efforts and present accomplishments. Plans here discussed were developed from ideas expressed and suggestions given by district councilors of the Auxiliary as we talked over district problems and from county auxiliary officers in their replies to questionnaires. As a result, your chairman herewith presents comments and recommendations for the thoughtful perusal of all readers whether they be medical society or auxiliary members on a county or state basis.

Publicity in regard to councilor district meetings should include: (1) At the county level, very early notice in the county medical society bulletin and letter-bulletin. (2) At the state level, if scheduled not later than December by the trustees and councilors, announced in February, and held not later than May, full publicity of all such meetings, medical and auxiliary, or if separate meetings, would readily appear in the April issue

of the PENNSYLVANIA MEDICAL JOURNAL. In addition, notice of such meetings should appear in the News Letter of the Auxiliary and the Public Relations Reporter of the State Medical Society. (3) Attractive notices of such meetings with return post cards addressed to the auxiliary councilor should be sent to auxiliary members, in addition to the notices of meetings which are addressed to the members of the county medical societies. (4) Newspaper publicity in advance of all such meetings and, where possible, a radio script presentation by visiting guests and speakers, if given press notice in advance, would tend to increase attendance and interest.

The custom of holding councilor district meetings seems to hold certain values, but the importance of early and careful planning remains paramount. Early planning and announcement are of great importance to the arrangement of schedules by officers and other representatives of the State Medical Society and of the Auxiliary. The auxiliary attendance at councilor district meetings held in June and July is seriously reduced by the conflicting interests of auxiliary members who are engaged at that time with plans for children returning from school or graduating or preparing for attendance at camps or other forms of vacation.

With the exception of three councilor districts, these annual meetings seem to have come to be regarded by those responsible for them as neces-

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sary evils. This type of leadership results in delay and confusion in securing meeting places, speakers, and satisfactory dates.

A system for rotating county medical societies to serve as the host for the annual councilor district meeting would not only divide the responsibility but acquaint more and more doctors and auxiliary members with the required effort and time to be spent in planning for a successful meeting as well as the satisfaction which comes to those who have succeeded in presenting a successful program.

In scheduling councilor district meetings, some thought should be given to the convenience of state society and auxiliary representatives expected to attend most of the meetings by arranging to hold them in the eastern, central, and western sections of the State, respectively, and so scheduled that not more than one day would intervene between such sectional meetings, e.g., of the Eighth, Ninth, Tenth, and Eleventh Councilor Districts. The adoption of such a plan, it is believed, might permit the auxiliary councilors to be of assistance to the medical society trustees and councilors and relieve them of considerable annoyance and effort such as reserving space in available clubs or hotels and arranging the dates of meetings, etc., far enough in advance. Combined councilor district meetings, such as that of the Third, Fourth, and Twelfth, tend to require distant traveling for members of the county societies and auxiliaries.

The Woman's Auxiliary to The Medical Society of the State of Pennsylvania is deeply concerned with the matter of attendance at councilor district meetings as well as the future success of such sessions; therefore, the appended summary of ideas based on this year's experience and suggestions received from the membership in general is herewith presented:

1. Annual councilor district meetings are very valuable as a means of promoting fellow-



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ship and unity and of imparting information and instruction to the members of both the medical societies and their respective auxiliaries.

2. The 1949 meetings were marked by the presentation of excellent programs of helpful study sessions with question and answer periods which were voted as highly popular among auxiliaries. A comparison of auxiliary membership in the various councilor districts with attendance by auxiliary members at the 1949 meetings may prove to be illuminating.

The combined meeting, medical society and auxiliary, in the First Councilor District, with 450 auxiliary members, had an attendance of between 75 and 100 women. Approximately the same number attended a similar combined meeting in the Tenth Councilor District from its total membership of 610 auxiliary members.

The average attendance of women in the ten other councilor districts was 40, with the smallest auxiliary membership of 117 in the Fourth District, and the highest of 693 in the Second District. Although district councilors have been most conscientious in

notifying the membership in their respective counties, ten county auxiliaries failed to send a representative to any of the meetings. No appreciable difference in attendance was noted between meetings where the women attended with their husbands or without their husbands. We are certain, however, that many doctors attended councilor district meetings because their Auxiliary-minded wives urged them to attend. It was true that in districts where the trustee and councilor worked in close cooperation with the auxiliary councilor, attendance and interest were increased.

3. In connection with earlier comments regarding the arrangement of 1950 meetings in series, it may be suggested that the president of the State Medical Society and the president of its Woman's Auxiliary, working with their respective presidents-elect, might very well between now and December arrange a tentative schedule of these councilor district meetings to be held in a single week, giving full consideration to geographic relationship.
4. This refers again to early advanced publicity regarding place, date, and time of

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1950 councilor district meetings by means of county and state society publications.

5. In conclusion, it is recommended that trustees and councilors early become acquainted with the auxiliary councilor for their respective districts, who will stand ready and willing to shoulder any of the time-consuming details of arranging for councilor district meetings.

In terms of service rendered, no group of officers in the entire State Auxiliary give more of time and energy to The Medical Society of the State of Pennsylvania than these fine women who stand ever ready to serve as a liaison between county and state medical societies and their respective woman's auxiliaries.

Respectively submitted,
(MRS. DRURY) ELIZABETH M. HINTON,
Chairman of Councilors 1948-1949.

WE BELIEVE

The people have a right to know that political medicine is bad medicine, that it means inferior medical care, that it means extortionate payroll taxes, that it means invasion of their privacy, that it means destruction of the splendid voluntary health insurance systems which provide good, honest medical care at lower cost than government ever can provide it.

KEEP MOTH BALLS AWAY FROM CHILDREN

Sucking moth balls can cause severe poisoning in children, warn two Detroit doctors.

Four cases in which two-year-old youngsters were made acutely ill by eating moth balls of naphthalene are reported in the September 17 *Journal of the American Medical Association* by Drs. Wolf W. Zuelzer and Leonard Apt of Wayne University College of Medicine.

The substance caused an anemic condition, they explain. All four children recovered completely after receiving blood transfusions and other treatment.

"In each of the four patients a definite history of naphthalene ingestion was obtained, although the exact amounts could not be established," the doctors say. "Each child previously had been in perfect health and had not been exposed to other chemicals with hemolytic action.

"Within a period varying from three to seven days, severe anemia developed in each case. The patients eventually made a complete recovery with return of the blood values to normal levels.

"All of our patients were approximately two years old, an age group particularly prone to the ingestion of household poisons. The symptoms begin with listlessness and loss of appetite followed by vomiting and other gastro-intestinal disturbances. Eventually pallor is noted.

"Since moth balls are a common and easily accessible household article, generally believed to be harmless, and since the American literature seems to contain no previous reports of this kind, the cases are reported in detail."

The doctors do not suggest that any first aid procedures to combat moth ball poisoning be carried out at home before a doctor is called.



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MEDICAL NEWS

Births

TO DR. AND MRS. CLARENCE C. BRISCOE, of Cynwyd, a son, Philip Suttle Briscoe, September 6.

TO DR. AND MRS. H. WALTER FORSTER, JR., of Wynnewood, a daughter, Barbara Kane Forster, September 3.

TO DR. AND MRS. LOUIS B. LAPLACE, of Ardmore, a son, Robert Laplace, September 22. Mrs. Laplace is the daughter of Dr. and Mrs. I. Pemberton P. Hollingsworth, of West Chester.

Engagements

MISS MARY ALICE SWINEHART, of Philadelphia, to Mr. Frank C. Gryczka, son of Dr. and Mrs. Frank B. Gryczka, of Reading.

MISS CONSTANCE LOUISE CAPLAN, daughter of Dr. and Mrs. Leon S. Caplan, to Mr. Barrie A. Marks, all of Philadelphia.

MISS BEATRICE ELFRETH, of Milford, Del., to Mr. G. Malcolm Laws, Jr., son of Dr. and Mrs. George M. Laws, of Philadelphia.

MISS HELEN JUNE FORESMAN, of Prospect Park, to Mr. Robert Hamilton Goepp, son of Dr. and Mrs. R. Max Goepp, of Philadelphia.

MISS MARY ELIZABETH ROMIG to Mr. Robert Bruce McKinstry, son of Dr. and Mrs. Herbert S. McKinstry, all of Kennett Square. Mr. McKinstry is a student at Hahnemann Medical College, Philadelphia.

MISS MARY ALICE GRABE, of Camp Hill, to David Dale Kirkpatrick, Jr., M.D., of Saegertown. Miss Grabe is head nurse in the surgical division of Pennsylvania Hospital, Philadelphia, and Dr. Kirkpatrick is on duty with the Navy at the Philadelphia Naval Hospital.

Marriages

MRS. HILDRED HOMSTEAD, of Brewer, Maine, to Milton I. Pentecost, M.D., of Scranton, August 25.

MISS HELEN POWELL PRATT, of Media, to Paul Nemir, Jr., M.D., of Navasota, Texas, September 10.

MISS MARIANA CLAIRE TOLAND, daughter of Dr. and Mrs. J. Hart Toland, to Mr. Robert Glendenning Ives, all of Philadelphia, October 1.

MISS DOLORES E. BIELSKI, daughter of Dr. and Mrs. Francis V. Bielski, of Chester, to Mr. William S. Johnson, Jr., of Garden City, August 27.

MRS. CHARLES HENRY WIGHT, of Wayne, to Mr. William George Gerhard, son of the late Dr. and Mrs. Arthur H. Gerhard, of Philadelphia, September 9.

MISS EUGENIA PRESLER BIRDSALL, daughter of Dr. and Mrs. Joseph C. Birdsall, of Haverford, to Mr. Spencer Raymond Stuart, of Chicago, September 24.

MISS SARAH ELIZABETH HENSYL, daughter of Dr. and Mrs. William C. Hensyl, of Berwick, to Mr. Frank Alexander Schute, of Philadelphia, September 10.

MISS JEANETTE WARNER HENNY, daughter of Dr. and Mrs. George C. Henny, of Philadelphia, to Mr. Thomas Raymond Conway, Jr., of Portland, Ore., in September.

Deaths

○ *Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.*

○ **Alfred Hand**, Philadelphia; University of Pennsylvania School of Medicine, 1892; aged 81; died Sept. 1, 1949, at his summer home in Montrose, Susquehanna County. He had fractured his leg in a fall last May and shortly before his death fell a second time. Dr. Hand was a practicing physician for fifty-five years. He was professor emeritus of pediatrics at the University of Pennsylvania School of Medicine, and served on the staff of the Methodist and Children's Hospitals and as consulting physician at the Widener School for Crippled Children for many years. He was active for many years in the Philadelphia Pediatric Society and was a member of the American Pediatric Society. Surviving are his widow, a daughter, and three sons, one of whom is John G. Hand, M.D., of Philadelphia.

○ **Sigmund S. Greenbaum**, Philadelphia; Jefferson Medical College of Philadelphia, 1913; aged 59; died Oct. 3, 1949. Dr. Greenbaum was professor of clinical dermatology and syphilology at the University of Pennsylvania Graduate School of Medicine and was the author of more than 100 articles on skin and allied diseases. In 1937 he outlined, and was largely responsible for, the development of therapy for the in-patient and out-patient division for social diseases at the Philadelphia General Hospital. During World War I, he served on the Medical Advisory Board 1, Selective Service. He was a member of the American College of Physicians and the American Academy of Dermatology and Syphilology. Surviving are his widow, two sons, a daughter, two brothers, and a sister.

○ **James D. Lewis**, Scranton; University of Michigan Medical School, Ann Arbor, 1909; aged 69; died Sept. 2, 1949. Dr. Lewis was born in Pontardawe, Wales, and came to this country in 1888. During World War I, he served with the Army Medical Corps in France. He was medical director for Lackawanna County, and formerly served as Director of Public Health in Scranton. He was one of the pioneers in the movement to ban fireworks in Scranton and was instrumental in having the state law outlawing fireworks passed by the State Legislature. In 1922 he served as president of the Lackawanna County Medical Society, and for several years was a member of its Industrial Health Committee. Surviving are his wife, a son, a daughter, and two brothers, one of whom is David E. Lewis, M.D., Knoxville, Pa.

○ **Glenn H. Heilman**, Tarentum; University of Pittsburgh School of Medicine, 1923; aged 54; died on his birthday, Sept. 6, 1949, following an illness of more than a year. A member of the surgical staff at Allegheny Valley Hospital, Tarentum, Dr. Heilman was highly regarded by all who knew him. Since 1925 he had been associated with his brother, Dr. Marlin W. Heilman, in the practice of medicine. In 1939 he became a fellow of the American College of Surgeons and was elected to a fellowship in the International College of Surgeons in 1947. He served with the Army Medical Corps during World War I. Surviving are his widow, a daughter, three sons, three sisters, and another brother.

○ **Joseph P. Kennedy**, Columbia; Jefferson Medical College of Philadelphia, 1900; aged 81; died Sept. 28, 1949, after an illness of three weeks. Dr. Kennedy was a leader in the building of the present Columbia Hospital and was a member of its board for forty years. In 1941 he presented an ambulance to the hospital as a memorial to his late wife, who was hospital superintendent from 1910 to 1913. He served for many years as a Pennsylvania Railroad Company surgeon.

○ **David M. Bell**, Canonsburg; Jefferson Medical College of Philadelphia, 1903; aged 74; died Sept. 8, 1949, after an illness of several years. Dr. Bell was a member of the staff of the Canonsburg Hospital for many years and was active in civic affairs. He was a veteran of both the Spanish-American and First World Wars. Surviving are his widow, a daughter, a son, David M. Bell, Jr., M.D., three brothers, and two sisters.

○ **Samuel H. Johnson**, Pittsburgh; University of Pittsburgh School of Medicine, 1906; aged 67; died Sept. 8, 1949, while vacationing in Atlantic City, N. J. Dr. Johnson was a former member of the Pittsburgh Civil Service Commission, and was long associated with West Penn Hospital, where his son, Dr. Samuel H. Johnson III, is a staff member. He is also survived by his widow.

○ **Henry P. Boyer**, Philadelphia; University of Pennsylvania School of Medicine, 1891; aged 80; died Aug. 25, 1949. He was neurologist and dean of the medical staff at Stetson Hospital, and also served as physician to the Philadelphia Home for Incurables.

Anne E. Smiley, Philadelphia; Woman's Medical College of Pennsylvania, 1891; aged 79; died Oct. 2, 1949. A former staff member of Woman's Hospital, Dr. Smiley retired in 1941. She was the widow of Dr. Edwin R. Smiley and is survived by a son.

George M. Evans, Philadelphia; Meharry Medical College, Nashville, Tenn., 1906; aged 69; died Sept. 5, 1949, at his summer home in Pleasantville, N. J., after a long illness. His widow survives.

William M. Gordon, Philadelphia; University of Pennsylvania School of Medicine, 1910; aged 61; died Sept. 18, 1949. He is survived by his widow, two sons, two daughters, and one sister.

James W. Dorworth, Oil City; Cleveland-Pulte Medical College, Ohio, 1911; aged 73; died Aug. 30, 1949, following an extended illness. He is survived by two brothers and three sisters.

○ **Harry A. Shute**, Philadelphia; University of Pennsylvania School of Medicine, 1894; aged 87; died Sept. 26, 1949. Dr. Shute was an eye specialist for forty years. He is survived by a daughter.

○ **Willis A. McCall**, Butler; University of Pittsburgh School of Medicine, 1904; aged 71; died July 29, 1949.

Miscellaneous

THE FRACTURE COMMITTEE OF WESTERN PENNSYLVANIA will meet at the University Club, Pittsburgh, November 16, at 2 p.m. There will be a conference on fracture problems by all present until five o'clock, followed by a social hour, and at six o'clock an address will be delivered by Harold A. Sofield, M.D., of Chicago, on "Medullary Nailing of Fractures."

THE NINETY-SIXTH MEETING OF THE READING EYE, EAR, NOSE AND THROAT SOCIETY was the sixth joint meeting with the Berks County Medical Society and was held on September 13. The meeting consisted of a symposium on diabetes and was addressed by Milton P. Adel, M.D., of New York City, on "What Can the Internist Tell Us?" and Irving H. Leopold, M.D., of

Philadelphia, on "How Does the Ophthalmologist Help?"

ROBERT H. IVY, M.D., professor of plastic surgery in the University of Pennsylvania School of Medicine and professor of maxillofacial surgery in the university's School of Dentistry, has been named head of the new cleft palate division of the State Department of Health. The 1949 legislature appropriated funds for expansion of care to cleft palate and harelip patients. The new division will be part of the department's Bureau of Maternal and Child Health.

HENRY L. BOCKUS, M.D., for years head of the department of gastro-enterology at the Graduate Hospital of the University of Pennsylvania, Philadelphia, has been named chairman of the department of internal medicine of the university's Graduate School of Medicine. **Herman Beerman, M.D.**, professor of dermatology and syphilology, has been made chairman of that department, and **James R. Cameron, M.D.**, professor of oral surgery, has been made acting director of the course in oral surgery and anesthesia.

THE ANNUAL DACOSTA ORATION OF THE PHILADELPHIA COUNTY MEDICAL SOCIETY was delivered Wednesday night, September 14, in the society's building by **Bradley L. Coley, M.D.**, of New York. Dr. Coley spoke on "Medical Education in Relation to the Cancer Problem." He is attending surgeon in charge of the bone tumor department at Memorial Hospital in New York City and surgeon-in-chief at Mary McClelland Hospital, Cambridge, N. Y. In the teaching field, he is professor of clinical surgery at the Cornell University Medical School. The annual DaCosta Oration was started in 1930 in memory of Dr. J. Chalmers DaCosta, one of Jefferson Medical College's foremost teachers and surgeons.

ON NOVEMBER 17, 18, AND 19 THE FRANK E. BUNTS INSTITUTE AND THE CLEVELAND CLINIC will present a continuation course for physicians on "Medical and Surgical Disorders of the Urinary Tract." **Herman L. Kretschmer, M.D.**, of Chicago, will give the evening address, November 17, on "Clinical Significance of Hematuria." The other out-of-town guest speaker will be **Louis Leiter, M.D.**, of New York, who will speak on "Uremia" Saturday morning, November 19, and who will take part in the panel discussion closing the course. Inquiries regarding the complete program and registration can be addressed to the Director of Education, Frank E. Bunts Educational Institute, 2020 East Ninety-third St., Cleveland 6, Ohio.

THE AMERICAN UROLOGICAL ASSOCIATION offers an annual award of \$1,000 (first prize \$500, second prize \$300, and third prize \$200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to residents in urology in recognized hospitals.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Statler, Washington, D. C., May 29 to June 1, 1950.

For full particulars write the secretary, Dr. Charles H. de T. Shivers, Boardwalk National Arcade Building, Atlantic City, N. J. Essays must be in his hands before Feb. 20, 1950.

THE PENNSYLVANIA CHAPTER OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS is holding a meeting at Devitt's Camp, Allenwood, on Saturday, October 22. The following program has been arranged:

"The Management of Tension Cavities in Tuberculosis" by John S. Packard, M.D.

- "The Treatment of Pulmonary Tuberculosis with Pneumoperitoneum" by Elmer R. Hodil, M.D.
 "Treatment of Tuberculosis with Para-aminosalicylic Acid" by Howard E. Stine, M.D.
 "Tuberculosis of the Larynx with Cases Showing Response to Streptomycin Therapy" (kodachrome motion picture) by William A. Lell, M.D.
 "Mediastinal Tumors" (motion picture) by Clarence E. Moore, M.D.

DIAGNOSIS AND TREATMENT OF MALIGNANT TUMORS will be the theme of the thirty-fifth annual meeting of the Radiological Society of North America according to Edgar P. McNamee, M.D., of Cleveland, president of the society.

The convention, scheduled for Dec. 4 to 9, 1949, will be held in Cleveland with headquarters at the Public Auditorium and the Statler Hotel.

Heading the executive committee on local arrangements is Harry Houser, M.D., of Cleveland. He reports that arrangements are well advanced and promises an outstanding program. Carefully planned refresher courses, and scientific and commercial exhibits are included in the over-all plan. Special emphasis is being placed on large-scale exhibits.

THE SIXTH SERIES OF PUBLIC MENTAL HYGIENE LECTURES presented by the Philadelphia County Medical Society started Monday evening, September 26, at 8:15 o'clock in the society's headquarters, 21st and Spruce Streets, Philadelphia. During the three following Monday evenings topics for discussion were: "Emotional Factors in the Development of Delinquency," "Schools and Delinquency," "Legal Void in Dealing with Constitutional Psychopathic Inferiority," "Hooray! School Today!," "Delinquency in the Adolescent Period," "An Employer's Experiences and Practices in Handling the Delinquent," "Religion in the Home as a Preventive of Delinquency," and "Factors Contributing to Normal and Delinquent Personalities."

The speakers included Drs. Louis P. Hoyer, Frederick H. Allen, Stuart M. Finch, Eleanor A. Steele, the Honorable Harold L. Ervin, Rev. Gerard Murphy, Messrs. H. W. Jones and George W. R. Kirkpatrick. There was no admission fee, and a question and answer period followed each lecture.

JEFFERSON MEDICAL COLLEGE OF PHILADELPHIA has received official word that Alexander J. Orenstein, M.D., of the class of 1905, has been elected an Honorary Fellow of the Royal Society of Tropical Medicine and Hygiene. This honor has been conferred upon only thirty-five men during the forty-two years of the society's existence. Seven of these men, now deceased, were Americans: Gorgas, Theobald Smith, W. S. Thayer, Samuel Darling, Simon Flexner, C. W. Stiles, and Richard Strong. There are only seven Honorary Fellows living today, including Dr. Orenstein, the only American.

Dr. Orenstein served as Director of Medical Services during World War I with the Union of South Africa Forces. In 1939 he was inducted into the Union Defense Forces as Director General of Medical Services and served in the East Africa-Somaliland-Abyssinia Campaign and later in the Egypt-Lybia Campaign with the South African troops. After his return to South Africa, he resumed the post of Director General of Medical Services in 1943 and was promoted to Major General in 1945.

Dr. Orenstein is a member of the Royal College of Physicians and has been awarded Companion of the Bath, Companion of St. Michael and St. George, and Commander of the Order of the British Empire. He has also received a Belgian award—Knight of the Crown.

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By ARNOLD GESELL, M.D., and FRANCES L. ILG, M.D., in collaboration with LOUISE BATES AMES, Ph.D., and GLENNA E. BULLIS; 475 pp., 1946, \$4.50

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By ARNOLD GESELL, M.D.; profusely illus., 78 pp., 1945, \$2.00.

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By ARNOLD GESELL, M.D., and associates; illus., 393 pp., 1940, \$4.00

THE EMBRYOLOGY OF BEHAVIOR: The Beginnings of the Human Mind

This book portrays the ontogenetic patterning of behavior in embryo, fetus, neonate and infant. A richly illustrated, photographically documented volume which clarifies the earliest stages of human development. ". . . for the medical student, pediatrician and student of behavior . . . one of the best of the many excellent publications by Dr. Gesell."—*J.A.M.A.*

By ARNOLD GESELL, M.D., in collaboration with CATHERINE S. AMATRUDA, M.D.; illustrated, 312 pp., 1945, \$6.00

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BOOK REVIEWS

HANDBOOK OF OPHTHALMOLOGY. By EVERETT L. GOAR, A.B., M.D., F.A.C.S., Professor of Ophthalmology, Baylor University College of Medicine, Houston, Texas. With 48 text illustrations and 7 color plates. St. Louis: The C. V. Mosby Company, 1948. Price, \$5.50.

This is a short, easy reference manual for the practitioner of general medicine as well as the ophthalmologist. It is easily read because there is no waste of words, yet the author begins the handbook with a brief historical description of ophthalmology bringing his story up to the present time. This is unusual, for history is found chiefly in lengthy textbooks.

Anatomy, embryology, and histology are considered applied to the pathology connected with diseases of the eye. Refractive errors and correction are explained, and the common ophthalmologic instruments are described with a brief explanation of their use.

The book is well illustrated with many colored plates in addition to the black and white drawings. Its form is similar to a continuous lecture for a group of students.

PRINCIPLES GOVERNING EYE OPERATING ROOM PROCEDURES. By EMMA I. CLEVINGER, R.N., Supervisor of Eye Operating Room, New York Eye and Ear Infirmary, New York City. Illustrated. St. Louis: The C. V. Mosby Company, 1948. Price, \$5.50.

This book is a valuable addition to the operating room of any hospital, for it illustrates by means of many cuts the instruments necessary for eye operations. Not only are the illustrations labeled but the nursing and operating room techniques are also described. The types of sutures used, the electrical equipment required, and the drugs commonly used are given—even to the dilutions of the solutions used as well as the care of them.

There is a glossary of eye terminology, also a list of manufacturers and drug companies from which necessary equipment may be purchased or where it may be repaired.

STERILITY AND IMPAIRED FERTILITY. Pathogenesis, Investigation, and Treatment. By CEDRIC LANE-ROBERTS, C.V.O., M.S., F.R.C.S., F.R.C.O.G., Gynecologic Surgeon, Royal Northern Hospital; Consulting Obstetric Surgeon, Queen Charlotte's Hospital; ALBERT SHARMAN, M.D., Ph.D., M.R.C.O.G., Senior Assistant Surgeon, Royal Samaritan Hospital for Women, Glasgow; Assistant Lecturer in Clinical Gynecology, University of Glasgow; KENNETH WALKER, M.A., M.B., B.C. (Cantab.), F.R.C.S., F.I.C.S., Jacksonian Prizeman and Hunterian Professor, Royal College of Surgeons; Emeritus Surgeon, Royal Northern Hospital; Andrologist, Philip Hill Parenthood Clinic; B. P. Wiesner, D.Sc., Ph.D., F.R.S.E., Consulting Biologist, Royal Northern Hospital; and MARY BARTON, M.B., B.S., First Assistant to the Fertility Clinic, Royal Free Hospital, London. 400 pages. New York and London: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1948. Price, \$6.50.

This book is a most adequate coverage of the problem of sterility. It is almost equally divided between the male factor and the female factor of sterility. The first part goes into great detail concerning the anatomy, physiology, and pathology of the male and female reproductive organs. All methods of diagnosis and treatment are adequately covered.

The appendix outlines the technique of the most common laboratory and diagnostic procedures used in the investigation of the infertile marriage.

ALLERGY TO COTTONSEED AND OTHER OILSEEDS AND THEIR EDIBLE DERIVATIVES. Excerpts from testimony before the Administrator, Federal Security Agency. In the matter of fixing and establishing definitions and standards of identity for mayonnaise, French dressing, and related salad dressings (Docket FDC-51). Public hearings held at Washington, D. C., Nov. 18, 1947, and Jan. 6 to 8, 1948. Memphis, Tenn.: National Cottonseed Products Association, Inc., 1948.

This book reviews excerpts from the direct testimony of six allergists and two vegetable oil technologists presented before the Administrator, Federal Security Agency, in the matter of fixing and establishing definitions and standards of identity for mayonnaise, French dressing, and related salad dressings.

These witnesses testified at a public hearing authorized by the Federal Food, Drug, and Cosmetic Act for the purpose of determining whether the interest of consumers would be best served if the common name of each vegetable oil contained in salad dressing was declared on the labels. Under the terms of this act, foods generally are required to state on the labels the common names of their ingredients. With reference to the dressings mentioned, it has been permissible to use the general term vegetable oil.

The National Cottonseed Products Association sponsored this publication to make available to the medical profession and to allergists in particular a review by experts of the possible allergenicity of oilseeds and edible oils; included are details in the production and marketing of these products.

The book provides an excellent reference source for the clinical impressions of the testifying, practicing allergists who have had special interest in the cottonseed protein and oil problem. The role of cottonseed sensitization is thoroughly reviewed in the opinions expressed by the allergists.

Much of the direct testimony, as well as that presented on the cross-examination, is concerned with the determination of true cottonseed protein sensitization versus possible cottonseed oil sensitization. The opinions of the allergists are at variance, and their techniques for determining specific antigenic effects are reviewed.

No conclusions are arrived at in this particular presentation.

ESSENTIALS OF GYNECOLOGY AND ENDOCRINOLOGY. By GARDNER M. RILEY, Ph.D., Assistant Professor of Obstetrics and Gynecology, University of Michigan Medical School. 205 pages. Ann Arbor, Mich.: Caduceus Press, 1948. Price, \$3.00.

Nothing but praise can be expressed concerning this book, and it is regrettable that more books are not written in this fashion. Only tried and accepted procedures and methods of treatment are outlined here in a way in which they can be easily found and easily understood. Section I is concerned with endocrinology including the pituitary, ovaries, adrenals, and thyroid glands. The physiologic changes during pregnancy are also discussed. Section II discusses the clinical manifestations of pathologic endocrinology, changes during puberty and menopause, the menstrual dysfunction, and abnormal sexual development. One chapter discusses the endo-

crinology of the male. Section III is extremely valuable in that it clinically outlines the more common diagnostic procedure in detail and the details of laboratory procedure in making an endocrinologic diagnosis. The final chapter of this section lists in outline form the various commercial endocrine preparations.

This book is of value to anyone who deals in endocrinology in any way—the medical student, the intern, the general practitioner, or the specialist. It is well written, well illustrated, and well printed.

THE BUSINESS SIDE OF MEDICAL PRACTICE. By THEODORE WIPRUD, Executive Director and Secretary of The Medical Society of the District



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of Columbia and Managing Editor of the *Medical Annals of the District of Columbia*. Second edition. Illustrated. Philadelphia and London: W. B. Saunders Company, 1949. Price, \$3.50.

The author has presented to the medical profession a volume replete with information so necessary for the young doctor just starting in practice; and even those who have been in practice for years will be able to read it with much profit.

Contained herein are the common deficiencies frequently encountered plus an intelligent approach to their solution or rectification. The contents of the text are divided into twenty chapters dealing with personal efficiency, on building a private practice, investments and insurance, the preparation of a manuscript, public speaking, and other pertinent subjects. It is well written and does provide the reader with information of a practical nature. Your reviewer recommends this book as a valuable adjunct for your non-scientific reading.

PAIN SYNDROMES. Treatment by Paravertebral Nerve Block. By BERNARD JUDOVICH, B.S., M.D., Instructor in Neurology, Graduate School of Medicine, University of Pennsylvania; Physician-in-Charge, Neuralgia Clinic, Graduate Hospital, Philadelphia; and WILLIAM BATES, B.S., M.D., F.A.C.S., F.I.C.S., Professor of Surgery, Graduate School of Medicine, University of Pennsylvania; Consulting Surgeon, Babies' Hospital and Philadelphia Home for Incurables; Consulting General Surgeon, Wills Hospital, Philadelphia. Foreword by Joseph C. Yaskin, M.D., Professor of Neurology, Graduate School of Medicine, University of Pennsylvania. 181 illustrations. Third edition. Philadelphia: F. A. Davis Company, 1949. Price, \$6.00.

In the third edition of this book (formerly called "Segmental Neuralgia in Painful Syndromes") the authors have continued their attempt to clarify the management of certain pain problems in the light of their vast clinical experiences. In the diagnosis and treatment of many problems, such as brachial plexus pain, scalenus anterior syndrome, endometriosis, migraine, and atypical facial pain, the authors have enlarged the scope of this book and brought the contents up to date. The contents are systematically arranged so as to include the following main topics in separate chapters: segmental neuralgia; posture in relation to pain; treatment; dermatomes; brachial plexus pain; scalenus anticus syndrome; pain of the chest wall; abdominal pain; lower quadrant pain following appendectomy; abdominal scars; low back pain; sciatic nerve pain; pitcher plant distillate; herpes zoster; occipital neu-



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ralgia; atypical facial and trigeminal neuralgia; control of pain in malignancy; intravenous procaine; technique of infiltration; paravertebral infiltration, and an index. Each chapter is supplemented by useful illustrations. The paper and printing are good. In its present form, because this edition offers a concise authoritative and a modern guide to treatment, this book should find favor with the general practitioner.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

PATHOLOGY OF THE NERVOUS SYSTEM. A Student's Introduction. By J. HENRY BIGGART, C.B.E., M.D., D.Sc., Professor of Pathology, Queen's University, Belfast; Pathologist to the Royal Victoria Hospital, Belfast Hospital for Sick Children, Claremont Street Hospital for Nervous Diseases, Mater Infirmorum Hospital; sometime Examiner in the Universities of Bristol, Dublin, Edinburgh, and Liverpool; formerly Pathologist to the Scottish Asylums Board; Neuropathologist to the Royal Infirmary, Edinburgh. Foreword by Professor A. Murray Drennan, M.D., F.R.C.P.E., F.R.S.E. With 232 illustrations and 10 colored plates. Second edition. Baltimore: The Williams & Wilkins Company, 1949. Price, \$6.00.

PROGRESS IN NEUROLOGY AND PSYCHIATRY. An Annual Review. Volume IV. Edited by E. A. SPIEGEL, M.D., Professor and Head of the De-

partment of Experimental Neurology, Temple University School of Medicine, Philadelphia, Pa. New York: Grune & Stratton, 1949. Price, \$10.00.

RATIONAL MEDICINE. By JOHN W. TODD, M.D. (Lond.), M.R.C.P. (Lond.), Assistant Physician to Farnham Hospital; Late Lt.-Col., R.A.M.C.; Late Resident Medical Officer, Middlesex Hospital, London. Baltimore: The Williams & Wilkins Company, 1949. Price, \$6.50.

SYNOPSIS OF HERNIA. By ALFRED H. IASON, M.D., Attending Surgeon, Adelphi Hospital; Director of Surgery, Brooklyn Hospital for the Aged; Instructor in Anatomy, New York Medical College. Illustrations by Alfred Feinberg, Instructor of Medical Illustration, Department of Pathology, College of Physicians and Surgeons, New York City. New York: Grune & Stratton, 1949. Price, \$6.50.

A TEXTBOOK OF NEUROPATHOLOGY. With Clinical, Anatomical, and Technical Supplements. By BEN W. LICHTENSTEIN, B.S., M.S., M.D., Associate Professor of Neurology, University of Illinois College of Medicine; State Neuropathologist, Illinois Neuropsychiatric Institute; Attending Neurologist, Cook County Hospital; Professor of Neurology, Cook County Graduate School of Medicine; Attending Neuropsychiatrist, Mount Sinai Hospital, Chicago. Illustrated. Philadelphia: W. B. Saunders Company, 1949. Price, \$9.50.

PHOTORADIOGRAPHY IN SEARCH OF TUBERCULOSIS. By DAVID ZACKS, M.D., Chief of Clinics, Massachusetts Department of Public Health. Baltimore: The Williams & Wilkins Company, 1949. Price, \$5.00.



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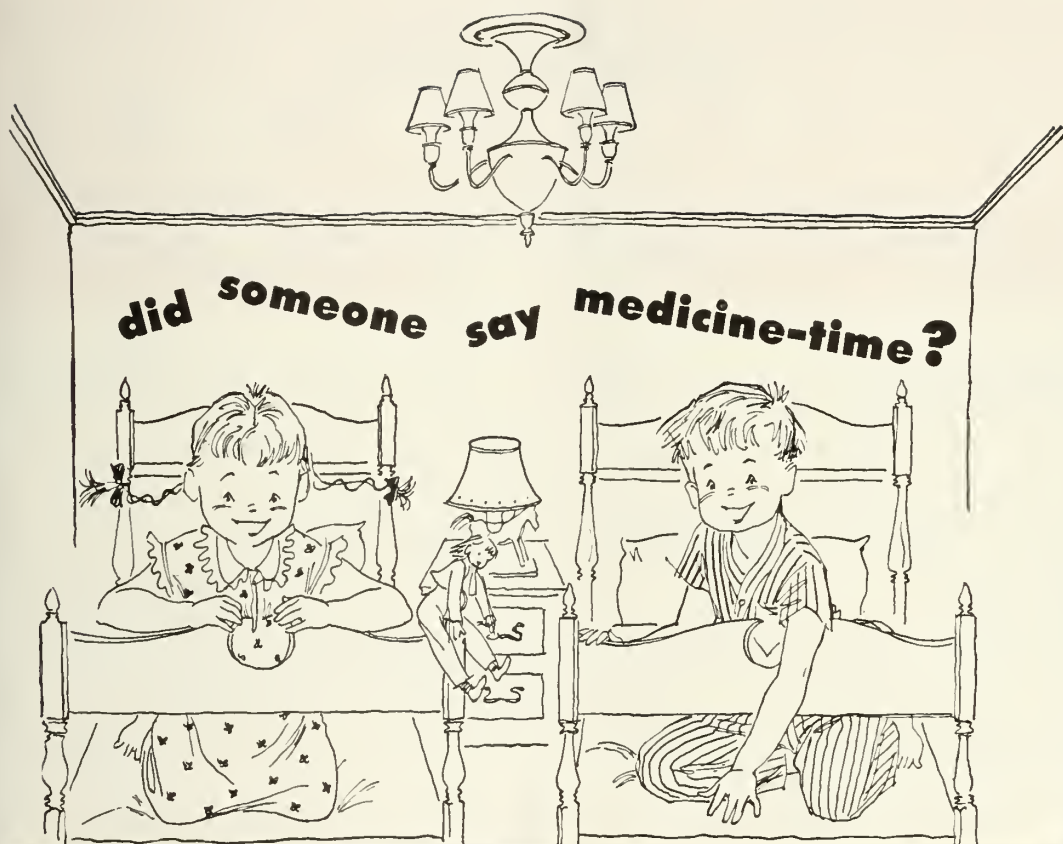
Ordinarily an operation or an autopsy must be performed strictly within the limits of the authority that has been given. Authority may be given, however, for the operating physician to use his own judgment, and this usually should be demanded by the physician.

Consent by word of mouth to an operation or an autopsy is probably the most common form of consent. . . . Oral consent is, however, open to misunderstanding and may be difficult of proof. Whenever it is to be relied on, consent should be given in unequivocal terms, in the presence of one or more disinterested witnesses. Written consent to an operation or to an autopsy is by far the safest, for it permits a clear record of the nature and extent of the operation or autopsy that is authorized. If the patient is a minor, authority for an operation must come from his parent or guardian.—*Board of Trustees, The Medical Society of the State of Pennsylvania.*

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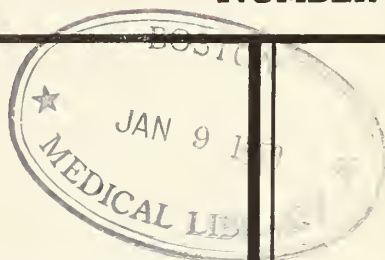
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Hantz, J. C., Jr., and Carr, C. J.:

Pharmacologic Principles of Medical Practice,
Williams & Wilkins Co.,
Baltimore, 1949, pps. 114-119.

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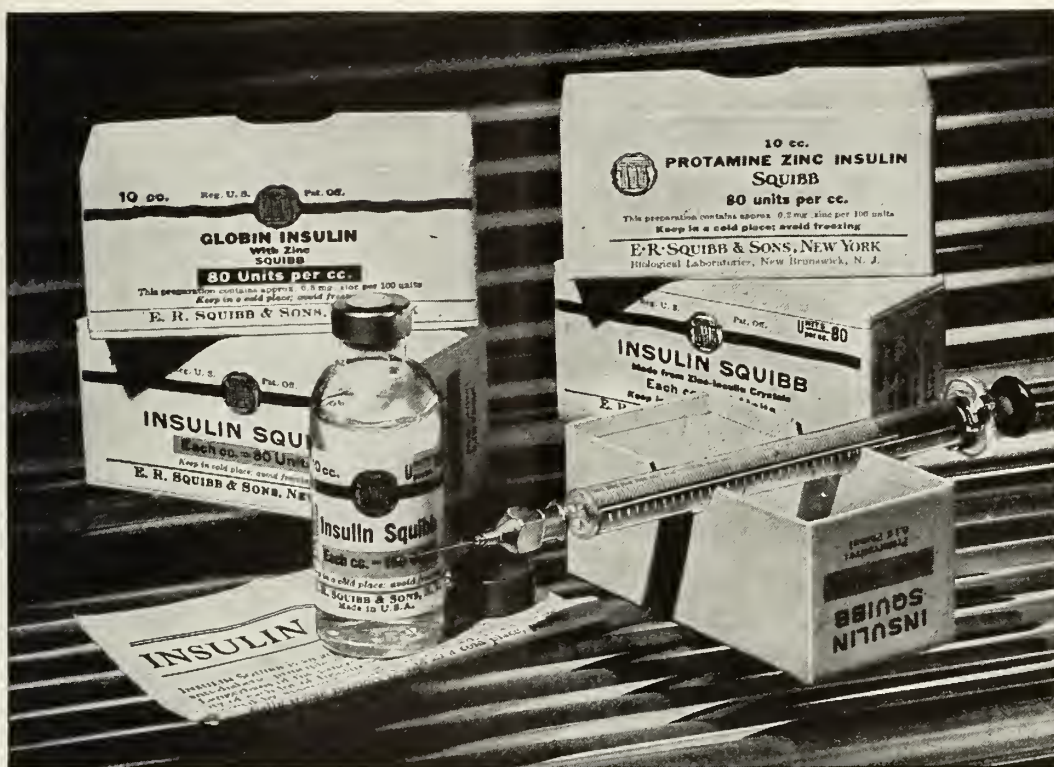
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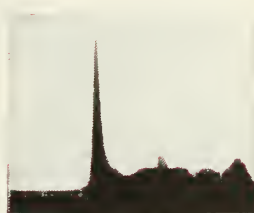
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Stable without refrigeration, LYOVAC plasma is pooled and rendered virus-free by ultraviolet irradiation; it is

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1. "A Study of Enriched Cereal in Child Feeding" Urbach, C.; Mack, P. B., and Stokes, Jr., J. Pediatrics 1:70, 1948.

*Cerevim contains neither vitamin A nor C but possibly exercises an A-and-C sparing effect attributed to its high content of protein and major B vitamins.

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...She depends on your help for a speedy return to gainful occupation. Women seeking employment who are nervous, apprehensive and generally distressed by symptoms of the climacteric, may find it difficult to meet competition. "Premarin" offers a solution. Many thousand physicians prescribe this naturally-occurring, oral estrogen because...

1. Prompt symptomatic improvement usually follows therapy.
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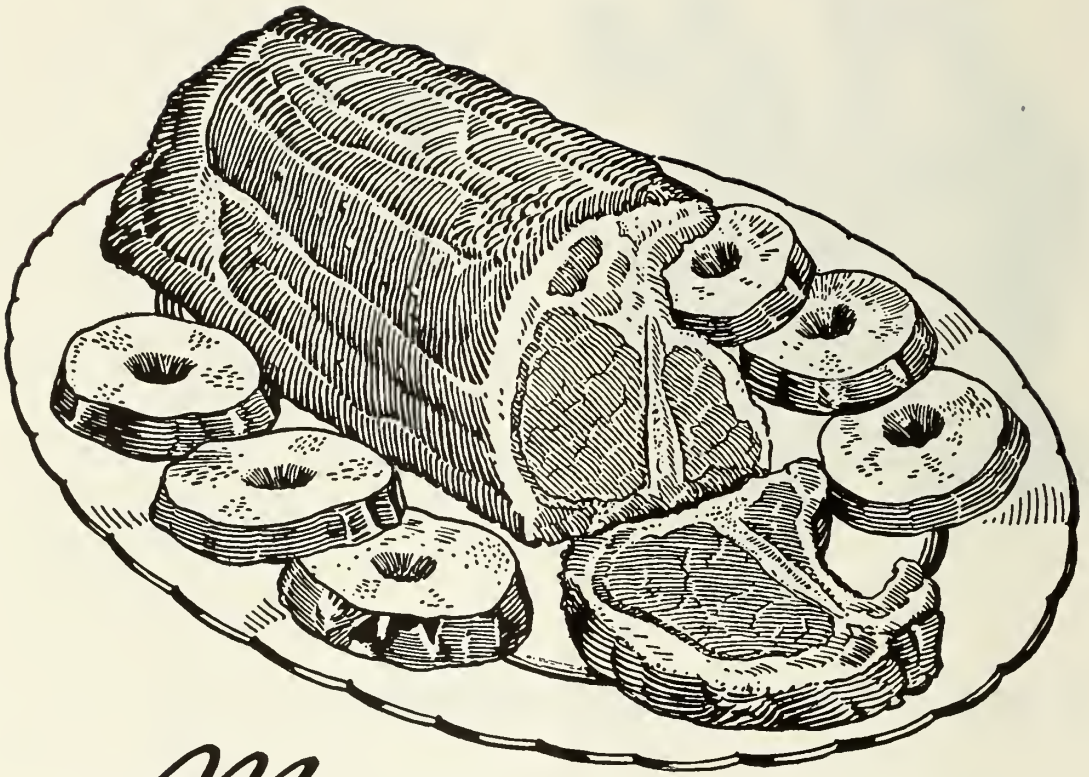
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Outstanding Value...

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Whether the pocketbook calls for economy or permits satisfaction of that urge for the fanciest cuts, meat gives your patients full value for their money. Every cut and kind of meat supplies, *in abundance*, these essential nutrients:

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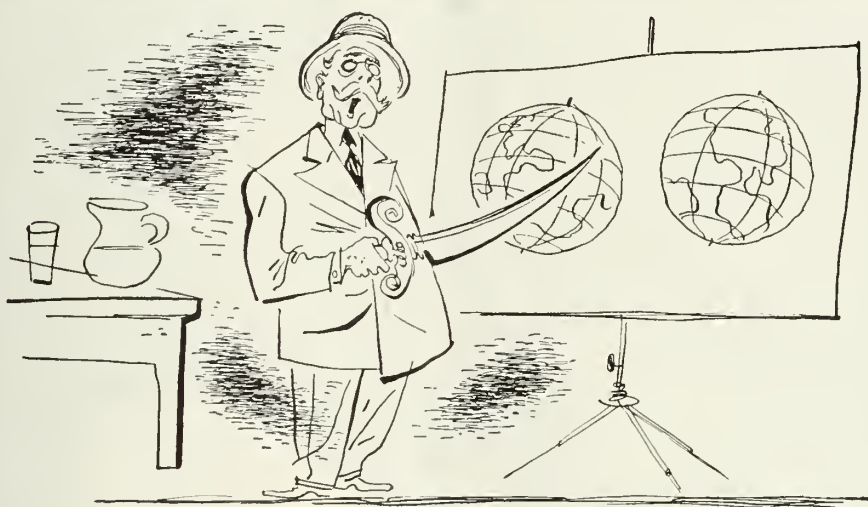
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The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. 139:897 (Apr. 2,) 1949

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WORLD TRAVELER . . . Dietary Dub

Food customs? He can describe the bill of fare in far away places some people never heard of. His personal eating habits, however, are those of most men in public life—a feast when the hectic schedule permits, just a bite here and there between times.

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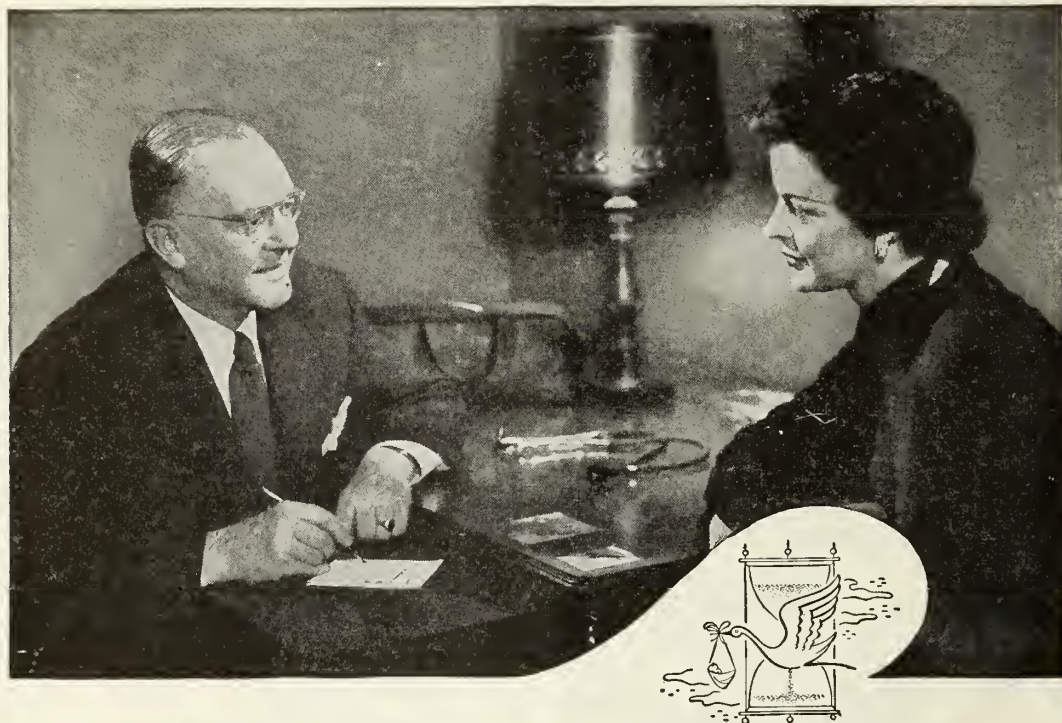
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Vitamin deficiency may occur as a result of increased requirements during pregnancy, febrile conditions, hyperthyroidism, or other conditions in which the metabolism is greatly augmented.

The vitamin deficiencies most commonly seen are those of the B complex. Since deficiency of only a single vitamin of this group rarely occurs, and since many of the metabolic functions of

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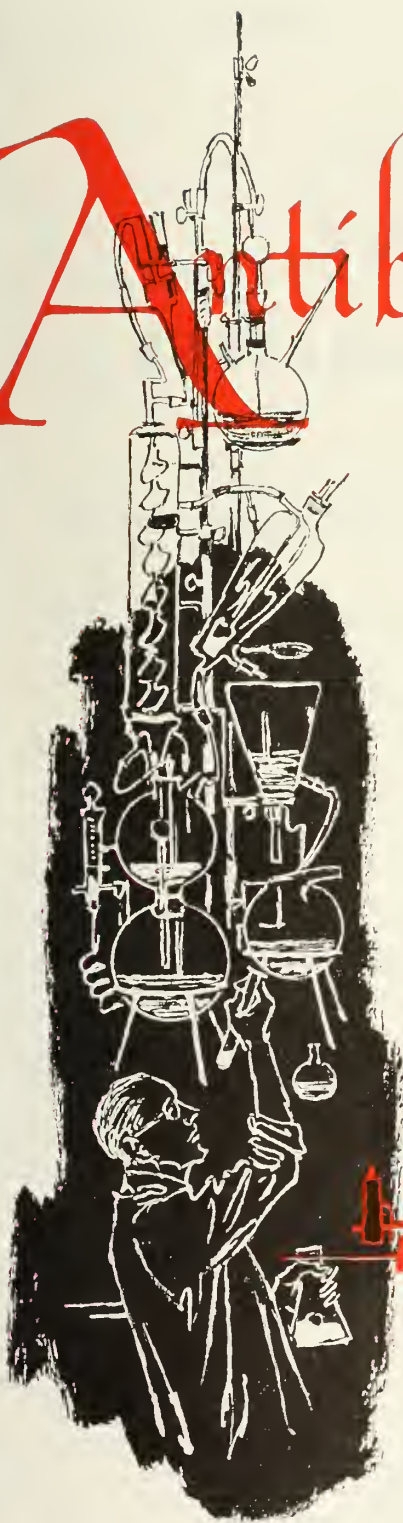
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**Reprints on request:

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60;
Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

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Death and Injury as Related to the Automobile and to the Engineering and Medical Professions

FLETCHER D. WOODWARD, M.D.

Charlottesville, Va.



THE rapidly increasing number of deaths and injuries occasioned by the automobile in 1947 induced me to study the types of injuries most frequently encountered, and to ascertain, when possible, the factors which caused them. From November, 1947 through May, 1948, a period of seven months, approximately 450 patients were treated

at the University of Virginia Hospital, Charlottesville, Va., for injuries occasioned by the automobile. Approximately one-third, or 145 patients, were able to give the sources of their injuries.

In 80 per cent of those receiving injuries to the head, the injuries were due to impact of the head against the windshield or dashboard. In 80 per cent of the injuries to the hip and leg, the causing factor was impact against the dashboard. In 66 per cent of those receiving chest injuries, they were due to impact against the steering wheel. The great majority of injuries were received by guest passengers.¹ Although the en-

tire group of patients studied was small, it does, I am sure, give an accurate index of the types and causes of such injuries, and the same proportion would hold for larger groups.

After studying these statistics, it seemed obvious that redesign of the automobile could prevent many accidents. So, with temerity, I decided to criticize the automotive engineers for their lack of consideration of the users of their machines, as against the so-called eye appeal of color, chromium, gadgets, and blown-up bodies. I also listed many suggestions which, if employed by the engineers, would minimize this carnage, so evident to the doctor who is called upon day and night to treat these victims and to pronounce death on those who are beyond medical help.

This criticism was published in the *Journal of the American Medical Association*, Oct. 30, 1948,² and has been subsequently reprinted in several other publications in this country, Canada, and England. The hundreds of letters I have since received have convinced me that many people, especially physicians, share my views that redesign of the automobile is imperative. The response of the manufacturers is best shown by the fact that, with few exceptions, the newer models are just as bad as those of a year ago, except for some improvements made by several manufacturers.

In studying the yearly statistics of the National Safety Council,³ it becomes obvious that

¹Read before the Section on Surgery of The Medical Society of the State of Pennsylvania, Pittsburgh, Pa., Sept. 27, 1949.

²From the Department of Otolaryngology, University of Virginia Hospital, Charlottesville, Va.

UNIVERSITY OF VIRGINIA HOSPITAL
7 MONTHS
OCT 1947 - MAY 1948

TYPE	NUMBER	WINDSHIELD	DASHBOARD	STEERING WHEEL	OTHERS
INJURIES - HEAD AND NECK					
ABRASIONS LACERATIONS CONTUSIONS	63	29	22	5	7
FRACTURES	10	2	5	1	2
CONCUSSIONS	9	4	4	0	1
TOTAL	82	35	31	6	10
INJURIES - HIP AND LEG					
ABRASIONS LACERATIONS CONTUSIONS	18	0	16	0	2
FRACTURES	10	0	6	0	4
TOTAL	28	0	22	0	6
INJURIES - ARM					
ABRASIONS LACERATIONS CONTUSIONS	4	2	1	0	1
FRACTURES	3	1	0	0	2
TOTAL	7	3	1	0	3
INJURIES - CHEST					
CONTUSIONS	9	2	1	6	0
FRACTURES	3	0	1	2	0
TOTAL	12	2	2	8	0
INJURIES - CENTRAL NERVOUS SYSTEM					
CONCUSSIONS	10	6	3	0	1
VERTEBRAL FRACTURE WITH OR WITHOUT CORD COMPRESSION	6	1	1	0	*4
TOTAL	16	7	4	0	5

* TWO OF THESE RESULTED FROM FRONT SEAT BEING THROWN FORWARD

TABLE I

A statistical record of the types and sources of injuries seen at the University of Virginia Hospital, Charlottesville, Va., during a period of seven months. This data was compiled from the records of approximately one-third of the cases only, since in the remaining two-thirds the source of the injury was not stated.

physicians, both individually and collectively, by lending their active support to safety and law enforcement campaigns, could also help in the reduction of these appalling figures. In their last full year's report, it was revealed that there were 32,000 deaths in 1948, 2 per cent less than for 1947, in spite of an 8 per cent increase in traffic mileage—a most encouraging fact.

Injuries were approximately 1,100,000; costs, including property damage, \$2,800,000,000. This means one death every sixteen and one-half minutes and one injury every twenty-nine seconds; or that, during the presentation of this paper, two deaths and sixty injuries will have taken place in this country.

The motor vehicle accident rate has also been decreasing despite heavy increases in traffic volume. At the end of the war approximately 11.5 persons were killed for every 100 million miles of motor vehicle travel. In 1948, in spite of an 8 per cent increase in travel, 8 persons were killed for every 100 million miles. These reductions

can be attributed to the indefatigable work of the National Safety Council and the many other organizations and persons who were interested in this problem. Without this reduction there would have been close to 46,000 deaths in 1948, as compared to the 32,000 which actually occurred.

The ratio of deaths to injuries has also been decreasing, largely because of better medical care, advances in surgical technique, and the antibiotic drugs.

Since the highest death rate is in the young adult age group, safe driving should be taught to teen-agers in high schools. Two million boys and girls reach driving age each year, of whom 50 per cent become drivers. A study, by the American Automobile Association, of young men drivers graduated from Cleveland high schools indicated that the accident rate of those who received such training was substantially lower than the accident rate of those without training.

Since approximately 13 per cent of all fatal accidents last year were caused by mechanical defects, the physician should urge frequent spot checks of automobiles by the state police. Since drivers with physical defects are involved in about 7 per cent of the fatal accidents, he should urge periodic and careful re-examination of all drivers.

From a medical point of view, the American Medical Association has recognized its interest and responsibility in regard to this problem by appointing a committee, headed by Dr. Herman A. Heise, of Milwaukee, to study motor vehicle accidents, and the Board of Trustees has also ordered the publication in the *Journal* of an annual report on this subject.

This committee, in conjunction with other similar committees of special societies, should set up minimal standards of physical fitness as a guide to state police in their examination of prospective drivers and in their periodic re-examination of all drivers. In establishing such minimal requirements, it would be necessary to consider visual acuity, visual fields, depth perception, night blindness, persistence of dazzle, hearing, reaction time, and many other physiologic qualities involved in the operation of the automobile. However, in defense of drivers with physical defects, I would like to quote the following statement of Mr. W. C. James, Director, Statistical Division, National Safety Council, in a personal communication: "I think the actual experience of drivers with some physical defect, as indicated by state reports, tends to bear out my belief that most drivers with defects, particularly when those defects are for the most part

corrected by mechanical devices, are able to compensate sufficiently to drive a car safely in non-commercial operations." Considerable work has already been done on chemical tests for the determination of critical levels of alcohol in the blood and urine for use in the detection of the drunken driver.

The opinion that automotive engineering is of professional interest to the physician may appear at first glance as rather ill-founded. However, a study of the types of injuries encountered and the close relationship between engineering and medicine as exemplified during the past war, particularly in aviation medicine, should convince the most doubtful of the advantages in such a relationship to the safety of the passenger.

In spite of the success of the medical profession in the saving of lives and in the plastic reconstruction of damaged tissue, and in spite of the success of safety campaigns and law enforcement procedures, the automobile still remains a lethal and crippling agent, with a vast number of injuries and deaths attributed to its use; and since there appears little likelihood of changing human nature in general or exuberant youth in particular, it seems logical that any further reduction in the rate of injuries and deaths must

come from alterations in the design of the machine itself.

Our highways are becoming increasingly laden with cars driven by average persons, and it is inevitable that these machines will continue to collide, pass on turns, fail to observe traffic signs, leave the road at high speeds, and afflict mankind much as they have in the past; and since there is evidence that collaboration of the medical and engineering professions can produce safer cars, if the manufacturers so desire, the following suggestions are offered. Most of these are directed at the design of the automobile, and can be immediately employed; others require new laws; and still others depend on further research in allied fields of science. But to reduce the accident and death rates further, it is the responsibility primarily of the automotive engineers and manufacturers. It is my sincere belief that much can be accomplished if an earnest effort is made to that end.

Suggestions for Safety

Speed.—Speed was a factor in one out of three fatal accidents last year, and for the first time collision between cars accounted for more deaths than collisions with pedestrians. The majority of these accidents occurred in rural areas, on

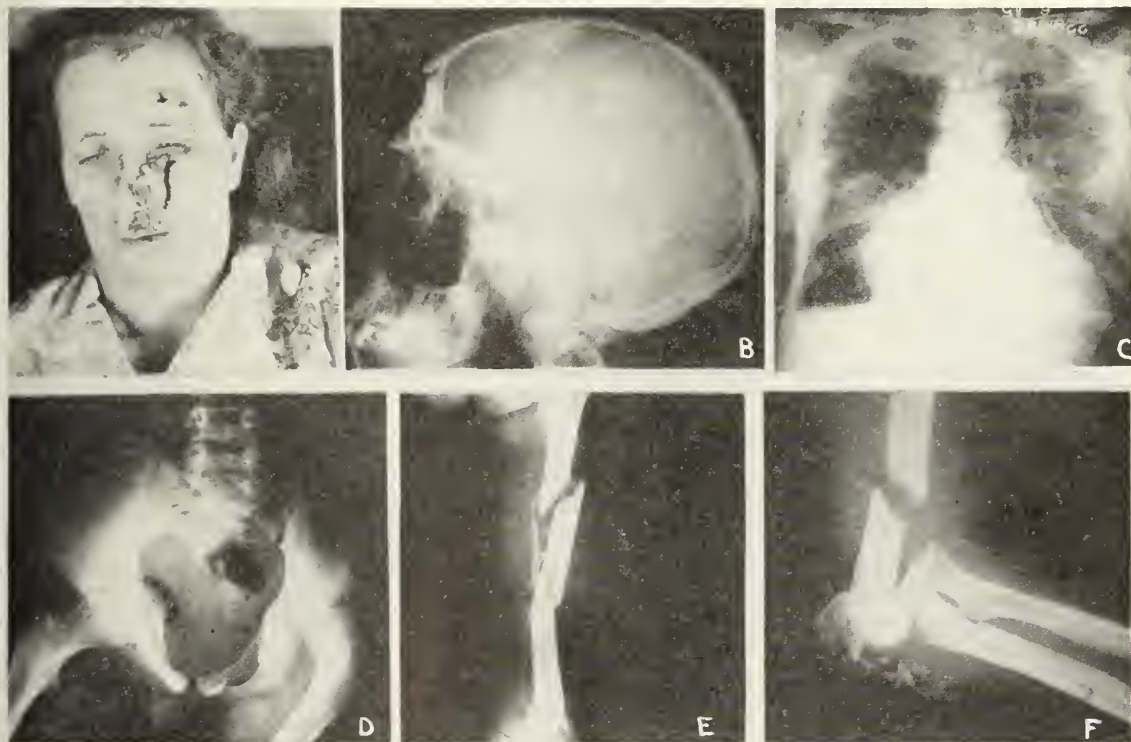


Fig. 1. (A) Facial contusion and laceration from dashboard or windshield. (B) Depressed fracture of frontal bone from impact against rear of front seat. (C) Severe crushing injury of chest from steering wheel, fractured ribs, pneumothorax (right), and interstitial emphysema. (D) Dislocation of hip from body rotation on impact. (E) Multiple fractures of femur from impact with dashboard. (F) Fractured elbow from side swipe while elbow was protruding from car window.

straight level roads with a dry surface. Whenever a driver is involved in an accident while operating faster than conditions warrant, speed is reported as a factor, although this speed may be no more than 15 to 20 miles per hour. However, in most of the fatal accidents in which speed was a factor, the speed was greater than 50 miles per hour.

The problem of high speed accidents could be solved simply by the use of governors on all cars, limiting the top speed to 55 miles per hour, but in no way interfering with acceleration at lower speeds. Since one is inclined at first hand to assume that the public will not tolerate such control, it might be interesting to quote from a survey made by the Traffic Engineering and Safety Department of the American Automobile Association.⁴ The following question was asked among many others: "If a simple device were developed to limit the top speed without affecting acceleration at lower speeds, would you favor its incorporation in new passenger cars?" Of the 4102 replies received, 4 persons answered "yes" for each 3 that answered "no." The top speed in the group favoring governors was 55 miles per hour.

This suggestion has met uniform opposition from car manufacturers, who state that reserve speed is needed in passing other cars. But if everyone knew his top speed was 55 miles per hour, he would be governed accordingly; and I feel sure that many serious accidents and deaths would then be prevented. However, an act of Congress would be necessary to create such a regulation.

Structure.—The frame and body should be of welded "unit construction" for added protection in a turnover; and all cloth top models should be discontinued, because of the danger in a turnover, as well as for the poor visibility inherent in such models.

Windshield and Windows.—Cuts and lacerations from broken safety glass is a common finding in accident victims, and until a suitable plastic material can be developed, the windshield should be moved farther forward and made ejectable on impact. This alone would prevent many head injuries. Impact of the head against the windshield was the cause of the most frequent injury in our series. Both windshield and rear window should more nearly revert to the vertical for better visibility, particularly in rain, sleet, and snow.

Doors.—Single doors would be desirable, with windows large enough to serve as escape hatches and high enough to prevent passengers from rid-

ing with their elbows comfortably protruding. Sponge rubber elbow rests would take care of passenger comfort. The door latches should be operated both from rear and front seats, with the safety lock on the front latch to prevent the opening of the door by children.

Bumpers.—The front bumpers should be mounted on "oleo shock absorbers," in a manner similar to the landing gear in airplanes, which quickly and efficiently absorbs the shock of the heaviest planes on landing, even when poorly executed. One would not expect such bumpers to absorb all the shock of a collision, but the absorption of even a small percentage would give added safety to the passengers.

Brakes.—Failure of hydraulic brakes is all too common. Better material should be used in the brake system to avoid leakage and loss of fluid. Under these circumstances, if one has time, he quickly realizes the inefficiency of the hand brake. They should be improved. The failure of brakes when wet, such as occurs after fording a stream, is inexcusable. Many accidents have occurred under such circumstances.

Tires.—Tire treads should be designed to give maximum traction and to provide the best anti-skid qualities, on the basis of actual tests by some disinterested agency. Further research is needed, such as the incorporation of other materials in the rubber to give better anti-skid protection. Danger from blowouts should be eliminated as far as possible by the use of blowout-proof tubes, even at the expense of some riding comfort, if necessary.

Interior Devices.—(a) A glareproof rear view mirror for night driving. (b) A latch to lock the backs of front seats in position in the coach type cars, or narrower bodies in front of these seats to accomplish the same end. Two of our patients received spinal cord injuries from the secondary impact of the back of the seat after a crash. (c) Safety belts, such as are used as standard equipment in aircraft. Their use might well be one of the most effective single factors in preventing serious injury. One automobile company stated that they would oppose their use because they did not wish the public to feel that automobiles were hazardous. (d) A hydraulic steering column which will move forward under a force of approximately 100 foot pounds. This would do much to prevent chest injuries of the driver from forceful impact against the wheel. (e) Crash pads. The installation of sponge rubber padding on the dash and back of front seats would eliminate many head and leg injuries, so

common today. These pads are partially installed on one model car today. Otherwise, they must be bought separately from a manufacturer of these pads, in Detroit, who has recognized their importance. (f) Elimination of all projecting handles, knobs, buttons, ash trays, and such items from the interior and also from the exterior wherever possible.

Exterior Lighting.—The importance of exterior lighting to safety is apparently well appreciated by the Interstate Commerce Commission, but has been neglected by passenger car manufacturers. Such lighting should include red reflectors at all corners, blinking turn indicators front and rear, larger stop lights, and dual tail lights. The use of luminous paint on the outside margins of trucks, trailers and buses, and consideration of its use for highway strip marking is advocated.

Vision.—(a) The provision of the largest possible visual field is of the utmost importance. This should be approximately a full 360 degrees, with a wide angle above and below, to afford better vision of the roadway. Front supporting columns should be moved further to the rear, or the driver moved further forward by installing the engine in the rear, as is commonly done now in many trucks and busses. The drivers of these vehicles readily testify to the importance of the extra vision thus gained, and their safety records testify to the same end.

Added visibility could also be gained with front-end engines by markedly lowering and shortening the hood, and at the same time providing a height adjustment to the driver's seat. This lack of roadway visibility is particularly noticed today on sharp hills. In the Automobile Association of America's survey,⁴ two-thirds of

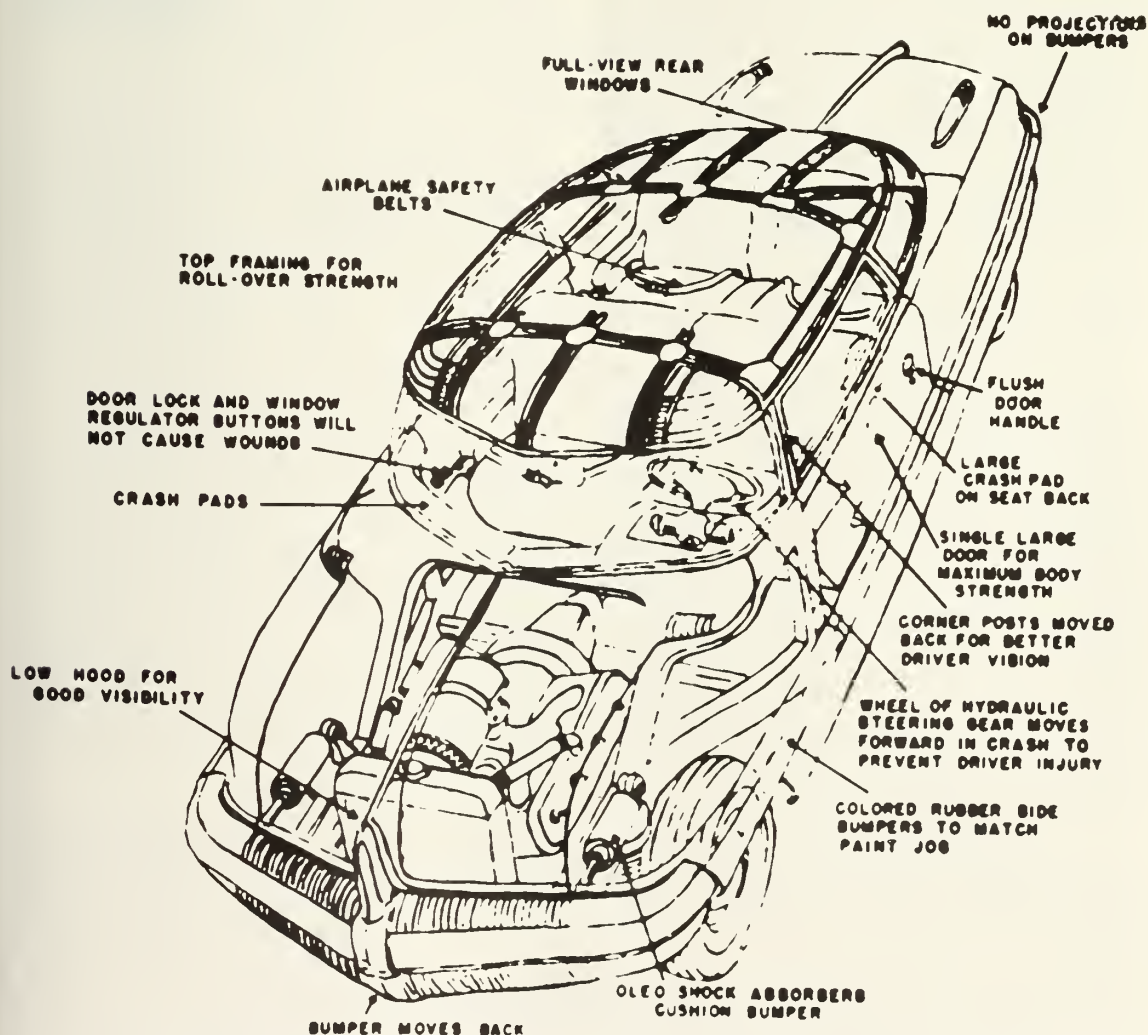


Fig. 2. Design of car embodying proposed safety devices, as drawn by Stewart Rouse, *Popular Science Monthly*, April, 1947, in article by Devon Francis on "Cars Can Be Safer."

the replies checked the driver's view of the roadway as the most important single factor in body design. Less than 1 in 6 voted for appearance. More nearly vertical windshields and rear windows are again emphasized, since in 20 per cent of the fatal accidents last year the driver's vision was reported as obscured, and in the majority of cases the obscuring cause was in or on the machine itself.

(b) Shiny, reflecting surfaces should be eliminated from the driver's visual field. This could be simply accomplished by eliminating all chromium trim, and by painting the top of the hood and dash a non-reflecting dull optical black. The use of such paint on metal aircraft has long been an established practice.

(c) The speedometer should be placed at the top of the instrument panel, directly in front of the driver, since it is his most important instrument. In addition to the miles per hour, it should also include stopping distances in feet under average driving conditions, as a constant reminder for safe driving. Both the speedometer and other dials should be illuminated by a "navy red" light to maintain the driver's dark adaptation at night. A flashing red light or auditory signal might well be included, to indicate the maximum safe speed under ideal conditions of 55 miles per hour. The light switch should be placed on the driver's side of the panel and designed to eliminate error when operated by "feel."

(d) When figured according to mileage rates, fatalities occur three times more often at night than in the daytime, and in many instances, these accidents are caused by blinding of the driver from approaching cars. The use of a polarized windshield would minimize glare in daytime driving and, when coupled with oppositely polarized lenses on headlights, would minimize night blinding. Of course, all cars would have to be so equipped. The added cost for such research and equipment could no doubt be largely absorbed by the elimination of clocks which do not run, radios, radiator ornaments, and other useless gadgets which are now included in the cost of an automobile, whether wanted or not.

(e) More adequate defrosters and windshield wipers should be provided. This defrosting and wiping equipment should be installed at both windshield and rear windows, and the wipers

should be so designed as to wipe a larger area than at present.

Comment

There is an abundance of evidence (obtainable from air crash reports) that the adoption of construction methods and safety features now employed by the aviation industry would render it at present possible to build motor cars capable of withstanding collisions, leaving the road at high speed and overturning, with greatly reduced likelihood of injury to their occupants, as well as reducing the likelihood of such accidents. It is suggested that a cooperative attempt by the automotive industry and the medical profession to produce such vehicles would be well worth while, especially since the automotive industry should soon be faced with the design of radically different vehicles.

The magnitude of the medical, economic, and social problems entailed by the continued use of the motor car in its present form far outweighs in importance any monetary consideration arising from the necessarily high costs of such research and new design. The only influence of aircraft design apparently so far adopted by automotive engineers is the erroneous one that the aerodynamic principles of a jet-propelled aircraft should be applied to a vehicle whose speed should be limited to 55 miles per hour on the ground. When this principle is combined with glittering color, falsies, bustles, and costume jewelry, they should be called the harlots of the highway, rather than automobiles for safe and sane transportation.

It is my confirmed belief that ultimately the design of the automobile will include installations necessary to the reasonable safety of its passengers. Meanwhile, it is interesting to speculate as to the traffic casualty incidence which will be tolerated before some concerted action will be taken along these lines—2,000,000 casualties annually? 3,000,000? It would be to the credit of the medical profession generally if the impetus toward furnishing the public with a safer means of transportation should be supplied from among their number.

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The Present-Day Treatment of Duodenal Ulcer

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THE cause of duodenal ulcer is not known. Because of this, many different medical and surgical therapeutic regimens have been recommended and tried during the course of years. However, ever since 1823, when William Prout demonstrated the presence of hydrochloric acid in gastric juice, innumerable studies have been made on the

relationship of acid to duodenal ulcer. Five years later, the suitability of milk for the dietary treatment of ulcer was suggested, although a specific milk diet for such treatment was not proposed until 1856. The ruling present-day treatment which combines the use of antacids with milk and cream to neutralize the acid, did not gain widespread acceptance until 1909 when it was introduced by Sippy. Its primary aim is to neutralize free hydrochloric acid during and between feedings. The present-day medical regimen is a modification of the Sippy treatment.

An adequately nutritious diet, divided into small and frequent feedings, is the essential of the present-day treatment. This diet must consist of low roughage, non-irritating foods that combine with hydrochloric acid and inhibit the motor and secretory activity of the stomach. It must include sufficient calories for energy and sufficient protein for tissue synthesis. The patient is thus kept in normal nitrogen balance. Antacids and antispasmodics are usually prescribed. Rest and attention to the emotional make-up of the patient and his family are also important aspects of this regimen. The patient must be made to understand that he must learn to live with his ulcer.

Eighty per cent of the patients seen in private practice are treated ambulant by this method and are relieved of their ulcer attack.

Patients not responding to this treatment, and

those with complications, are hospitalized for stricter dietetic supervision, more intense antacid and antispasmodic therapy, and in some cases, for gastric aspiration and lavage at night.

When adequate medical treatment fails, or in cases of frequent hemorrhages and in pyloric obstruction not relieved by adequate medical therapy, surgical procedures are resorted to. These also aim at combatting the hydrochloric acid factor—by resection, as in subtotal gastrectomy, or by reducing the volume of acid secretion, as in vagotomy.

X-ray irradiation of the stomach has been given to a large series of patients by Palmer and his associates during the past twenty years. This method of treatment is also directed at hydrochloric acid. It aims at impairing or inactivating the acid secreting area of the stomach and at producing an anacidity.

The common physiologic conception behind all these methods of treatment (i.e., medical, surgical, or roentgenologic) is that duodenal ulcer is caused or aggravated by hydrochloric acid.

The present-day medical regimen, however, is not entirely adequate. It fails to relieve ulcer symptoms in from 10 to 15 per cent of the patients. Furthermore, it fails to prevent recurrences in those whom it does help. Even after surgery or x-ray irradiation, at times, the ulcer returns or a new one forms or a new group of symptoms not infrequently begins. Moreover, many normal individuals have a high volume of gastric juice and a high concentration of hydrochloric acid and yet do not develop peptic ulcer. Many workers (including myself) therefore question the acid theory of ulcer. New ideas have been expounded, which are presently under critical evaluation.

Possible Hormonal Relationship

Work that I have carried on stresses the possibility of a hormonal relationship to duodenal ulcer. Following a clinical observation that pregnancy has a beneficial effect on human duodenal ulcer, I reviewed the literature and with others, carried on extensive studies.

Presented before the Section on Medicine at the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 29, 1949.

These studies showed that:

1. Peptic ulcer and its complications are less common in women than in men. The ratio is 8 men to 1 woman.

2. The sex incidence in children before puberty shows a ratio of 1 to 1, but as the child approaches maturity the incidence is higher in the male, approaching the ratio in the adult.

3. With the onset of pregnancy peptic ulcer symptoms generally disappear.

4. *Active peptic ulcer is extremely rare during pregnancy.* Of over 70,000 consecutive admissions of pregnant women to four Detroit hospitals during a ten-year period, only one proved case of active peptic ulcer was recorded. The incidence of other gastro-intestinal disorders was relatively high in this group.

5. Peptic ulcer, not infrequently, has its onset during the climacterium. Symptoms are aggravated during the menopause.

6. In a study of 30 women with proved duodenal ulcer, 47 per cent showed an endocrine imbalance (exclusive of menopause).

These observations led to the theory that the normal female may be protected against peptic ulcer by some inherent mechanism peculiar to her sex. In turn, this suggested the possibility that protection from ulcer might depend upon sex hormones. Accordingly, dogs with experimentally produced Mann-Williamson ulcers were studied following administration of various hormone preparations.

A series of Mann-Williamson dogs was treated with extracts from human pregnancy urine administered parenterally. We found that human urine (from pregnant women, non-pregnant women, and normal man) contains an anti-ulcer principle which we named anthelone. This factor has a prophylactic, therapeutic, and "immunizing" effect on Mann-Williamson ulcers without depressing gastric secretion. Ivy and his associates observed the same phenomena following treatment with anthelone from hog's small bowel mucosa (enterogastrone concentrates). Microscopically, we found that anthelone stimulated fibroblastic proliferation, new formation of blood vessels, and epithelization of the mucosa. Our interpretation was that anthelone healed many ulcers, prevented ulcer formation in some of the animals, and prevented ulcer recurrences in others.

On the basis of these encouraging experimental results on animals, anthelone was tried clinically with the hope that the same beneficial effect might be produced in the human as was obtained in the experimental animals. Thus a new concept

was introduced in the treatment of patients—the *increase of their defensive mechanism against ulceration* by the addition of anthelone to the usual medical regimen. Subsequently, Ivy and his associates also tried anthelone from the small bowel mucosa (enterogastrone concentrates) on patients. To date, however, the injection of anthelone products in patients has not produced completely satisfactory results. My own experience, though encouraging, is not yet conclusive. Attempts to prepare more potent products are in progress.

Anthelone prepared from pregnant mares' urine is being tried orally. Page and Heffner reported encouraging clinical results from the oral use of an anthelone preparation which they prepared from pregnant mares' urine. Bercovitz observed similar encouraging clinical results. I am presently evaluating this product both experimentally and clinically. Anthelone is still in the experimental stage.

Work with anthelone has been based on the possibility of a pituitary gonadal relationship to ulcer. My more recent studies, however, focus on the possibility of a pituitary-adrenal-gonad relationship. The striking similarity in the protective effect of pregnancy upon both rheumatoid arthritis and peptic ulcer, and the dramatic results reported by Hench in treatment of rheumatoid arthritis with cortisone (Compound E: 17-hydroxy-11-dehydrocorticosterone) and ACTH (the adrenocorticotrophic hormone) led to the speculation that cortisone or ACTH, or some related product, may benefit peptic ulcer as they appear to benefit rheumatoid arthritis. The evidence, justifying further pursuit of this possibility, has been summarized in the May, 1949 Harper Hospital Bulletin.

I am now conducting studies with ACTH on experimental Mann-Williamson ulcers in dogs. The preliminary experimental observations appear encouraging.

I am also studying the adrenal function in patients with duodenal ulcer. Of particular interest in this connection is the urinary 11-oxycorticosteroid excretion. Seventy per cent of patients with duodenal ulcer showed 11-oxycorticosteroid values below the normal values for normal healthy men and women (below 1 mg. per 24 hours of urine). The 17-ketosteroids in ulcer patients also appear to be somewhat altered, especially in the female ulcer patients.

These findings may represent a straw in the wind. Further, more extensive studies are essential and are in progress. However, these preliminary (11-oxycorticosteroid) findings are presented in the hope of inciting further inquiry.

But these recent developments are still in the experimental stage. Even the anthelones have not been tried clinically on the hundreds and perhaps thousands of cases necessary to establish their efficacy. Moreover, even if they were fully established clinically, the materials for using them on a large scale are not yet available. Therefore, I turn now in the second half of my discussion to a consideration of the standard present-day therapy for the treatment of duodenal ulcer.

Medical Treatment of Ambulant Patient

Regardless of what our ideas might be on the cause of duodenal ulcer or what our ideas might be on the relation of hydrochloric acid to this disease (or its recurrences), we must accept the fact that hydrochloric acid is an aggravating factor when an ulcer is present. Therefore, until new methods have demonstrated superior effectiveness, the medical regimen should have as one of its aims the neutralization and inhibition of hydrochloric acid.

Of the patients with duodenal ulcer whom we see in private practice, approximately 80 per cent can be treated satisfactorily with an adequate ambulatory ulcer regimen. This regimen includes *diet, antacids, antispasmodics*, and attention to the *psychosomatic problems*, if present.

DIET: The fundamental principles underlying the diet for ulcer patients have been discussed elsewhere. Chiefly, they are aimed at combatting the hydrochloric acid factor. In addition, it is important to stress that the ambulatory ulcer patient as a rule is working and attending to his daily routine. The ambulatory patient, therefore, should have a nutritionally adequate diet.

In prescribing a diet for the ambulatory patient, one must take into consideration the following fundamentals:

A nutritionally adequate diet. Nearly all of the patients who are treated ambulant stay on their jobs and attend to their daily routine. Their diet should thus be nutritionally adequate, not alone in calories to provide energy but also in proteins, minerals, and vitamins. Table I lists the minimum requirements for a normal man of 70 Kg. (154 pounds) and for a normal woman of 56 Kg. (123 pounds). Please note the protein content of this diet, a *minimum* of 60 grams for a woman and 70 grams for a man. These keep the patient in normal nitrogen balance. These minimum requirements have been determined and are recommended by the National Research Council for normal men and normal women (1948 Rev.) and should form the basis for the diet of the ambulatory ulcer patient.

The inclusion of bland foods, of smooth consistency, that combine with hydrochloric acid or inhibit gastric secretion and gastric motility. These foods include milk, cream, eggs, jello, custard, puddings, cream soups, and cheese. They are of good nutrient value. Milk and the foods containing it have a high acid combining power. Milk itself is capable of combining with its own volume 0.3 hydrochloric acid. Non-meat proteins as jello, cheese, and the white of the egg act as effective buffers of gastric acidity. Fat, particularly in the cream and in the yolk of the egg, as well as in the milk, stimulate enterogastrone. It is well known that when fat comes in contact with the mucosa of the duodenum, enterogastrone is liberated. Enterogastrone inhibits both gastric secretion and gastric motility. It is for these reasons that milk and cream in the ulcer dietary (and in the foods containing them) have withstood the test of time and still constitute the bulwark of the ulcer regimen.

The exclusion of irritating foods and those foods that stimulate gastric secretion. These foods are raw fruits, raw vegetables, condiments, caffeine-containing beverages, alcohol, meat and meat extractives. Raw vegetables and raw fruits are mechanical irritants because of their high cellulose content. Alcohol in the stomach causes the release of histamine; caffeine acts directly on the parietal cells, and meat and meat extractives (as meat soups and bouillons) are potent gastric secretory stimulants releasing gastrin which in turn stimulates the parietal cells. Certainly, during the early stages of ulcer therapy and during the convalescence, these gastric secretory stimulants must be excluded from the ulcer dietary.

Small but frequent feedings. Small feedings are prescribed so as not to distend the antrum. Distention of the latter even by liquids stimulates gastrin. Frequent feedings are given not only to allow for more adequate nutrition but also to permit better neutralization since the foods mentioned act as antacids.

Ulcer Diet No. 3 meets nearly all of the above requirements. Because of the exclusion of raw vegetables, raw fruits and meats, the diet is inadequate in iron and niacin (nicotinic acid). Until these foods are added, vitamin B complex should be prescribed. If the ulcer patient has hypochromic anemia, enteric-coated iron tablets should be added.

The above Ulcer Diet No. 3 is prescribed for a period of three to four weeks, after which (if the patient is symptom-free) Ulcer Diet No. 4 is prescribed. This latter diet is entirely ade-

TABLE I
ANALYSIS OF DIETS

	Calories	Protein (grams)	Fat (grams)	Calcium (grams)	Iron (mg.)	Vitamin A (I.U.)	Thiamine (mg.)	Riboflavin (mg.)	Niacin (mg.)	Ascorbic Acid (mg.)
<i>National Research Council recommended daily dietary allowance (1948 Rev.)</i>										
<i>Man (154 lb., 70 Kg.)</i>										
Sedentary	2400	70	..	1.0	12	5000	1.2	1.8	12	75
Physically active	3000	70	..	1.0	12	5000	1.5	1.8	15	75
<i>Woman (123 lb., 56 Kg.)</i>										
Sedentary	2000	60	..	1.0	12	5000	1.0	1.5	10	70
Moderately active	2400	60	..	1.0	12	5000	1.2	1.5	12	70
<i>Diet for hospital and ambulant patients</i>										
Ulcer Diet No. 1 (Hosp. Pts.) ..	1870	45.2	161	1.4	0.9	6683	0.5	2.1	1.4	14
Ulcer Diet No. 2 (Hosp. Pts.) ..	2631	76.	190	1.4	7.9	10121	2.6	2.9	4.9	114
Ulcer Diet No. 3 (Hosp. & Amb.)	3047	80.6	215	2.2	6.0	10653	1.8	3.3	4.7	96
Ulcer Diet No. 4 (Amb. Pts.) ...	3075	109.	172	2.0	13.8	8019	3.1	4.0	32.7	272

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Note: Ulcer Diet No. 1 is inadequate in calories, protein, iron, thiamine, niacin, and ascorbic acid.
Ulcer Diet No. 2 is inadequate in iron and niacin.
Ulcer Diet No. 3 is inadequate in iron and niacin.
Ulcer Diet No. 4 is entirely adequate in all nutrients.

I wish to express my appreciation to Miss Mary M. Harrington, director of the Department of Dietetics at Harper Hospital, for the analysis of these diets.

quate in all nutrients. The patient is asked to continue with this diet for approximately one year.

In summary, when prescribing a diet for an ambulatory ulcer patient, select bland non-irritating foods—not only those of good nutritive value but also those foods that combine with hydrochloric acid and stimulate the enterogastrone mechanism. Divide them in small feedings and feed the patient frequently. Give sufficient calories for energy and sufficient protein for tissue synthesis and thus keep the ulcer patient in nitrogen balance.

ANTACIDS. Experimentally, hydrochloric acid in physiologic concentration does not cause an ulcer. It only damages the mucosa and makes it susceptible to peptic digestion. "For acid alone to cause an ulcer, the stomach must secrete at the maximal rate of which it is capable, a condition which rarely occurs in the ulcer patient." However, because acid can be shown to cause damage and because an ulcer rarely, if ever, is found in the absence of acid, we try to neutralize the acid gastric content, not only by frequent feedings but also by administering antacids.

An ideal antacid is one which acts promptly, maintains neutralization of gastric acidity for a long duration, does not cause rebound stimulation of gastric secretion, and does not produce alkalosis. On the basis of these criteria, calcium carbonate is the most effective (Kirsner and Palmer). It is relatively insoluble and does not cause alkalosis.

Aluminum hydroxide is also a very effective antacid, but frequently it results in constipation, and when used should be supplemented with a laxative. Magnesium trisilicate and tribasic calcium or magnesium phosphate are satisfactory antacids, but are less effective than calcium carbonate and aluminum hydroxide.

Sodium bicarbonate acts promptly and as a rule produces immediate relief. However, it causes a rebound gastric secretion and is highly absorbable. When used frequently and in high doses, there is danger of alkalosis.

Complete neutralization of the gastric contents with antacids is practically impossible. It has been estimated that on standard Sippy management from twenty-five to fifty times as much antacid is given as would be required to neutralize the total daily output of hydrochloric acid. Still, complete neutralization is rarely achieved.

In practice, I prescribe a combination of calcium carbonate and sodium bicarbonate (calcium carbonate precipitate oz. 1 and sodium bicarbonate oz. $2\frac{1}{2}$). Dose: one-half teaspoon in one-

half glass water four to six times daily and at bedtime). In patients whose renal function is impaired (as is the case frequently in older individuals), I prefer aluminum hydroxide.

ANTISPASMODICS. Antispasmodics, such as atropine and tincture of belladonna, are frequently used in the ulcer regimen. They are used primarily to relieve spasm, since spasm is one of the components of ulcer pain. They are used also for the purpose of potentiating the action of antacids. When used in physiologic doses, it is thought that they decrease acid secretion and delay the gastric emptying. By delaying gastric emptying, the antacids stay in the stomach for a longer period of time.

These antispasmodics act by paralyzing the vagus nerve endings, thus blocking the cholinergic stimulation to smooth muscle and secretory cells. Frequently one refers to the action of these antispasmodics as medical vagotomy. However, it is questionable whether this phenomenon has ever been produced in man by the antispasmodics.

I usually prescribe atropine sulfate (hypodermic tablets) in doses of grains 1/150 or 1/100 four times daily. Tincture of belladonna is administered, 20 to 30 drops four times daily. The latter is the drug of choice since it can be accurately adjusted to each patient.

I frequently use trasentine. It is a musculo-tropic antispasmodic acting directly on muscle fibers, relaxing them, and producing few, if any, side effects. The dose is one tablet before each of the three main meals and one at bedtime.

REST AND SEDATION: Rest, both mental and physical, is generally agreed upon to be valuable in the management of patients with duodenal ulcer. Since the ambulatory patient, as a rule, continues on his job and attends to his daily routine, he should rest when returning home after his day's work. Phenobarbital gr. $\frac{1}{2}$ three times daily and seconal gr. $1\frac{1}{2}$ or nembutal gr. $1\frac{1}{2}$ at bedtime usually promote relaxation and sleep.

It has been shown, both clinically and experimentally, that emotional disturbances, such as prolonged anxiety, resentment, and hostility, increase the secretion of acid gastric juice and possibly the susceptibility of the mucosa to ulceration. In this respect it is important not only to advise the patient of these effects but also to take into confidence all the members of the patient's family and stress the importance of both physical and mental relaxation. This is often difficult to accomplish. However, difficult as this might seem, it appears to me that if a patient with un-

complicated duodenal ulcer wishes to live comfortably and be relatively free from distress, he must learn to adjust his life to the ulcer he has. He should not expect his physician or surgeon to do it for him, though I am sure that a sympathetic and encouraging attitude on the part of the physician is valuable. He must learn to live with his ulcer or the ulcer will make life miserable for him, regardless of the diet he follows or the drugs he takes, important as the latter are.

GASTRIC SECRETORY INHIBITORS:

Enterogastrone: Enterogastrone is a hormone prepared from the mucosa of the hog's small bowel which, when administered intravenously in the dog, inhibits gastric secretion. It was discovered by Kosaka and Lim in 1930. Ivy and his associates prepared more potent extracts and tried them clinically. To date, however, with the enterogastrone presently available, we have been unsuccessful uniformly to inhibit gastric secretion in the human. Enterogastrone, as presently available (i.e., the gastric secretory depressant), has no clinical application as an inhibitor to gastric secretion. At times, when administered in large doses intramuscularly, inhibition of secretion is obtained in the human but its secretory effect is unpredictable. It is still in the experimental stages.

Urogastrone: As a result of our work with human urine extracts on experimental Mann-Williamson ulcers, urogastrone was discovered in 1939. It is a hormone or hormone-like substance prepared from human and canine urine which, when administered intravenously in the dog, inhibits gastric secretion. Ivy and his associates and our group have tried concentrated extracts clinically. As with enterogastrone, we have been unsuccessful to date in inhibiting gastric secretion in the human with the intramuscular injection of thirty times the intravenous dose found effective in the dog. Urogastrone, as presently available (i.e., the gastric secretory depressant from urine), has no clinical application as an inhibitor to gastric secretion. It is still in the experimental stages.

In summary, inhibition of gastric secretion with enterogastrone and urogastrone is still not within the clinical horizon. These are still in the experimental stages.

Medical Management of Hospitalized Patients

As stated earlier, 80 per cent of the patients whom I see in private practice are treated ambulatory with relief of their acute exacerbations by the medical regimen outlined above. The remaining 20 per cent are hospitalized. Hospital-

ization is resorted to for the following reasons: failure to respond to ambulatory management, hemorrhage, gastric retention, or acute perforation.

FAILURES UNDER AMBULATORY MANAGEMENT: These patients are hospitalized either because they fail to respond to ambulatory treatment or, if they respond, have frequent recurrences following short symptom-free intervals. They are hospitalized not only to receive a more rigid ulcer regimen but also to undergo re-examination to rule out possible ulcer complications or associated diseases.

The principles underlying treatment of the hospitalized patient with uncomplicated duodenal ulcer are exactly those outlined above for the ambulatory-treated patient except that the patient is at bed rest, the diet is more restricted, feedings and antacids are administered more frequently, and rest and sedation can be accomplished with greater ease. In addition, I resort frequently to nocturnal gastric aspiration and lavage.

The Diet: For the first day or two I resort to hourly feedings of 3 ounces of half milk and half cream, from 7 a.m. to 10 p.m. On the second or third day one strained cereal is added to the so-called breakfast meal, and a soft boiled egg to the dinner and supper meal. We refer to this diet as Ulcer Diet No. 1. As soon as the patient becomes symptom-free, Ulcer Diet No. 2 is prescribed. In cases with only mild ulcer distress, Ulcer Diet No. 2 is prescribed on admission to the hospital. After a period of approximately one week of hospitalization, the patient is given Ulcer Diet No. 3.

The diet during the first few days of hospitalization is inadequate in calories, proteins, iron, thiamine, niacin, and ascorbic acid. During this stage of treatment vitamin C tablets (one three times daily; one tablet each 25 mg.) and vitamin B complex (one three times daily) are prescribed. Frequently, especially when the patient cannot tolerate these orally, and especially when the patient is dehydrated, he is given 1000 cc. of 5 per cent glucose in saline intravenously with both vitamin C (100 mg. ampule) and vitamin B complex (2 cc. ampule of betalin complex) added by administering them through the tubing, each separately, since the two are not as effective when both are in the same solution. If the patient has a hypoproteinemia, protein hydrolysates may be given intravenously.

Antacids and antispasmodics: Antacids are prescribed one hour after each of the three main meals, at 2:30 p.m., 4:30 p.m., and at bedtime

ULCER DIET NO. 1

8 a.m. to 10 p.m.

Milk and cream—3 ounces

Note: With relief of symptoms (even on second hospital day) strained cereal or soft boiled eggs at three regular meal periods. As soon as tolerated, the diet is increased by the addition of cream soups, jello, custard, and pudding. If patient tolerates above, diet is advanced to Ulcer Diet No. 2.

ULCER DIET NO. 2

8 a.m. Strained cereal—6 oz. and cream—3 oz.
Sugar—1 teaspoon
Milk and cream—6 oz.
Orange albumin (4 oz. orange juice and 1 egg white)

10 a.m. Milk and cream—6 oz.

12 Noon Strained creamed vegetable soup—6 oz.
Mashed potatoes—4 ounces
Soft boiled eggs—2
Toast and butter—1 slice

2 p.m. Milk and cream—6 ounces

4 p.m. Milk and cream—6 ounces

6 p.m. Strained creamed vegetable soup—6 oz.
Cream cheese—2 ounces
Custard—1 serving
Toast with butter—1 slice

8 p.m. Milk and cream—6 ounces

10 p.m. Milk and cream—6 ounces

ULCER DIET NO. 3

Breakfast:

Strained fruit— $\frac{1}{4}$ cup or strained fruit juice— $\frac{1}{2}$ cup
Strained cereal—4 tablespoons
Toast—1 slice with butter
Milk and cream—1 glass
Postum or weak tea

10 a.m.

Milk and cream—1 glass
Custard—1 serving

Luncheon:

Soft boiled egg—1 or cottage cheese—2 tablespoons
Mashed potatoes—4 tablespoons
Strained vegetable—4 tablespoons
Strained fruit or dessert—4 tablespoons
Toast—1 slice with butter
Milk—1 glass
Postum or weak tea

3 p.m.

Jello, custard, or pudding—1 serving
Milk and cream—1 glass

Dinner:

Strained creamed soup or strained vegetable—4 tablespoons and milk and cream—1 glass
Cream cheese or cottage cheese—1 serving
Strained fruit or dessert—4 tablespoons
Toast—1 slice with butter

8 p.m.

Milk and cream—1 glass

Note: After one week, if comfortable, add to lunch meal white meat of chicken and fish.

ULCER DIET NO. 4

8 a.m. *Breakfast:*

Strained fruit (preferably citrus)—1 serving
Strained cereal—1 serving
Egg—1
Toast or bread (white or rye)—1 slice
Butter—1 square
Cream— $\frac{1}{2}$ cup
Milk—1 glass
Sugar—1 teaspoon

10 a.m.

Milk and dry toast (white or rye bread) or soda crackers

12 Noon *Luncheon:*

Strained cream soup—1 serving
Lean meat, fish, fowl or cheese—1 serving (see list)
Strained vegetable—1 serving
Dessert— $\frac{1}{2}$ cup (see list)
White or rye bread—1 slice
Butter—2 squares
Milk—1 glass
Strained orange, grapefruit, or tomato juice—1 glass

3 p.m.

Milk and dry toast (white or rye bread) or soda crackers

6 p.m. *Dinner:*

Strained soup, if desired—1 serving
Lean meat, fish, fowl, or cottage cheese—1 serving
White potato—1 serving
White or rye bread—1 slice
Butter—2 squares
Strained vegetable—1 serving
Dessert—1 serving (see list)
Milk—1 glass
Strained orange, grapefruit, or tomato juice—1 glass

9 p.m.

Milk and dry toast (white or rye bread) or soda crackers

Directions:

1. Small meals at regular intervals, usually six feedings daily.
 2. Desserts: rice or tapioca pudding, junket, blanc mange, custard, gelatin, plain ice cream, plain cookies, plain cake, or strained fruit.
 3. Meat: lamb; beef; cooked, creamed, or roasted chicken; sweetbreads; baked, creamed, or stewed fish.
- If symptom-free after one month, need not strain vegetables and fruits.

(six times daily) and as the patient desires. I never aspire to complete neutralization. This is not only impossible but in my experience not essential. Frequently, if the patient has night distress, he is awakened at 12:30 a.m. and 2 a.m. and given one-half glass of one-half milk and one-half cream.

Sedation: Sedation is essential during the hospitalization regimen. If the patient cannot tolerate all medications orally, sedation may be accomplished by giving the patient rectally nembutal (grains 3) dissolved in one ounce of lukewarm water, once in the morning and again at bedtime for sleep.

Gastric aspiration and lavage: If on hospital admission the patient experiences acute distress, especially during the night, I add to the above routine gastric aspiration and lavage with instillation into the stomach of one ounce of warm olive oil each night for three consecutive nights. This is resorted to regardless of whether the patient has retention or a high hydrochloric acid concentration.

The Levin tube is passed into the stomach at about 11 p.m. and the gastric content is completely aspirated. The stomach is then lavaged with a quart of hot water containing a tablespoon of sodium bicarbonate. After aspirating completely the gastric contents, one ounce of warm olive oil is instilled into the stomach and the tube is withdrawn. Nembutal is then given orally or rectally for sleep.

Experience has taught me that this is the most potent technique of controlling night distress. At times this procedure alone results in subsidence of symptoms and initiates a symptom-free interval, even at home when under ambulatory management.

Aspiration and lavage relax the stomach. The olive oil acts by liberating enterogastrone, which in turn inhibits gastric secretion and gastric motility.

HEMORRHAGE: The differential diagnosis and treatment of hemorrhage from the gastro-intestinal tract and the treatment of hemorrhage from peptic ulcer have been adequately presented in the Symposium on Gastro-intestinal Hemorrhage. I shall thus make only two comments:

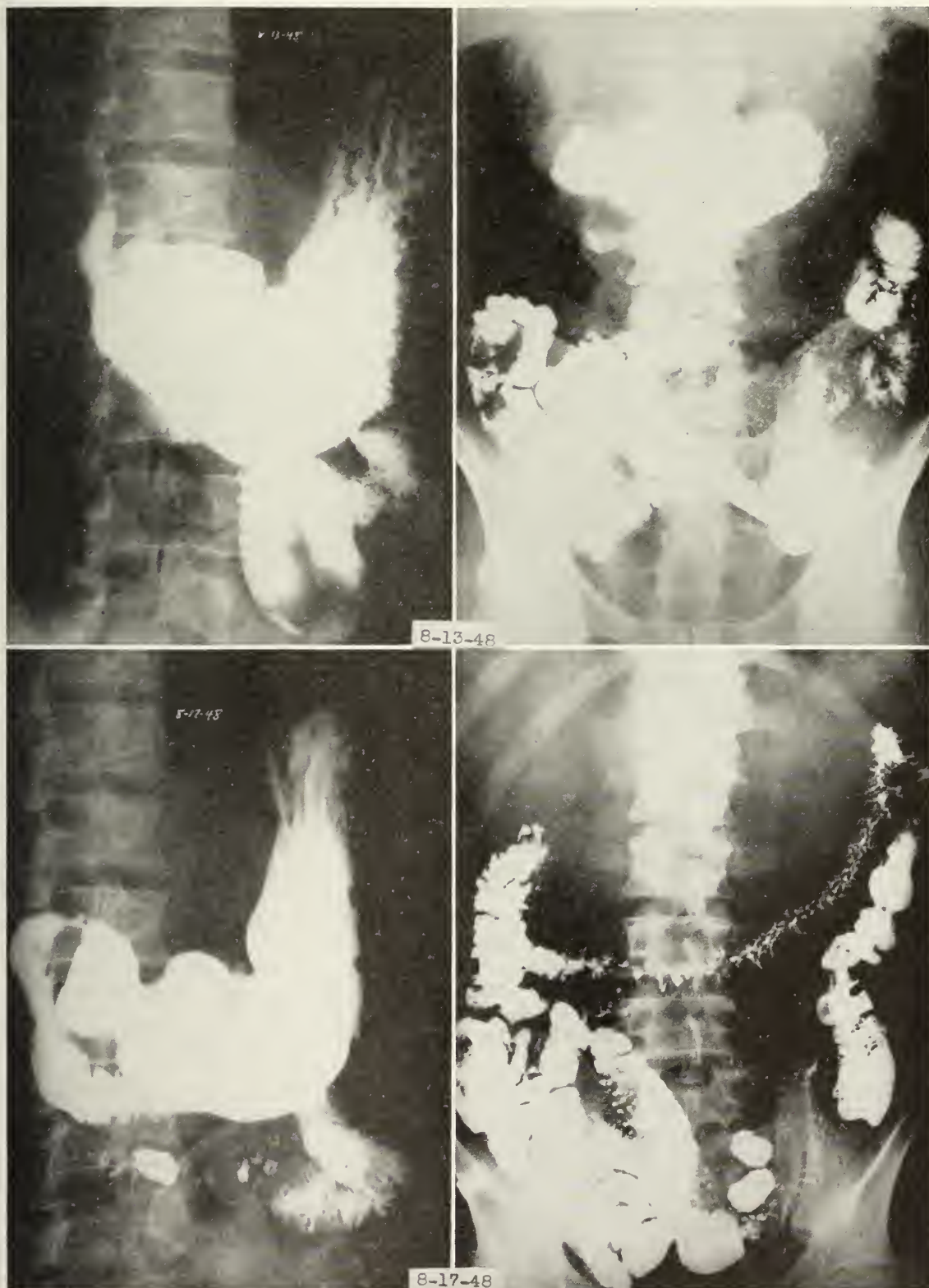
1. In my practice, hemorrhage has not been a major problem. During twenty-five years, fortunately, I have seen only one death from hemorrhage (and that in a patient who had myocarditis and a recent coronary thrombosis) and only one patient in whom bleeding persisted and for which surgery was resorted to. The surgeon in the latter case not only was unable to find the

bleeding vessel but was unable to feel or see the gastric ulcer even after opening the stomach. One month previously an ulcer was observed on the roentgen films high on the lesser curvature of the stomach. The patient recovered in spite of the added risk of surgery.

The treatment includes complete bed rest, sedation with morphine sulfate hypodermically if necessary, small and frequent whole blood transfusions (500 cc. daily for several days), and feedings as outlined before for the hospitalized patient. I do not starve my patients, nor do I employ the Meulengracht diet. If the patient continues to vomit blood, food is withheld and gastric aspiration is resorted to, at the same time lavaging the stomach with hot water and emptying it completely. The stomach is thus deflated. The gastric tone is resumed and bleeding at times ceases. Occasionally, in persistent bleeding, continuous aspiration is employed for 24 to 48 hours. The possible need of surgery must be kept in mind if the pulse continues to be rapid, if the blood pressure is near shock level, and if the erythrocyte count is at about 2.0 to 2.5 million, especially in patients 45 years of age or older with persistent severe bleeding. A patient may be bleeding from an eroded arteriosclerotic artery.

2. The differential diagnosis of hemorrhage from the gastro-intestinal tract, medical versus surgical treatment, the type of surgical procedure to be performed when surgery is indicated, and the high mortality appearing in the literature following both medical and surgical regimens present difficult problems. In recognition of these problems the National Committee of the American Gastroenterological Association for the Study of Peptic Ulcer appointed a Subcommittee on Hemorrhage with Dr. Burrill B. Crohn as chairman and Drs. Julian H. Comroe, Howard K. Gray, H. Marvin Pollard, Leon Schiff, and Franklin W. White as the other members of the committee. They are presently engaged in a national survey and a critical analysis of the literature. I am certain that in the near future Dr. Crohn and his committee will come forth with a very helpful report.

GASTRIC RETENTION: Gastric retention of varying degree is a common complication of duodenal ulcer. Obstruction in these patients is usually due to the inflammatory edema and spasm about the ulcer. Not infrequently the edema and spasm are associated with a cicatricial contraction which is an added factor in the retention. When scar tissue is not the chief factor, the patient responds usually and very read-



The two top roentgenograms, taken Aug. 13, 1948, show the stomach immediately after the ingestion of barium (upper left) and marked retention of barium in the four-hour film (upper right). On August 14 continuous suction was instituted and was continued for 72 hours, after which a repeat barium study was done. The two lower roentgenograms, taken Aug. 17, 1948, show the stomach immediately after the ingestion of barium (lower left) and complete evacuation of the stomach in the four-hour film (lower right).

ily to medical management, even if the obstruction appears to be complete by both clinical and roentgenologic observations. Pyloric obstruction, per se, even of a marked degree, is not in itself an indication for surgery, unless adequate medical management fails to relieve the obstruction or unless a malignant lesion is suspected clinically, roentgenologically, or gastroscopically.

It is essential that the medical regimen have definite aims in view in order that differentiation may be made between medical and surgical pyloric obstruction in the shortest possible time. These are: (1) to control spasm and edema; (2) to establish the normal blood chemistry during the period of medical management (as serum protein, non-protein nitrogen, blood chlorides, CO₂ combining power of the plasma); (3) to establish the normal tonus of the stomach, since the stomach is nearly always dilated; and (4) to have the patient prepared for surgery during the short period of medical management, so that there may be no delay in instituting surgery, if the latter is then considered to be the treatment of choice.

The time-honored medical measures to relieve obstruction (such as small frequent feedings of bland foods that leave the stomach readily, frequent gastric aspirations with or without lavage, intravenous glucose in saline, antispasmodics, hot abdominal stupes, etc.) are usually satisfactory. However, they have a disadvantage in that it takes from two to three weeks, as a rule, to relieve high-grade obstruction. In 1941 Wilkinson outlined a routine regimen in the medical management of these patients which has proved successful in his hands. After the stomach is emptied through a Levin tube, he institutes a plan of alternate feeding and drainage throughout the 24 hours of the day. Every hour on the hour he feeds the patient (through the tube) 3 ounces of malted milk made with water or 3 ounces of peptonized milk. The tube is clamped for 30 minutes of each hour so that no drainage from the stomach is permitted. For the second 30 minutes of each hour the tube is unclamped and the terminal end of the tube is lowered beneath the level of the bed into a bottle and the stomach is allowed to drain by siphonage. A record is kept of the total fluid intake through the tube and the total output into the drainage bottle. The total amount of fluid given by tube during each 24 hours is approximately 72 ounces. By comparing the amount returned daily over a period of three or four days, he determines whether the obstruction is being relieved. "If the drainage amounts to more than 20 ounces (600 cc.) for the 24 hours and if the drainage persists at

or above this 20-ounce level for more than 48 hours, the patient will require surgery."

During the past ten years I have applied the following regimen with success in most of the patients. Retention, when due to spasm and edema, is greatly reduced or completely relieved within three or four days. (See roentgenograms.) The details of the regimen follow:

1. Lavaging the stomach by means of a large tube and suction pump until the solution returns clear. The large tube is used so as to remove the larger pulpy material which will not be removed by the smaller nasal (Levin) tube and which tends to block it.

2. Continuous gastric aspiration (day and night) for a period of three or four days, using the Levin tube and attaching it to a Wangenstein or Gumco suction apparatus.

3. Clear fluids by mouth ad lib.

4. Hydration is maintained and nutrition supported by intravenous administration of glucose, saline, water, and amino acids. I usually give 1000 cc. of 5 per cent glucose in saline twice daily, and 1000 cc. of glucose in water once daily.

5. Other medicaments: vitamin C (100 mg.) and vitamin B complex (2 cc. ampule of betalin complex) are added, each once daily, to the intravenous glucose. (Blood transfusions are given if indicated.)

6. The patient is kept out of bed and as active as the nasal tube will permit. The Levin tube is disconnected from the suction apparatus for short periods to permit the patient to go to the bathroom and for short walks.

By the above-outlined regimen, spasm and edema of the pylorus and duodenum are greatly reduced, if not completely controlled, within a period of three or four days; the gastric musculature resumes a more nearly normal degree of tonus; normal blood chemistry is established, and the patient is ready for the ordeal of gastric resection, if surgery is then indicated.

Surgical Treatment

Among the significant changes that have occurred in the treatment of duodenal ulcer during the past thirty years has been the gradual decline in the use of operative procedures. In the early part of the twentieth century, Moynihan, Deaver, and other surgeons advised that every chronic ulcer of the stomach and duodenum be treated surgically. However, with the realization that most patients with duodenal ulcer respond satisfactorily to medical therapy over a period of years (in spite of recurrences), surgery has come to be reserved for patients who fail to

respond to adequate medical therapy or who have frequent hemorrhages or high-grade obstruction. These patients have one or another of the complications associated with duodenal ulcer.

Surgery is indicated in cases of duodenal ulcer when the patient fails to respond to adequate medical therapy. The term adequate medical therapy should be stressed. It must include a period of hospitalization for at least two weeks and longer, if possible, during which time the patient should have complete bed rest; hourly feedings of milk and cream with a gradual liberalization of the diet; frequent administration of antacids, antispasmodics, and sedatives; nocturnal gastric aspiration and lavage and, if necessary, continuous gastric aspiration for 72 hours (especially in cases of retention), and last but not the least, a sympathetic discussion with the patient and his family with regard to the patient's environmental difficulties and emotional conflicts. All too frequently patients are operated upon because they are considered to have an "intractable ulcer" and yet the patient has never had the benefit of an adequate hospital regimen.

In my own practice about 7 per cent of approximately 1000 patients required surgery. Brown and his associates have referred to surgery 10.6 per cent of 1500 patients treated by them since 1930. At the Lahey Clinic 6.1 per cent of 8380 patients with duodenal ulcer were treated surgically. At the Mayo Clinic, during 1944, 12 per cent of the patients with duodenal ulcer required operations, compared with 26 per cent in 1930.

The indications for surgery are: acute perforation; frequent hemorrhages; pyloric obstruction not relieved by adequate medical management; and intractable pain not relieved by an adequate hospital regimen.

An operation for duodenal ulcer should have a high percentage of satisfactory results and a low incidence of recurrences. The operative mortality and the incidence of undesirable sequelae should also be low. I advise the following surgical procedures:

For acute perforation: Simple suture of the perforation and reinforcement with omentum. Seely's method of medical treatment (continuous gastric drainage and chemotherapy) should not be widely used. As stated by Ravdin, "if widely used, it will lead to an increased mortality, for Seely's rigid criteria may be ignored."

For all other patients: If the physical condition permits, a three-quarter subtotal gastrectomy.

With regard to vagotomy as a surgical procedure for duodenal ulcer, I have no comment at present other than that I have never recommended this procedure to any of my patients. I am awaiting the results of a national survey, in progress since 1947, under the chairmanship of Dr. Sara Jordan and under the auspices of the American Gastroenterological Association. From the literature, however, (and more especially from personal correspondence with many surgeons) one gains the following impressions:

1. That vagotomy alone (supradiaphragmatic or infradiaphragmatic) has been discontinued.

2. That infradiaphragmatic vagotomy plus posterior gastro-enterostomy and infradiaphragmatic vagotomy plus subtotal gastrectomy are still being employed by some surgeons, but it is too early to express an opinion as to remote end results.

3. There appears to be unanimity of opinion that bilateral vagotomy is indicated in patients with gastrojejunal ulcers that follow an adequate subtotal gastrectomy.

A word of warning with regard to surgical indications:

1. Not infrequently a patient insists on surgery because his neighbor or friend has done so well after having undergone one or another of the surgical procedures. He does not know of the patients who do not fare so well. Needless to say, this does not constitute an indication for surgery.

2. "Intractable pain" frequently constitutes the only indication for surgery, the physician being unable to find any complication that might explain why the patient does not improve. While it is true that many of these patients have posterior wall ulcers that have penetrated into the head of the pancreas, a complication suspected clinically but very difficult to diagnose preoperatively, nevertheless it is also true that a number of these patients are "intractable" because of environmental difficulties or emotional conflicts. As an example, Mr. A. M. continued to have severe ulcer distress during a period of three weeks while in the hospital receiving adequate medical care. Surgery was advised because of "intractable pain and failure to respond to adequate medical treatment." Suddenly it was learned that his wife, during her hospital visits, daily hammered at the patient that "the creditors are knocking on the door at home threatening to put us through bankruptcy unless the bills are taken care of." Instead of keeping this patient in the hospital, I advised that the patient be discharged in spite of the "intractable" pain. With-

in 24 hours, after amicable arrangements with his creditors, the symptoms disappeared and the patient continued to be symptom-free for approximately one year.

Attempt at Prevention of Recurrences

The problem in the treatment of duodenal ulcer is not so much the relief of symptoms during the acute exacerbations as it is the prevention of recurrences which characterize the disease and which are responsible for the complications that follow. An adequate medical regimen thus should include not only measures for the acute attack but also measures to prevent recurrences. The two are inseparable since one is merely a continuation of the other.

If recurrences are to be prevented, the patient must be willing to cooperate by continuing on a diet and by observing a prescribed schedule of rest and vacations. As stated above, the diet should be free of mechanical roughage and chemical irritations as outlined in Ulcer Diet No. 4. Alcohol, tobacco, and caffeinated beverages should be used with temperance, if at all. The patient should be taught to live a calm life and to avoid fatigue. He should be told that recurrences are common but that these are not serious. He and his family must be told that both he and the family must learn to live with his ulcer. The doctors cannot do it for him.

Althausen recently re-outlined a medical regimen for the prevention of recurrences. Quoting Althausen: "It is the duty of the physician to inform patients with peptic ulcer of the true nature and probable course of their disease and to convince them of the necessity of long-continued preventive measures. The prevention measures proper consist of:

- "1. Elimination of overwork and adjustment of occupational predicaments.
- "2. Attention to psychosomatic factors.
- "3. Precaution in regard to diet and so-called 'stimulants.'
- "4. Prophylaxis and therapy of respiratory infections.

"5. Institution of a protective régime during periods of unavoidable stress.

"6. Prompt treatment of recurrences of 'epigastric distress.'"

The above measures seem to me inadequate and unsatisfactory for the prevention of recurrences. Search for additional methods is necessary. Anti-ulcer preparations such as "enterogastrone-concentrates" (Ivy) and "anthelone" (Sandweiss) have hopeful possibilities and have reached the stage of clinical investigation.

Summary

1. The real cause of peptic ulcer is still under investigation.

2. An adequately nutritious diet, with feedings between meals, is the essential of the present-day treatment. The diet consists of low-roughage, non-irritating foods, with sufficient calories for energy, sufficient protein for tissue synthesis, and adequate amounts of minerals and vitamins.

3. The present-day treatment is aimed at reducing gastric secretion and gastric motility and at reducing emotional conflicts. It relieves symptoms in most of the patients with duodenal ulcer. It does not, however, prevent recurrences.

4. Surgery is resorted to only when patients present complications that do not respond to adequate medical therapy in the hospital. When indications for surgery are present, subtotal gastric resection is the surgical procedure of choice.

5. Experimental and clinical evidence points toward a possible pituitary gonad or pituitary adrenal relationship to ulcer. The outcome of studies, in these relations, now being carried out, may in time alter the present methods of therapy.

6. Until new methods have demonstrated superior effectiveness, the two cardinal elements in the treatment of most duodenal ulcers are to teach the patient:

To learn to live with his ulcer, and

To take feedings between meals even during periods when he is symptom-free.

Meckel's Diverticulum Causing Recurrent Intussusception

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THE incidence of intussusception provoked by Meckel's diverticulum is not rare, but it is sufficiently uncommon to consider the following case to be of interest. A brief review of the literature shows that approximately 200 cases of this nature have been reported, although certain aspects of this case are unusual. The incidence of Meckel's diverticulum has been estimated at 1.5 to 3 per cent and the incidence of Meckel's diverticulum as a cause of intussusception is 1 to 12 per cent. The average age of this condition is about 13 years, and it has been shown that intussusception, if caused by Meckel's diverticulum, occurs more often in adults than in children.

Case History

This case is that of a 15-year-old boy who presented himself to Abington Memorial Hospital Sept. 3, 1948, with a three-day history of crampy lower abdominal pain associated with nausea and vomiting.

His past history is interesting in that he had been severely constipated since childhood, often requiring daily enemas. He had had several attacks of pain, nausea, and vomiting, relieved by enemas which often filled the toilet bowl. There was no history of blood or mucus in the stool.

Physical examination revealed moderate abdominal distention, absence of peristalsis, and a mass, thought to be the sigmoid colon, palpable in the left lower quadrant. The temperature on admission was normal and the white blood count was 18,550 with 85 per cent polymorphonuclear cells. Rectal examination was negative. The initial impression was that the boy had megacolon or Hirschsprung's disease, and he was given several enemas which gave him complete relief of his symptoms, although the returns from the enemas were not impressive.

The following day his white blood count fell to 9750 and he felt quite comfortable. Peristalsis returned, though not actively normal. The following day he was given a barium enema which was evacuated with a bloody stool. The x-ray showed an unusual degree of elongation of the colon with a pressure defect on the mesial border of the colon immediately above the level of the ileocecal valve (Fig. 1).

There followed a return of abdominal pain and the patient for the first time appeared somewhat toxic. A flat plate of the abdomen at this time showed multiple

fluid levels in the small bowel, so laparotomy was decided upon.

He was operated upon September 8 by one of us (Dr. Levering) through a right paramedian incision. There was little free fluid in the abdominal cavity. There was an intussusception of the terminal ileum with a small walled-off perforation of the small bowel, and while a Meckel's diverticulum was not visible, it was felt that this was the most likely cause because of the location of the obstruction. There were several small areas of gangrene, so it was believed unwise to attempt reduction of the mass. Resection of the terminal ileum was performed, with end-to-end anastomosis, followed by appendectomy. Inspection of the suture line showed it to encroach upon the ileocecal valve, so a lateral anastomosis was made between the ileum and the ascending colon. An ileostomy was then performed, since all the tissues were extremely friable and it was considered safer to decompress the bowel by this means in addition to an inlying Harris single lumen tube.

His postoperative course was satisfactory. The chemistry remained within normal limits except for a transient rise in blood urea nitrogen. He was given a total of 22 grams of streptomycin and 2,600,000 units of pen-



Fig. 1. Barium study of the colon showing pressure defect along mesial border of ascending colon.

Read before the Philadelphia Academy of Surgery, December 6, 1948.

From the Pfeiffer Surgical Clinic, Abington Memorial Hospital, Abington, Pa.



Fig. 2. Unopened specimen of terminal ileum showing obstructed segment with area of perforation.

icillin by intermittent injection, and he was maintained on intravenous fluid therapy consisting of amigen, glucose and saline, and glucose and water, until able to take sufficient nourishment by mouth. He was out of bed on his sixth postoperative day and the ileostomy tube was removed on the eighth postoperative day. He was discharged on his sixteenth postoperative day and has remained in excellent health.

Fig. 2 shows the major pathology in the unopened specimen. The arrow points to the perforation.

Fig. 3 shows the opened specimen.

The Meckel's diverticulum apparently acted as the lead point of the intussusception and was considerably enlarged, due most likely to the repeated attacks of invagination.

Summary

A case of recurrent intussusception provoked by Meckel's diverticulum is presented, which eventually required surgery due to irreducible intussusception.

Resection of the ileum, ileocolostomy, and ileostomy were performed.



Fig. 3. Opened specimen. Meckel's diverticulum outlined in white is several centimeters proximal to lead point of intussuscepted small bowel.

Conclusion

In retrospect, it was felt that this patient had undoubtedly suffered from repeated attacks of invagination of Meckel's diverticulum, causing intussusception, which relieved itself spontaneously with the aid of enemas. Finally, he had an attack which was irreducible. The picture was confusing because of relief of symptoms following the initial enemas, and the diagnosis of obstruction could not be accurately made until the return of symptoms together with the x-ray picture of typical distended small bowel with fluid levels.

Ileostomy was considered to be indicated in order to protect the anastomoses performed with friable tissues.

Intestinal obstruction due to this condition is uncommon. It occurs more frequently in adults than in children, and should be considered in differential diagnosis of obstruction due to obscure mechanisms.

THE PATHOGENESIS OF SILICOSIS

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Dr. Evans

arthritis, and other disease states.

Silicosis is of great historical and industrial importance, but it is perhaps of even greater phenomenologic interest. In the early era, the fibrous response to quartz dust was considered a reaction to "sharp-pointed" particles. This view was invalidated when diamond dust and carborundum were shown to be benign. The next era saw the development of the solubility theory of silicosis, which theory has served well as a working concept to the present time. This theory considers silica as a slightly soluble poison, and the fundamental requisite for reactivity becomes the surface area in contact with the tissue fluid. This concept has promoted study of particle size, which recently appears to be of even more importance than was originally suspected. The inconsistencies of the solubility theory have been pointed out by others, and the statement has been repeatedly made that another theory would ultimately be developed to reconcile these inconsistencies.

The most striking objections to the solubility theory appear to be the following:

1. Several benign silicates supply a greater number of soluble ions to the local tissue than does quartz.
2. There is no constant relationship between solubility and fibrosiveness.

3. A local concentration of ions, or a dissolution of the dust deposit has not been demonstrated.
4. Silica in solution in the tissues would be precipitated as sodium silicate, which is benign.
5. The fibrotic nodule would appear to offer little functional defense to a substance in solution, as diffusion would progress through such a barrier.

An examination of the various substances commonly responsible for the production of the pneumoconioses failed to reveal anything in the nature of a common chemical or physical property, such as solubility, hardness, sharpness, or known chemical reactivity, in the tissues that could explain satisfactorily the production of the characteristic fibrotic nodule. It was, at first, casually observed that dusts known to be fibrosive were composed of substances whose most stable form was that of an asymmetric crystal, and therefore potentially piezoelectric. Those benign dusts studied by other investigators, conversely, were either amorphous or of crystalline classes which are not piezoelectric. As an example, a review of the investigations reported by Gardner illustrate the classification of tissue reactions on this basis (see Table I).

One may conclude from such an analysis of a typical study that:

1. In general, only crystalline forms produce fibrosis.
2. Not all crystals produce fibrosis.
3. Hardness and solubility do not appear to be related to fibrosiveness.
4. Silica is not peculiarly fibrosive, except in certain forms.
5. The fibrosiveness of the crystalline forms of silica, in the quartz group, suggests some singular property responsible for their fibrosiveness other than those commonly considered.
6. Such a peculiar property might be piezoelectricity.

Read at the ninety-ninth annual session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 26, 1949.
From Marquette University Medical School, Department of Anatomy.

For the purpose of definition, piezoelectricity may be stated to be that property possessed by certain asymmetric crystals which allows a transformation of energy, in either direction, mechanical and electrical energy. If such a crystal is distorted by pressure, an electric polarity is produced, and conversely, if such a crystal is placed in the proper electric field, a distortion of the crystal surfaces results.

On the basis of this preliminary observation, a series of experiments was undertaken, injecting white rats with dusts known to be piezoelectric, and controls similarly injected with substances which were comparable in hardness, sharpness, and solubility, but which were of symmetrical crystal classes or were amorphous, and hence could not be piezoelectrically active, inasmuch as piezoelectricity is a function of asymmetric crystal orientation.

It is important to stress at this point that the statement that a substance is amorphous cannot be made from a casual examination. The method employed for this is x-ray diffractionometry. The results of our early work were criticized by another investigator on the basis of purported attempts to reproduce these results, with the conflicting conclusion that there was no difference in the reaction to the amorphous and crystalline materials. It must be borne in mind that a substance, although once amorphous, may in time reconstitute a crystal orientation, and that the determination of the amorphous state at one time is no assurance that it is still amorphous at a later time. Also, it is noteworthy that heating, which might be done for sterilization prior to injection, would readily alter the crystal structure. These technicalities are offered to explain the possible difference in experimental results that have been stated by others interested in the sub-

ject, but which do not, we believe, invalidate our conclusions.

As was stated, on a predictive basis of known piezoelectric activity, a number of mineral dusts, including quartz, wulfenite, barium titanite, and berillite, substances which had not been previously studied nor encountered clinically, were finely ground and injected intratracheally and intra-abdominally into white rats. Control animals were similarly prepared with ground glass, mica, and carborundum, none of which were piezoelectric. The results of these early experiments have been reported in the literature.

Inasmuch as the charge on these piezoelectric substances depends on mechanical distortion, and is proportional to such distortion, suspensions of the test substances were injected intrapericardially where the pounding would be greater than in the lung. There was a corresponding rapid and extensive fibrosis, which in a rough attempt at quantitative evaluation had increased the gross weight of the pericardium 300 per cent over the normal weight. Again, no fibrosis resulted from the non-piezoelectric substances.

In an attempt to show that current or electric field is *the* fibrous stimulant, metals of dissimilar electromotive activity, aluminum and silver, were finely powdered, mixed, and injected intratracheally and intra-abdominally. Thus a minute galvanic cell was produced. Fibrotic nodules, displaying a pattern of polarity not unlike the arrangement of iron filings in a magnetic field, resulted. As a control, neither of these metals, aluminum or silver, could be used separately because of the electromotive differential between the metal and the tissue which would result in current flow. Instead, iron, intermediate in the electromotive series and near the tissue activity, was used, and produced little or no fibrosis, and

TABLE I

<i>Substances Investigated (Gardner, L. U.: J. A. M. A., 111: 1925, 1938)</i>	<i>Number of Substances Tested</i>	<i>Number of Fibrotic Tissue Reactions</i>	<i>Piezo- electric Substances</i>
I. Free forms of silica			
A. Crystalline or cryptocrystalline Including quartz, tridymite, and cristobalite	7	7	4*
B. Amorphous forms Including colloidal silica gel and opal	4	1	0
II. Combined silica or silicates	21	0	0
A. Crystalline forms 16 Including garnet, amphibole, biotite, beryl, and mica			
B. Amorphous forms 5			
III. Non-silicious materials	7	0	0
All crystalline Including diamond, rutile, gypsum, and galena			

* Uncertainty about piezoelectricity of others in this group.

serves to illustrate the nature of the foreign body reaction as compared with the fibrosive reaction.

Up to this point, it has been shown that there is a difference in the malignity or fibrosiveness of substances depending on their crystalline structure and the derivative piezoelectricity, and further demonstration has been made that current is a fibroblastic stimulant.

As further evidence for this hypothesis, quartz which had been rendered amorphous was obtained from the Vitracil Corporation and was injected intratracheally into rats. A sample of this amorphous material was heated to 2500 degrees F., which restored it to a crystal form with the identifiable diffraction pattern of cristobalite, one of the quartz forms. Rats were similarly injected with this restored cristobalite. Animals of each group were sacrificed at intervals and histologic preparations made. Only the original quartz and the restored crystalline form produced fibrosis, while the amorphous material, of the same chemical composition, was inactive. This demonstrates that the stimulation of fibrosis depends on the presence of a crystalline form, and inasmuch as the distinctive difference between the amorphous and crystalline materials was that of crystal orientation, particle size, and solubility, sharpness being similar in both substances, it follows that the fibrogenic factor is a function of the particular crystal orientation. This derivative property of the crystal is piezoelectricity.

It should be mentioned that one of the most difficult aspects of this investigation is the determination of the piezoelectricity of a substance. It is not a property that is commonly listed in the tables of physical and chemical constants. There are only infrequent studies providing such lists, and often these are not in complete agreement. Moreover, the quantitative piezoelectric

determinations are inexact and do not permit a close correlation between the degree of fibrosiveness and a coefficient of piezoelectricity. The substances used in these experiments were among those studied and reported in the Bell Telephone Journal by W. L. Bond. This list has been adequate for the past experiments, but further tests are to be done by the Bell laboratories. Fibrotic reactions have been obtained from the injection of cholesterol and testosterone, but as yet there is no authority to say that the sterols are piezoelectric.

At present, a number of additional substances of known piezoelectric activity are being prepared for similar experiments. Among these are calamine, boracite, sphalerite, wurtzite, and others. The preliminary observations on the studies of calamine were completed too late to obtain photomicrographs for this presentation, but it appears to be very fibrosive. Also, representative dusts of this piezoelectric group are being tested biologically after coating the particles with paraffin or plastic to eliminate the factors of solubility and sharpness. Preliminary observations are supportive of the piezoelectric hypothesis, and should be ready for publication in the near future.

Conclusions

1. The hypothesis is presented, and the supporting experimental evidence reviewed, that the fibrosiveness of various dusts depends on their being piezoelectrically active.

2. The possible application of this principle in other diseases characterized by fibrosis is suggested, awaiting the demonstration of the piezoelectricity of certain endogenous metabolites, especially the sterols.

EACH DOCTOR'S JOB

The individual doctor's job in this campaign of education is of *paramount importance*.

The A.M.A. and the state and county medical societies can provide an effective framework for the campaign, but every doctor who values his freedom in practice needs to work at keeping that freedom by crusading every day of the week.

Doctors who have devoted their lives to fighting physical ills must do double duty until this issue is resolved—and help in *treating the ills of the body politic*.

Every doctor needs to talk to *every patient* who is able to listen—and tell him the truth about political medicine, how it destroys the quality of medical care, how it breaks down the physician-patient relationship,

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Every doctor, too, needs to encourage patients to get good, sound voluntary health insurance for their own protection and the protection of their families.

The doctor's job in the campaign will be more fully outlined in a special pamphlet which will be mailed direct to every member of the A.M.A. throughout the Nation.

No group of men can reach the people of America more quickly or effectively than the doctors of America—and *doctors can cure this sickness* if they fight it as they would any other plague which threatened their country or community.

This is an emergency—and we believe the doctors of America will measure up to it!—Whitaker & Baxter, Chicago, Ill.

The Clinical Aspects of Anthracosilicosis

BURGESS GORDON, M.D.

Philadelphia, Pa.

THE clinical problems of anthracosilicosis are involved in the complex and important questions of social betterment, legislative acts, and the economics of coal production. With an insidious, tenacious, and progressive nature, the disease strikes the home, the community, and industry. Thus, while the miner's physical condition is of primary importance, the wide ramifications are emphasized. In the present paper, there is an attempt to illustrate the extraneous factors in a discussion of significant criteria for diagnosis, medical care, and the evaluation of disability.

Anthracosilicosis is present with varying degrees of activity in more than 35,000 anthracite miners in the State of Pennsylvania, and possibly there is a high incidence in the bituminous coal fields elsewhere in the United States. While the figures are significant, the potential cases are not fully reflected in any existing graph, since numerous cases of anthracosilicosis will be carried over from the era of active silica hazard. It appears that the value of preventive measures will not be fully realized in the present generation of coal miners.

It is a curious paradox that anthracosilicosis appears alternately as an incapacitating and benign disease, leading to faulty conceptions in diagnosis and evaluation of disability. While anthracosilicosis is a pathologic and physiologic condition characterized by exacerbations, there is a trend of physical incapacity in parallel with disability due to age. Likewise, the manifestations encountered during the fourth and fifth decades of life, in the early and moderately advanced stages of the disease, often are the physical expressions of a variety of influences including acute chest colds, retained bronchial secretions, general body fatigue, faulty habits of breathing, anxiety states, cardiovascular impairment, and the wear and tear of effort. In a sense,

the coal miner is affected with the same intercurrent and associated conditions that plague normal persons, the difference being the relative and added influences of physiologic impairment due to the anthracosilicosis *per se*.

In the pre-antibiotic era, numerous coal miners died from pneumonia and intercurrent infections. Others were rendered permanently incapacitated because of the resulting pneumonitis, atelectasis, and the various complications. With the advent of the antibiotic drugs, a new paradox has appeared. Lives have been spared, permitting the continued development of the fundamental fibrotic and emphysematous processes and resulting disability. The burden of domiciliary care, with increased compensation, is becoming serious in the problem of anthracosilicosis. Indeed, while the immediate effects of specific therapy have been gainful, there has developed a train of circumstances and situations that are as pertinent in the social and industrial aspects as the disease is complex physically and physiologically.

The practitioner of medicine is called upon to employ the greatest care in the diagnosis, observation, and management of anthracosilicosis. There also is the challenge to industry, labor, and the law to compose the economic and social problems of the disease that has been literally carved from the rocks in man's quest for livelihood. Indeed, the proper evaluation of disability and the interpretation of statutes are serious responsibilities of physicians and attorneys.

The fundamental problems in anthracosilicosis are displayed in correlations of the pathologic features and the clinical course. Witness the striking disproportion between the extensive necropsy findings and the minimal symptoms in cases of accidental death. In these instances, the discovery of extensive pulmonary disease almost belies the possibility of laborious work, and yet the coal miners had been able to follow their occupation faithfully and efficiently. In other instances, accidental death had terminated lives that had been burdensome and trying, and yet the pathology was limited, and on this basis there

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From the Department of Medicine, Jefferson Medical College, and the Department for Diseases of the Chest, the Barton Memorial and the White Haven Divisions, Jefferson Hospital, Philadelphia, Pa.

was no adequate explanation for the clinical manifestations. A similar disproportion between the clinical features and the structural alterations of the lungs has been noted in death following illness. It has been impossible, in some instances, to explain the continuance of work in the presence of the barest remnant of normal lung tissue.

Physicians are confronted with the following types of cases for evaluation and treatment: (a) those for symptomatic treatment and general management; (b) those with minimal or moderately advanced disease affected with dyspnea and paroxysmal cough, possessing the ability to work; (c) those with moderately advanced structural disease or physiologic impairment, for evaluation of disability in the performance of heavy labor or light work generally; (d) those with one or more complications of anthracosilicosis, for differential diagnosis as to the respective influences; and (e) those with questionable disease for diagnosis. In the physical examinations, the following data are required: verification of the history of silicate hazard, with notation of symptoms and the clinical findings; the use of special laboratory procedures in doubtful cases; a trial of symptomatic treatment; and a critical interpretation of the fundamental pathology and physiologic disturbances.

In referring to the etiology and pathology, the term anthracosilicosis is used for designating the peculiar characteristics of coal miners' pneumoconiosis caused by silicate. It presents the bizarre features of fibrosis and emphysema, with the extensive alterations and complications not ordinarily found in "pure" silicosis. The exact role of carbon is debated, but the effects of coal dust are recognized. In observing the effects of the dust, Gough¹ studied the pathology of British coal trimmers, whose only employment in the coal industry was to load semi-bituminous or steam coal onto ships in an atmosphere laden with coal dust. He found that the changes in the lungs were identical with those of miners who worked in the mines. He reported also that the roentgenographic features were similar in miners who had been employed in the mining of bituminous and anthracite coal.

The basic pathology is the silicotic nodule, which invades the lung parenchyma, the pleura, the hilar nodes, and the lymphatic pathways between the alveoli and the hilum. The nodules are located at the entrance of lobules and may appear microscopically as avascular, laminated fibrous whorls. Perilymphatic fibrosis is not uncommon. Conglomeration of the minute miliary nodules with dense fibrous masses occurs in advanced cases. With marked involvement, there is a com-

bination of structural change and displacement phenomena involving the bronchi and mediastinum.

In the emphysema of anthracosilicosis there is distention of the lungs, especially of the bases and sternal margins, with loss of elasticity, pallor, and deposition of pigment. The emphysema is closely associated with fibrosis and it may be hypertrophic, compensatory, senile, or focal in type. The feathery consistence is noted on palpating the less fibrous parts of the lungs. Blebs, bullae, and spontaneous pneumothorax may be a part and parcel of the emphysema. With the senile type predominating, the lungs may be distended but small, and sometimes lengthened. The alveoli are distended, ruptured, or fused with other air sacs. With focal emphysema, small patches of dilated alveoli are surrounded by fibrotic processes.

The features of tuberculosis in anthracosilicosis include the formation of granulation tissue and scarring in a remarkably chronic state. Caseation and cavitation are late developments; tubercle bacilli, even in long-standing lesions, are rarely present in ordinary examinations. In some instances, the tuberculous lesion may entirely supersede or mask the underlying silicosis in a conglomerate or pneumonic process. With non-tuberculous infections there are the evidences of chronic bronchitis, bronchiolitis, and bronchiectasis, atelectasis, frank consolidation, focal emphysema, bronchial obstruction, and pressure phenomena due to retained secretions.

The gross pathology of the cardiovascular system in anthracosilicosis is hypertrophy of the right ventricle with evidences of heart failure. Compression, occlusion, and sclerosis of the pulmonary blood vessels and lymphatics are present in areas of extensive fibrotic and emphysematous involvement.

General Considerations of Pulmonary Function

The characteristic features of normal breathing are expansion of the chest with lowering of the diaphragm during inspiration, followed by diaphragmatic elevation and normal thoracic contraction on expiration. The excursions of the lungs are both horizontal and vertical. While inspiration occurs as an active muscular effort, expiration is passive and depends on the recoil of the lungs and the elasticity of the chest wall. In strenuous exercise there is a modification of the respiratory movements, the diaphragm rising only partially during expiration, the lungs remaining somewhat distended. In a sense, expiration is accomplished imperfectly, and each succeeding inspiration begins before expiration

is fully accomplished. With a demand for more air there is an increase of inspiratory effort, which, however, remains uncompensated since there is no similar degree of expiratory stress. Although the expiratory muscles are brought into play, their effectiveness is transient because of fatigue and the difficulty of coordination, with the result that inspiration remains essentially compensatory. While the normal lungs resume their previous positions, movements and functions following exercise, the abnormal lungs tend to remain stretched, even after prolonged rest. Thus the combined effects of increased inspiratory and expiratory pressure are definitely contributory in the development of emphysema.²

The state of overdistention of the bronchi and alveoli is an important cause of atrophy of the alveolar walls and their permanent dilatation. This phenomenon, occurring especially in fibrosis and chronic bronchitis, is accentuated by episodes of partial or transient obstruction of the bronchi with retention of secretions and swelling of the mucous membrane. Bronchial spasm, an important mechanism in blockage of the bronchi, is especially evident during attacks of acute tracheobronchitis. Additional contributing factors relate to the traumatizing action of cough and forceful respiration, which aggravate bronchial spasm and subsequently favor the permanent dilatation of alveoli, especially in areas of diseased pulmonary tissue.

Symptoms

The symptoms of pulmonary fibrosis are related chiefly to the irritating effects of the silicosis, the reduction of normal lung tissue, and displacement of pulmonary structures. Cough is a predominant feature. It occurs with exercise, talking, and the need to expel tenacious coal-laden mucus from the bronchial tree; it may be hard, racking, or paroxysmal in type and is apt to precipitate attacks of shortness of breath. Dyspnea is a variable symptom. It may be proportional to the extent of gross pulmonary fibrosis and the degree of distention of the lungs. In other instances, it reflects the functional impairment of the cardiorespiratory or cardiovascular systems.

The acute infections are characterized as superimposed bouts of fever, tightness of the chest, malaise, and dyspnea, with delayed periods of convalescence. Pneumonic processes are not uncommon in the advanced cases. With atelectasis, there are the more serious effects of retained secretions, the tendency to abscess formation, involvement of the pleura, and the compensatory burden carried necessarily by the op-

posite and more normal lung. With bronchiectasis, the expectoration of pus is marked, especially on rising in the mornings; blood spitting is not uncommon. In tuberculosis, cough and expectoration may occur periodically throughout the day, with afternoon fever, sweating, and loss of weight, depending on the activity of the disease. It is remarkable that tuberculosis may be held in abeyance while the manifestations of anthracosilicosis predominate.

The symptoms of emphysema are characterized as insidious and gradual in onset. They may be minimal and overlooked entirely until the occurrence of an acute chest cold. Puffiness and shortness of breath occur at first in hurried walking and stair climbing, followed eventually by extreme dyspnea on the slightest physical effort; orthopnea is common in advanced cases. Moderate to marked cyanosis is sometimes noted. In comparison with the dyspnea of heart disease, the difficulty in breathing usually is not accentuated on lying down flat in bed. It is realized that the symptoms of emphysema may be closely associated with the lack of resiliency of the lungs due to fibrosis, and consequently the exact role of the emphysema may not be fully recognized.

Physical Signs

The findings in pulmonary fibrosis depend essentially on the degree of tissue replacement with fibrosis and the extent of displacement phenomena of the heart and mediastinum. With predominant fibrosis there is retraction and deformity of the chest with narrowing of the intercostal spaces. The shoulders may be drawn down. Scoliosis of the spine is not uncommon. Lagging of the chest is present over massive areas of fibrosis. The percussion note is impaired, the breath sounds exaggerated, and scattered fine and medium rales are heard, the number and intensity varying with the degree of pulmonary ventilation and the presence of superimposed infection. An overlay of emphysema may completely mask the signs of an extensive fibrotic process. Cyanosis of the lips and nail beds, with clubbing of the fingers, may be present.

In characteristic emphysema, there is prominence of the sternum with marked accentuation of the intercostal cartilages and a relative increase in the anteroposterior diameters of the chest. The ribs in front may be almost completely horizontal. In marked cases, there is elevation of the chest with no appreciable expansion even during full inspiration. Abdominal type of breathing is predominant in the advanced cases. The apex beat may not be observed. The percussion note is hyperresonant, while the breath

sounds may be either harsh or distant, especially at the bases, and greatly prolonged during expiration. Rales are present in the majority of cases and vary with the degree of associated bronchitis; they are usually medium, "dry," "musical," or moderately coarse in type. Diaphragmatic excursions are restricted within the inspiratory range; the fluoroscopic examination in advanced disease reveals only the slightest degree of diaphragmatic excursion.

While the physical signs of anthracosilicosis are characteristic in the majority of cases, striking exceptions should be noted. These refer especially to the constitutional features of the individual case, with reference to the physical development, weight, posture, and habits of work. In some instances, there seemingly is a pattern of physical development that more or less influences the future structure of the thorax and the subsequent pulmonary alterations. The rachitic chest is possibly an influence in the development of a prominent sternum. Primary hyperplasia, premature ossification of the costal cartilages, and disease of the intervertebral disks may be predisposing factors in accentuating the rounded or barrel-shaped contours of the chest. In some miners the thoracic spine is straighter than normal, the ribs and the entire thorax elevated, while the anteroposterior diameters of the chest are not markedly increased. In others there is a long type of chest with flattening of the anterior surface. In obese subjects the dorsal spine may be shifted backward with exaggeration of the thoracic curve, the dorsal and lumbar spines assuming the shape of the letter S.³ Thus it should be emphasized that the barrel-shaped chest does not necessarily establish the presence of advanced anthracosilicosis any more than the flattened chest excludes the possibility that emphysema is present.

The examination of the heart in anthracosilicosis should include the differentiation from primary disease of the valves and myocardium. With the abnormal heart, organic murmurs and myocardial involvement will be noted or suspected. Significant disturbances of the normal heart may not be observed until the pulmonary fibrosis and emphysema cause right-sided heart strain, as suggested by abnormality of the T waves or S-T intervals in leads II and III. The heart sounds may be distant due to the muffling effects of the emphysema, or exaggerated as a result of displacement phenomena of the mediastinum, with rotation of the heart, causing "slaps" and false sounds, especially in subjects with poor nutrition.

The x-rays play an important role in the diag-

nosis of anthracosilicosis. However, their greatest value is in the study of lesions and the gross alterations of the diaphragm, lungs, and mediastinum. Special techniques of exposure and timing in relation to the respiratory cycle are useful in determining the movement of air in and out of the lungs. While fluoroscopy is useful for the study of diaphragmatic function and the differences in illumination of the lungs, the permanent record provided in the x-ray is of greater value. With due regard for roentgenography, it should be emphasized that the x-rays are not reliable in establishing the degree of function impairment based on the extent of the pulmonary fibrosis and emphysema.

Special Studies

The usual criteria for differential diagnosis and the evaluation of disability in anthracosilicosis may be inadequate. There often is need for special procedures, especially in cases with fever, loss of weight, paroxysmal cough, and blood-streaked expectoration. In such cases, bronchoscopic examinations and special cultures of the secretions are indicated. The possibilities of new growth and tuberculosis should be excluded. Physiologic testing is indicated in cases with disproportionate symptoms, physical signs, and x-rays.

Physiologic Testing

Involved in the condition of anthracosilicosis is the important phenomenon of pulmonary function. This is related chiefly to the movement of air in and out of the lungs, and the transfer of gases between the alveoli and blood vessels. The exact influence of disturbed pulmonary function is often the medical hurdle that must be cleared before a correct evaluation of disability can be established, as emphasized repeatedly in the physiologic studies at the Barton Memorial Division of the Jefferson Hospital. While the clinician and roentgenologist remain foremost in dealing with anthracosilicosis, they should have at their disposal the benefit of physiologic testing,^{4, 5, 6, 7} in the same manner as the differential blood count should be used in supplementing the ordinary blood count in the diagnosis of pernicious anemia.

Treatment

The treatment of anthracosilicosis relates (a) to the control of acute episodes of infection and resulting dyspnea, (b) to symptomatic relief of persistent dyspnea, and (c) to general medical care.^{8, 9, 10} Intermittent positive pressure breathing treatments with oxygen and bronchodilator

drugs are of definite value in cases with acute episodes of infection and dyspnea related to physical effort. While the pressure breathing provides a form of respiratory exercise, the bronchodilator drugs facilitate the exit of trapped air and mucus from the bronchioles and dilated alveoli. Diaphragmatic elevation, as obtained from the use of a special abdominal support, may be effective in obese subjects and others with low positions of the diaphragm. With this procedure, the diaphragm is displaced to a higher expiratory position, thus reducing the trauma of cough and favoring the passage of secretions and residual air from dependent areas of the lungs.

Although rest is indicated for advanced anthracosilicosis, especially in aged coal miners with cardiorespiratory distress, undue physical inactivity may become harmful. Exercise is valuable for maintaining the general health and should not be discontinued entirely unless definitely indicated, since it favors the resolution of intercurrent infections and serves in maintaining the proper circulation. Marked discomfort, with increased pulse and respiratory rates, calls for limitation of activities; stair climbing and walking rapidly, especially against the wind, should be avoided. The value of drugs in emphysema is disappointing. The expectorant and sedative drugs usually are more disturbing than effectual. Codeine favors the retention of secretions and should be used conservatively for severe racking cough. In failure of the circulation due to primary myocardial disease, digitalis and theobromine derivatives are indicated. Mer-

cuhydrin, 2 cc., given intramuscularly once weekly, is sometimes useful in controlling edema. It is essential to maintain an adequate intake of protein.

Conclusions

1. The medical problems of diagnosis and evaluation of disability in anthracosilicosis are discussed in light of the social and economic background.
2. The clinical features are amplified in consideration of the pathologic and physiologic aspects.
3. The value of coordinating the clinical findings with physiologic testing is important in the critical study and management of obscure cases of anthracosilicosis.

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IS SHE REALLY A NURSE?

Important reading for every person, especially those connected with the nursing profession, can be found in the shocking facts about the frauds who endanger public health which are disclosed in the article "Is She Really a Nurse?" in the October issue of *Good Housekeeping* magazine.

According to Dr. Esther Lucille Brown of the Russell Sage Foundation, who made a definitive study of the nursing profession, "anyone may put on a uniform and simply call herself a 'nurse.'"

The article cites the fact that the 280,000 registered nurses, with three or four years of specialized training, who are practicing in the country today are outnumbered by "some 300,000 other women who call themselves nurses, or sometimes practical nurses, but who lack the most elementary knowledge of their profession."

Contrasted with the three states (New York, Arkansas, and Louisiana) which have recently passed laws forbidding any unlicensed person to nurse for hire, there

are forty-five remaining states which "still allow any unlicensed, untrained person to call herself a nurse and get paid for it." California, Michigan, and Pennsylvania are among the states without any restrictive legislation at all.

The article exposes the more than 300 so-called "quickie commercial and correspondence schools," some of which claim to teach, in fifty-three lessons by mail, the entire range of nursing skills for \$75.00. These schools, one of which turns out over 200 "graduates" each month, are compared with the Civil Service training requirement for a practical nurse—400 hours of instruction and 1200 hours of supervised nursing care. One of the commercial schools registers a student in the morning and sends her out as a "nurse" the same evening.

As a means of combatting this real danger to public health, the article recommends that all states pass laws forbidding anyone to nurse for hire who has not met prescribed standards and passed prescribed tests.

The American Nurses' Association has described the article as "an outstanding public service."

THE PENNSYLVANIA MEDICAL JOURNAL

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EDITORIALS

"LEAVE US ALONE WEEK"

If you live in a fair-sized American city, doubtless you are approached forty weeks out of each fifty-two by a sidewalk solicitor for funds to aid some benevolent organization, which may or may not be worthy but is beneficent, which means "well doing." During the remaining ten weeks in the year the city and the rural dweller as well are "dingdonged" for more than pocket change by nationally recognized organizations that may be both benevolent and beneficent. It is the national soliciting organizations which tend to appeal largely to the well-to-do and the influential that are depriving the less fortunate of opportunities to exercise their intentions to do good, such as they might enjoy through basic local combined efforts to raise and spend benevolent funds on a smaller scale.

The *New England Medical Journal* recently discussed this subject editorially under the caption "First Things First," from which we quote excerpts:

"The complaint has become almost universal that the national power drives, appealing to the emotions of a still generous people, are cutting across the supply lines of the vital locally organized services of all major communities and are threatening their continued existence.

"Nor is it only the March of Dimes, the National Tuberculosis League, the American Heart Association, the American Cancer Society, the American Red Cross, and other nationally recognized organizations that are in this fashion, and certainly with the best of inten-

tions, tapping in on the resources of each community. The number of worthy appeals has grown to the point where rarely is there a moment in which one or more is not in existence.

"Basil O'Connor, former president of the American Red Cross—a supercolossal and particularly independent organization—took it upon himself to bring into the open the danger that now threatens the future of all voluntary health and welfare agencies. In his address before the annual convention of the Red Cross, in June, he indicated plainly that compulsion under state control may yet supersede 'voluntary association for the alleviation of human suffering.'

"Such a change in method is actually not at all unlikely to take place even in this country, as it pursues its course toward the condition of a welfare state. The outcome can only be hastened by the non-cooperation of the fund-raising organizations that ignore the equal if not the prior rights of those charities that begin at home.

"No more than two intensive campaigns should be tolerated by the people of any community. These should be a community fund drive at one time of year for the local health and welfare organizations, and as remote from this as possible in point of time a combined drive for all the other health and relief agencies.

"*'Responsibility rests with the community leaders who sponsor, support, and give direction to these miscellaneous campaigns. When they wish correction they can bring it about.'*"

This last paragraph is quoted from the report of the recent "Greater Boston Community Survey," which also found that in addition to the Community Fund drive ten organized campaigns sought \$12,000,000 in metropolitan Boston.

DECREASING MATERNAL MORTALITY RATES REFUTE CERTAIN CHARGES

An editorial on the above subject appearing in the *Journal A.M.A.*, October 1, 1949, must have been based on "provisional figures on maternal mortality in the United States, collected by correspondence with state public health agencies" from the A.M.A. Bureau of Medical Economic Research.

Twenty-seven states and the District of Columbia have rates at least as low as 1 maternal death per thousand live births. The best state record was the phenomenal rate of 0.4 reported for Oregon. Three states (Connecticut, Nebraska, and Utah) now hold second place, each with a rate of 0.6. An accompanying table shows that Pennsylvania and seven other states have a rate for 1948 of 0.7.

The highest rates in 1948 were 2.7 for Mississippi and 2.3 for Alabama and South Carolina. Considering the differences in climate and racial composition, some students of vital statistics may consider the drop from 2.6 to 2.3 for Alabama and South Carolina an accomplishment as great as or greater, from the social point of view, than the reduction for Oregon from 0.9 in 1947 to 0.4 in 1948.

For thirty-seven states and the District of Columbia, the 1948 rates were at least as low as those reported in 1947; the decrease ranged from 0.1 to 0.8. In only eleven states were the rates higher in 1948, and the increases were small (0.1 to 0.4). The progress against maternal mortality in the United States continues to be general throughout the country.

Many other nations are also experiencing a considerable drop in their maternal mortality rates. Obviously, future decreases in the number of maternal deaths per thousand live births will be smaller. There are enough states in the United States with maternal mortality rates above 1.0, however, to anticipate some further decreases in the rates for individual states.

The spread between the rates of the healthier countries continues to narrow. As maternal mortality rates approach the level of 1.0, they will no longer be a gauge for comparison of the health of nations. In fact, a spread of only 0.1 or 0.2

between the rates for any two nations may well be statistically insignificant; that is, the small differences may be due to errors in reporting the number of maternal deaths and live births.

Since 1933, the United States has made tremendous progress, with the rate declining from 6.2 to 1.2 in fifteen years. More important than the decline for the whole nation is the fact that the highest state rate in 1948 was 2.7, which was less than two-thirds of the rate (4.3) for the best state in 1933. To the extent that this one vital statistic can be considered an index of health, the charge that rapid improvement in health has been limited to the wealthier sections of the country is clearly and emphatically refuted.

TWENTY-FIVE MAN TEAM STUDIES DONORA 1948 TRAGEDY

It should be a source of great satisfaction to all Pennsylvanians to learn that the spectacular Donora, Pa. smog tragedy, which so suddenly developed in November, 1948 and resulted in the death of twenty citizens and the illness of many others, has been carefully studied during the intervening twelve months by the United States Public Health Service.

JOURNAL readers are given an opportunity in this issue to read the recent report by Surgeon General Leonard A. Scheele, of the U. S. Public Health Service.

That the study has been characteristically sound and scientific is indicated in the appended paragraph, and because of Pennsylvania's industrial leadership we hope that reading it will stimulate a careful reading of the entire interestingly composed yet, of necessity, incomplete report (see page 1580).

"This study has been the most exhaustive ever made into a problem of air contamination," Dr. Scheele said, "and one of its most important results is to show us what we do not know. It has taken the full time of twenty-five technical people from the Public Health Service's Division of Industrial Hygiene for almost a year. What we have now is the certain knowledge that this problem of air pollution is of major importance. And we have a blueprint of how we may proceed toward a solution."

PRECANCEROUS AND PREDISPOSING LESIONS READILY DETECTABLE

The appended report of the Committee on Cancer Detection Examinations, of our state society's Commission on Cancer, should serve to stimulate active support of this practical plan for early detection of cancerous and precancerous and predisposing lesions by the class of physicians upon whom greater achievements depend, namely, the general practitioners.

Report of the Committee on Cancer Detection Examinations

Approximately 1650 cancer detection forms have been distributed. Three hundred and seventy-five have been returned, as of Sept. 22, 1949. Three hundred and sixty-four have been returned by detection centers, and 11 by practicing physicians. Three members of the Commission on Cancer returned cards.

Tabulation of the results of the examinations is as follows:

<i>Cancers detected</i>	4	1.1%
1 skin cancer		
1 scirrhus cancer of the breast		
1 squamous cell cancer developing in a rectal polyp		
1 lymphosarcoma of the mesentery		
<i>Lesions predisposing to cancer</i>	67	17.9%
including pigmented moles, cervical erosions, rectal polyps		
<i>Other significant pathology</i>	153	40.8%
including cysts of the ovary, mucous polyps of the cervix, cystic mastitis, hypertension		
<i>Predisposing lesions and other significant pathology coexisting</i>	26	6.9%
<i>Negative findings</i>	123	32.8%
<i>Diagnosis pending</i>	2	.5%
	375	100.0%

The members of the committee feel that a good start has been made, but are still at a loss to know how best to interest the general practitioner in making these examinations. Suggestions to this end, and suggestions as to revising the history form, would be greatly appreciated.

S. GORDON CASTIGLIANO, M.D.
 GEORGE W. HAWK, M.D.
 CATHARINE MACFARLANE, M.D., *Chairman*

WHY THE INCREASE IN DUES?

Several weeks ago we all received a letter from the State Society notifying us that the annual membership dues shall be increased from \$15.00 to \$23.00; that is an increase of \$8.00 per member. It was explained that this was necessary to balance the annual budget and "eliminate deficit spending." It was pleasing to read that phrase because it was so unlike the usual phraseology one sees in the daily papers in regard to the financial manipulations of our Federal Government. It

gave the impression that our own medical organization is still operating on old-fashioned, sound, economic principles. Another paragraph implied that we may anticipate annual dues to retain membership in the A.M.A. This, so far, was an automatic honor conferred upon us when we paid our local and state dues. Until now the yearly subscription to the A.M.A. *Journal* (or several other of its publications) was the only source of revenue from the individual physician. . . .

We are in an era of power politics, and our government is, in a large part, led by power-hungry bureaucrats, socialistic schemers, and dollar-happy spend-thrifts who are already confident that democracy is a lost cause and must be replaced by a "welfare state." . . .

Knowing these things and realizing the costs necessarily involved, we feel that every doctor will be proud of his part in the program and willing to pay his share of the expense.—Editorial, *Lancaster County Medical Bulletin*.

DRUGS IN TUBERCULOSIS TREATMENT

Buy Christmas Seals



Help Stamp Out TB

Patients and physicians have always longed for a drug capable of eradicating tuberculosis infection, one that would obviate the need for long discouraging months of bed rest, the risk and pain of surgical operations, and that would shorten the years of uncertainty, with fear of recurrent disease, after apparent arrest of active tuberculosis. Un-

critical stories and rumors of new drugs have repeatedly aroused the hope that this vision might become a reality.

Confused by accounts of uncertain authenticity which suggest unbelievable properties of new "wonder drugs" and curative procedures, patients are often in a hopeless quandary. They do not have ready access to technical literature, nor could they comprehend and apply to their own problems the mass of complicated, and at times conflicting, experimental studies recorded in medical journals.

Some salient facts have emerged from the many studies on drug treatment of tuberculosis which have been agreed upon by numerous competent investigators. It has been demonstrated repeatedly that the bacillus of tuberculosis may be restrained in its growth and multiplication within the human body by means of newer drugs. This restraint is not always complete and frequently it is operable for a limited period of time only.

Drug treatment is best omitted when not truly needed, most physicians now believe. Not only are undesirable effects of treatment avoided but treatment might be needed more desperately to meet some subsequent crisis, and unfortunately such treatment often cannot be employed more than once. The physician must estimate the patient's powers of resistance against the infection and fortify them by every means known. Rest, balanced nutrition, emotional serenity, and an indomitable will to recover are priceless assets to every patient.

Surgery or lung collapse combined with newer drug

treatments may yield results greatly superior to those of previous years. To choose the best combination of treatments, the physician must estimate which tissues are destroyed and which are only inflamed and capable of healing. This requires skill and experience, since there are nearly as many different problems as there are patients. The growing tendency is to train all weapons upon the enemy microbe simultaneously when serious progressive disease is present.

New antituberculosis drugs have appeared and others are on the horizon. Genuine advances in the treatment of tuberculosis will be recorded in the years ahead, but how is the bewildered patient to distinguish facts from fancies? The prudent patient will not attempt, as an amateur, to assay rumors or to trace sensational stories, but he will place his trust in a dependable physician of his choice. Few people are so rash as to trust their lives and property to their own legal judgment when difficulties arise with courts of law, but many have lost everything by choosing to ignore sound medical advice.

The nation-wide facilities of the National Tuberculosis Association, its state and local affiliates, and its medical section, the American Trudeau Society, have been used repeatedly to distribute reliable information to physicians and to patients about new methods of treating tuberculosis.

Under National Tuberculosis Association sponsorship, committees of scientists and physicians are constantly studying new and unproved treatments, hoping to render judicial opinions for the guidance of physicians in treating patients. This committee work is one of the activities supported by the Christmas Seal funds and has been an important integrating influence in a shifting field of turbulent scientific activity.—H. CORWIN HINSHAW, M.D.

REVISED DEFINITION OF PERSONS WITH LOW INCOME ANNOUNCED BY MSAP

Following approval by members of the corporation of the Medical Service Association of Pennsylvania, the Board of Trustees of The Medical Society of the State of Pennsylvania, and the State Insurance Commissioner, a revised definition of income limits for subscribers of Blue Shield has been announced by J. Arthur Daugherty, M.D., president of the association.

Effective November 1, 1949, persons with a low income, who are served by more than 8000 participating doctors under the Blue Shield Plan of prepaid medical care, will be defined as:

1. Subscriber without dependents—any person in receipt of an income that does not exceed \$2,000 a year.
2. Subscriber with one dependent—any person in receipt of an income that, together with the income of the dependent, does not exceed \$3,000 a year.
3. Subscriber with more than one dependent—any person in receipt of an income that, together with the incomes of all income-earning dependents, does not exceed \$4,000 a year.

The new definition of persons with low incomes is further evidence of the desire of MSAP to maintain the basic principle upon which it was founded in 1939—providing a "service plan" for persons with a low income. At that time income limits were set at \$1,560,

\$2,340, and \$3,120, respectively. Changes in economic conditions, particularly during the past few years, made those income limits far from realistic.

A study of the problem was conducted during recent months by a committee composed of members appointed by the Board of Trustees of the State Medical Society and the Board of Directors of MSAP. The revised definition of persons with a low income was recommended by this committee and received approval as stated above.

As in the past, persons with a low income receive only the professional care included in their subscription agreement from participating doctors without additional charge. All charges for other services are billed directly to the subscriber, who is personally responsible to the physician for their payment. All persons earning more than the above amounts are likewise billed personally for the difference, if any, between the amount paid the physician by the association and his usual charge to such patients.

Dr. Daugherty has requested that all participating doctors in Blue Shield advise their assistants and associates of this change in income limits.

CARE PROGRAM SENDS MEDICAL BOOKS ABROAD

To supply the latest medical and other scientific knowledge for professional people and students overseas, CARE, in cooperation with UNESCO, has added a book program to its food and textile package service.

Under the plan, endorsed by the American Medical Association, CARE and UNESCO representatives in Europe and Asia are obtaining lists of the book needs in specified scientific and technical categories from war-wrecked universities and libraries abroad. With the funds contributed by Americans, CARE then fills those needs as closely as possible by purchasing the latest and best books in those fields published in English.

All books purchased by CARE are selected from a bibliography compiled by a committee of scientists and libraries headed by Dr. Luther Evans, Librarian of Congress, with Dr. John F. Fulton, Sterling Professor of Yale Medical School, as one of the members. Concentration on books in English fills the express requests of educational institutions in foreign countries.

The various fields of medicine are one of 19 categories covered by the plan. In order to reach the greatest number of people, delivery is made to institutions only, not individuals. Countries now served are Austria, Belgium, Czechoslovakia, Finland, France, Greece, Italy, Japan, Korea, the Netherlands, Norway, Great Britain, the three western zones of Germany, and all Berlin. Negotiations to extend the program to Poland and several Far East countries are pending.

Contributions in any amount can be sent to the CARE Book Program, 20 Broad St., New York 5, N. Y., or to any CARE office in the country. Donations under \$10 are pooled in a general fund. Donors of \$10 or more can specify the institution, country, and category (such as medical) of book to be sent. They receive a receipt signed by the recipient on delivery, so that they know exactly where and to whom their gift has gone. On undesignated orders, CARE will select recipients on the basis of greatest need.

PENNSYLVANIA ADOPTS LATEST REVISED FORM OF CERTIFICATES OF LIVE BIRTH, DEATH AND STILLBIRTH BEGINNING JANUARY 1, 1950

Published through the cooperation of The Pennsylvania Department of Health and The Medical Society of The State of Pennsylvania.

Registration of births, deaths and stillbirths in the United States is not only of extreme importance to the individual and his family, but is also essential in the fields of public health and social welfare.

The Pennsylvania certificates have been revised on the basis of the standard certificates recommended by the National Office of Vital Statistics, U. S. Public Health Service, Federal Security Agency. The forms were adopted in consultation with State health officers and registrars; national and State medical societies and private organizations concerned with legal, medical, public health, social welfare and demographic uses of vital records. This revision program is carried out periodically to keep the certificates abreast of advances in registration practices and to meet the changing needs for vital statistics data.

Major changes in the live birth certificate are the addition of the items "weight at birth," "length at birth" and the substitution of the item "length of pregnancy ——— weeks," for a similar one in terms of months. These items provide valuable information with regard to premature births and are to be made part of comprehensive studies of prematurity.

The principal changes in the death certificate are revision of the medical certification of cause of death to accord with the international form of medical certification recommended by the International Conference for the Sixth Decennial Revision of the International Lists of Diseases and Causes of Death and prescribed by the World Health Assembly for use by signatory nations, beginning in 1949 or 1950. The new medical certification form is designed to secure the physician's judgment of the train of events leading to death. Its use is essential to uniform application of the internationally adopted principle of selecting the underlying cause of death for statistical tabulation.

The most important feature of this certification is its emphasis on the underlying cause, as determined by the attending physician. Thus, the physician has both a heavy responsibility and a great opportunity to make mortality statistics reflect the true frequencies of the underlying causes of death.

The principle of asking the physician to indicate the underlying cause is not different from the procedure previously in existence by which he was asked to indicate the causal or chronological sequence of conditions leading up to the immediate cause of death. However, in the absence of adequate instructions on the standard death certificate for the past decade, there was some variation in the way that causes of death were reported. With the adoption of the new certification form, which specifies the sequence in which causes of death should be reported, more meaningful information should come from the physician's statement of the causes of death in proper order.

The form consists of two parts for entry of the causes of death with space for indicating the interval between onset and death for each condition, additional space for reporting any operation performed, and check boxes for indicating whether or not an autopsy was performed. The explanation as to the occupation item is of the greatest importance for studies of mortality in various occupations.

Adoption of a stillbirth certificate in Pennsylvania is quite a change from the previous practice. Prior to the present revision of the standard certificates it was required that both a certificate of birth and a certificate of death be completed and filed for every stillbirth after twenty weeks gestation. Pennsylvania is now adopting a single certificate which is the only certificate necessary for the registration of a stillbirth.

The design of the revised certificates has been modified to provide more adequate space for making entries than did the old format. This arrangement and the provision of two typewriter spaces for each row simplifies the use of the typewriter in completing the certificates.

THE STANDARD CERTIFICATE OF LIVE BIRTH

This is a permanent document. Type or use permanent black ink. Do not use ball-type pen.

HVS 20021—125M—5-49  -10		COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS		Birth No. _____	
Primary Dist. No. _____		CERTIFICATE OF LIVE BIRTH		Registered No. _____	
1. PLACE OF BIRTH a. County Cumberland b. City (If outside corporate limits, write RURAL and give township) or Borough Carlisle c. Full Name (If NOT in hospital or institution, give street address or location) of Hospital or Institution Carlisle Hospital			2. USUAL RESIDENCE OF MOTHER (Where does mother live?) a. State Penna. b. County Cumberland c. City (If outside corporate limits, write RURAL and give township) or Borough Rural - Middlesex Twp. d. Street Address (If rural, give location) Carlisle Springs		
3. CHILD'S NAME (Type or print) a. (First) John b. (Middle) Henry c. (Last) Doe					
4. SEX Male	5a. THIS BIRTH Single ☒ Twin ☐ Triplet ☐	5b. If TWIN or TRIPLET (This child born) 1st ☐ 2nd ☐ 3rd ☐	6. DATE OF BIRTH (Month) (Day) (Year) March 8, 1949		
FATHER OF CHILD					
7. FULL NAME a. (First) Robert		b. (Middle) Thomas		c. (Last) Doe	
8. COLOR OR RACE White					
9. AGE (At time of this birth) 29 Years	10. BIRTHPLACE (Also give State or foreign country) Rockville, Illinois	11a. USUAL OCCUPATION Farm Laborer	11b. KIND OF BUSINESS OR INDUSTRY Farm		
MOTHER OF CHILD					
12. FULL MAIDEN NAME a. (First) Sarah		b. (Middle) Jane		c. (Last) Mathews	
13. COLOR OR RACE White					
14. AGE (At time of this birth) 26 Years	15. BIRTHPLACE (Also give State or foreign country) Arlington, Missouri	16. CHILDREN Previously Born to This Mother (Do NOT include this child) a. How many other children are now living? 1 b. How many other children were born alive but are now dead? 1 c. How many children were stillborn (born dead after 20 weeks pregnancy)? 0			
17. INFORMANT (Name, address and relationship) Sarah Jane Doe, Carlisle Springs, Pa.					
I hereby certify that this child was born alive on the date stated above at 2 P. m., E.S.T.		18a. ATTENDANT'S OWN SIGNATURE Wilson B. Garfield, M.D. 18c. ADDRESS 205 Peach St., Carlisle, Penna.		18b. ATTENDANT AT BIRTH M. D. ☒ Midwife ☐ Other (Specify) 18d. DATE SIGNED March 9 1949	
19. DATE REC'D BY LOCAL REG. March 10, 1949		20. REGISTRAR'S SIGNATURE Bryan S. Franklin		21. DATE ON WHICH GIVEN NAME ADDED BY (Registrar)	
22a. LENGTH of PREGNANCY 40 Weeks	22b. WEIGHT at BIRTH 7 Lbs. 2 Oza	23. LEGITIMATE Yes ☒ No ☐	24. LENGTH at BIRTH 19.675 Inches	25. NOTIFICATION MAILED BY REGISTRAR Data March 10, 1949 Initials BS-2	

The birth certificate, as a legal document, provides evidence for establishing such important facts as the date of birth, the place of birth, parentage, and citizenship. The birth certificate provides information on which health departments base their plans for immunization of children, the care of crippled children, evaluation of the need for health facilities, and the effectiveness of infant care. In addition, statistics derived from birth records provide basic data for population research and for planning programs related to education, housing, marketing, and consumer research.

In general, the duties and responsibilities of the attending physician or licensed midwife are:

Prepare the certificate of live birth on the form prescribed and furnished by the State Department of Health.

Be certain that accurate information is entered for every item on the certificate. The mother or father of the child should be asked to verify the information recorded.

File the certificate of birth with the local registrar of vital statistics of the district wherein birth occurred within ten days from the date of birth. Do not delay the certificate because the given name of the child or some other item of information is not immediately available. Careful observance of the time requirement is essential to the successful operation of the local and State vital statistics system.

Answer promptly all queries from the local or State registrar regarding entries on the certificate.

THE STANDARD CERTIFICATE OF DEATH

This is a permanent document. Type or use permanent black ink. Do not use ball-type pen.

HVS 20008—650M—5-49  10		COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS		File No.
Primary Dist. No.		CERTIFICATE OF DEATH		Registered No.
1. PLACE OF DEATH a. COUNTY Philadelphia		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Penna. b. COUNTY Montgomery		
b. CITY (If outside corporate limits, write RURAL and give township) OR BOROUGHS Philadelphia		c. CITY (If outside corporate limits, write RURAL and give township) OR BOROUGHS Rural-Lower Merion Twp.		
d. FULL NAME OF HOSPITAL OR INSTITUTION Meroy Hospital		d. STREET ADDRESS (If rural, give location) Bryn Mawr		
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Henry c. (Last) Doe		4. DATE OF DEATH (Month) (Day) (Year) Jan. 12, 1947		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 3, 1880	9. AGE (In years last birthday) 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, also if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Retail Coal		11. BIRTHPLACE (Also give State or foreign country) South Carolina
13. FATHER'S NAME James Doe		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, complete reverse side of certificate) Yes		16. SOCIAL SECURITY NO. 232-02-5678		
17. INFORMANT'S OWN SIGNATURE <i>Mary Alice Smith</i>		ADDRESS <i>Bryn Mawr Pa.</i>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia Metastatic cancer of bladder and abdomen ANTECEDENT CAUSES DUE TO (b) Adenocarcinoma of rectum II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Syphilis		INTERVAL BETWEEN ONSET AND DEATH 5 days 1 year 3 years 3 years
19a. DATE OF DEATH Sept. 13, 1944		19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma of rectum		20. AUTOPSY? YES ☒ NO ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN AND TOWNSHIP) (COUNTY) (STATE)
21d. TIME (Month) (Day) (Year) OF INJURY		21e. INJURY OCCURRED (Hour) (m. E.S.T.) While at Work ☐ Not While at Work ☐		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from August 25, 1944 to January 12, 1947 , that I last saw the deceased alive on January 12, 1947 , and that death occurred at 1:00 a.m. E.S.T. , from the causes and on the date stated above.				
23a. SIGNATURE <i>Walter A. Bliss, M.D.</i>		23b. ADDRESS 129 Reed St., Philadelphia		23c. DATE SIGNED Jan. 12, 1947
24a. BURIAL CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan. 15, 1947		24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery
24d. LOCATION (Town, township and county) (State) Manoa, Haverford Twp., Delaware Co., Penna.				
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE Jan. 13, 1947 <i>John D. Jones</i>		25. SIGNATURE OF FUNERAL DIRECTOR <i>Robert W. Bliss, Thilma, Penna.</i>		

The death certificate is of primary value to the bereaved family as a legal document for establishing the date of death in claiming life insurance, pensions, or other benefits, in settling a deceased's estate. Collectively, death certificates serve as the source of mortality statistics, which are of utmost importance to medical, health, and welfare organizations. The data are used for determining the importance of specific diseases as causes of death; in measuring the need for medical, health, and hospital services; and in planning and evaluating programs for the prevention and control of diseases.

In general, the duties of the attending physician are:

Prepare and sign the medical certification section of the death certificate, and enter the date of death, i.e., Items 4 and 18 to 23, inclusive. Item 18, part I, should give the sequence of events that led to death, specifying last the underlying cause which initiated the train of events. The mode of dying should not be reported. Item 18, part II, should set forth other important diseases or conditions, if any, that contributed to the death but were not related to the causes given in part I. When death is the result of an accident, homicide, or suicide, the death should be reported to the coroner, or similarly, if death occurred without medical attendance, the coroner should be notified.

The funeral director is responsible for completing Items 1 to 3, 5 to 17, 24 and 25, inclusive, which, in addition to the personal and statistical particulars, supplies information pertaining to the final disposition of the remains. The funeral director must file the certificate of death with the local registrar of vital statistics in the district where death occurred.

THE STANDARD CERTIFICATE OF STILLBIRTH

This is a permanent document. Type or use permanent black ink. Do not use ball-type pen.

HVS 20024-235M-5-49		COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS		File No. _____	
Primary Dist. No. _____		CERTIFICATE OF STILLBIRTH		Registered No. _____	
1. PLACE OF STILLBIRTH a. COUNTY <u>Allegheny</u>			2. USUAL RESIDENCE OF MOTHER (Where does mother live?) a. STATE <u>Penna.</u> b. COUNTY <u>Allegheny</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR BOROUGH <u>Pittsburgh</u>			c. CITY (If outside corporate limits, write RURAL and give township) OR BOROUGH <u>Dormont Bor.</u>		
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Cedarville Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>243 W. Pomfret St.</u>		
3. CHILD'S NAME (Type or Print) <u>Baby Boy Simmons</u>					
4. SEX <u>Male</u>	5a. THIS BIRTH Single ☒ Twin ☐ Triplet ☐	5b. IF TWIN OR TRIPLET (This child born) 1st ☐ 2nd ☐ 3rd ☐	6. DATE OF STILLBIRTH (Month) (Day) (Year) <u>February 22, 1949</u>		
7. FATHER'S NAME a. (First) <u>Howard</u> b. (Middle) <u>William</u> c. (Last) <u>Simmons</u>		8. COLOR OR RACE <u>White</u>			
9. AGE (At time of this birth) <u>28</u> YEARS	10. BIRTHPLACE (also give state or foreign country) <u>Pittsburgh, Penna.</u>	11a. USUAL OCCUPATION <u>Lawyer</u>	11b. KIND OF BUSINESS OR INDUSTRY <u>Private Practice</u>		
12. MOTHER'S MAIDEN NAME a. (First) <u>Irene</u> b. (Middle) <u>Lewis</u> c. (Last) <u>Clayborn</u>		13. COLOR OR RACE <u>White</u>			
14. AGE (At time of this birth) <u>24</u> YEARS	15. BIRTHPLACE (also give state or foreign country) <u>Dormont, Penna.</u>	16. CHILDREN PREVIOUSLY BORN TO THIS MOTHER (Do NOT include this child) a. How many children are now living? <u>1</u> b. How many children were born alive but are now dead? <u>0</u> c. How many OTHER children were stillborn (born dead after 20 weeks pregnancy)? <u>0</u>			
17. INFORMANT'S OWN SIGNATURE <u>Irene Lewis Simmons, Dormont, Penna.</u>		18a. LENGTH OF PREGNANCY <u>36</u> WEEKS			
18b. WEIGHT AT BIRTH <u>5</u> LBS. <u>12</u> OZS		19. LEGITIMATE Yes ☒ No. ☐			
CAUSE OF STILLBIRTH State only morbid conditions causing fetal death (do NOT use such terms as Stillbirth, Prematurity, Asphyxia, etc.)		20a. FETAL CAUSES <u>Premature separation of placenta</u>			
		20b. MATERNAL CAUSES <u>Toxemia of pregnancy</u>			
21. STATE ANY COMPLICATIONS OF PREGNANCY AND LABOR <u>Nephritis and hypertension</u>			22. STATE ALL OPERATIONS FOR DELIVERY <u>Cesarian section</u>		
I hereby certify that I attended the birth of this child who was born dead on the date stated above at <u>2... P. m. E.S.T.</u>		23a. SIGNATURE OF PHYSICIAN <u>Marion A. Harfield, M.D.</u>		23b. DATE SIGNED <u>Feb. 22, 1949</u>	
		23c. ATTENDANT'S ADDRESS <u>216 Penn St., Pittsburgh, Pa.</u>		24. SIGNATURE OF CORONER <u>J. A. Hamey, Pittsburgh, Penna.</u>	
25a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		25b. DATE <u>Feb. 22, 1949</u>	25c. NAME OF CEMETERY OR CREMATORY <u>Forest Hills</u>	25d. LOCATION (Town, township and county) (State) <u>Pittsburgh, Penna.</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 22 1949</u>		REGISTRAR'S SIGNATURE <u>George Williams</u>		26. SIGNATURE OF FUNERAL DIRECTOR <u>J. A. Hamey, Pittsburgh, Penna.</u>	

DEFINITION OF A STILLBIRTH: a fetus showing no evidence of life after birth (no action of heart, breathing, or movement of voluntary muscle) if the 20th week of gestation has been reached, should be registered as a stillbirth.

IMPORTANT: If the child shows any evidence of life after complete birth, even though it be only momentary, the birth should be registered as a live birth, and a death certificate should also be filed.

Registration of all stillbirths is important; first on account of the great loss of human life occurring in the prenatal and natal periods; second on account of the relationship between fetal deaths and maternal morbidity and mortality. To reduce effectively the fetal and maternal losses resulting from stillbirths, it is of the greatest importance that medical and health agencies have information with regard to the magnitude of the problem and a knowledge of the underlying fetal and maternal conditions associated with stillbirths.

In general, the duties of the attending physician are:

To prepare the medical part of the stillbirth certificate and enter the date of stillbirth, i.e., Items 6 and 18 to 23. If the stillbirth was not attended by a physician the case should be reported to the coroner who shall be responsible for Items 6 and 18 to 22, 23b and 24.

The duties of the funeral director are:

The funeral director is responsible for the completion of Items 1 to 5, 7 to 17, 25 and 26 and filing the certificate with the local registrar of vital statistics of the district wherein death occurred.

PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division of the American Cancer Society in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

Acceptable Projects Advocated

Showing anew the close ties between the medical profession and the American Cancer Society, John H. Harris, M.D., for the past two years president of the Pennsylvania Division of the society, cautioned more than 200 volunteer cancer workers at a state-wide training school this fall to avoid "controversial service projects" in their communities. Dr. Harris said:

"The expansion of the service program depends upon approval of the county medical societies as well as upon the amount of funds available. All county units should follow the lead of Fayette County in that no service project was insisted upon which encountered resistance from the local physicians."

"This policy," he said, "should be the *watchword* of the officers of all county units of the American Cancer Society. It is surprising what can be accomplished in time if non-controversial service projects are developed and, as time goes by, resistance to other good projects will disappear."

Dr. Harris said that one phase of the society's service program "merits special comment. Our work during the coming year will be strengthened by a better understanding of the cancer detection program. The thinking of the leaders in the medical profession and of the American Cancer Society regarding cancer detection is beginning to crystallize. It is becoming obvious that the cancer detection clinics, of which we have heard and read so much, have great potentiality when located in the large metropolitan centers. However, this method of locating cancer is not feasible in the small communities. There are many reasons for the lack of adaptability in the communities where most of us live, the most important of which are (1) lack of facilities, (2) lack of physicians, and (3) most important—too few people can be surveyed to make any appreciable headway in the detection of cancer.

"The plan of detection which holds the greatest promise is that of making every doctor's office a cancer detection center. This plan is being used in several communities of our division

and any unit of the division interested in cancer detection as a service program will do well to look into this method of detection."

Dr. Harris asked not to be re-elected to a third term as president of the society's Pennsylvania Division, but he remains active as a member of the executive committee. Harold J. Harris, M.D., of Wilkes-Barre, is the new president. They are not related.

Professional Services Available

The medical and scientific department of the American Cancer Society, directed by Charles S. Cameron, M.D., has prepared a résumé of the professional education services of the American Cancer Society, which will appear at an early date in these columns.

Among the projects currently underway are those dealing with the production of professional films, illustrated brochures, a bimonthly professional journal, fellowships in clinical cancer, fellowships in exfoliative cytology, sponsorship of medical meetings, and exhibits for the profession.

Other services available include lantern slides, a professional film loan library, and state programs dealing with professional information.

The society is making every effort to provide factual information in easy-to-read form, well documented, illustrated, and designed to enable the busy doctor to obtain maximum value with a minimum expenditure of time. The available services to be discussed in more detail later are well rounded and suitable for a variety of uses.

Postgraduate Courses Helpful

Physicians in increasing numbers are taking advantage of the benefits to them of the program of observation and "refresher" courses promoted by the Division of Cancer Control, State Department of Health.

Leverett D. Bristol, M.D., who is chief of the Division, says that the purpose of these courses at leading medical centers, both within and outside the State, is "to give the doctors the most modern ideas on diagnosis and treatment in their own best interest as well as that of the public."

ONE-MINUTE CASE REPORTS

Prepared by the Commission on Diabetes of The
Medical Society of the State of Pennsylvania

CASE I

Cardiovascular Collapse in Diabetic Coma

(Reading time 50 seconds)

R. J., a 15-year-old white male, was admitted to the hospital in a coma of three hours' duration which had been preceded for three weeks by progressive polyuria, polydipsia, drowsiness, and a weight loss of 23 pounds. Examination revealed a pulse rate of 136 per minute, blood pressure of 90/60, respirations 64 per minute, strong acetone odor to the breath, liver edge 2 cm. below the costal edge, and absence of all deep reflexes. A diagnosis of diabetic coma in this previously unsuspected diabetic was made from the clinical picture and the laboratory findings of acetonuria, glycosuria, and elevated blood sugar (1395 mg. per cent).

Following therapy with insulin, saline solutions, and subsequently carbohydrate, the blood sugar returned toward normal, overbreathing ceased, and acetonuria disappeared. The low blood pressure persisted however. The patient was therefore given 750 cc. of whole blood, and there was a prompt return of the systolic and diastolic pressures to normal limits. *It should be kept in mind that circulatory collapse may occur in diabetic coma and that it may be responsible for fatalities in otherwise adequately treated patients.*

CASE II

(Reading time 55 seconds)

M. C. had diabetes at the age of 49 in 1920. Treatment was haphazard until 1926 when she started taking insulin and began to follow a prescribed diet.

On a diet of protein 70 grams, fat 100 grams, and carbohydrate 150 grams she required 30 units of insulin a day. Her control generally was good.

Late in 1943, at the age of 72, she began to complain of some irregularity in bowel habit. A barium enema showed "an obstructive lesion in the mid-sigmoid due to a large carcinoma." In December, 1943, a Rankin obstructive resection was performed. She was discharged from the hospital in March, 1944, having normal bowel movements and no complaints. Her diet was protein 100 grams, fat 130 grams, and carbohydrate 180 grams; insulin—protamine zinc, 14 units—regular, 14 units before breakfast and 15 of regular before supper. When last seen, July 22, 1949, she was in good health and her diabetes was well controlled.

Diabetics are subject to the same disease as non-diabetics. The duration of the diabetes and the age of the patient are not contraindications to surgery if the diabetes is well controlled.

ON THE CANCER FRONT

Four more cancer detection centers have been acquired by the Philadelphia Division of the American Cancer Society, it was announced recently by Dr. Catharine Macfarlane, president of the organization.

Cancer detection units now being operated at Hahnemann Hospital, Jefferson Hospital, Woman's Medical

College and Hospital, and University of Pennsylvania Hospital have been taken over by the society and will operate with funds furnished by the local division.

The addition of the four new centers makes a total of nine which the society is now subsidizing in Philadelphia and Montgomery counties. The other five are at Frankford Hospital, Mercy-Douglass Hospital, Methodist Hospital, Mt. Sinai Hospital, and Pottstown Hospital.

On the research front, the American Cancer Society has sent checks totaling \$170,000 to the Institute for Cancer Research at Fox Chase. One grant, of \$150,000, will be used to finance cancer research at the institute. The other award, of \$20,000, will be used to endow beds at Jeanes Hospital and Lankenau Hospital in memory of the late Babe Ruth, baseball star, who died of cancer.

Dr. Catherine B. Hess, of 3422 Midvale Avenue, has been named medical director for the Philadelphia Division of the society. She is a graduate of Temple University Medical School.

The division is scheduling a new series of fall and winter cancer educational meetings. Speakers and motion pictures will be furnished groups or organizations which make application at the division's offices at 1518 Walnut St., Philadelphia.

COMPLETE INVENTORY OF PROFESSIONAL REGISTERED NURSES AVAILABLE

A complete inventory of registered professional nurses in the United States and its territories is being released by the American Nurses' Association at the request of the National Security Resources Board according to Pearl McIver, president of the American Nurses' Association, and Ruth Freeman, chief of the Nursing Section of the National Security Resources Board.

The inventory of nurses, which has been secured by the A.N.A. through cooperation with state nurse-licensing boards and state nurses' associations, provides data on the number and location, age, marital status, responsibility for dependents, whether the nurse is actively engaged in nursing and the field of employment and position, type of preparation and experience in special fields.

The inventory is hailed by nurses and other leaders in the health services who are concerned with planning to meet the present enormous and increasing demand for nursing service. Effective planning requires accurate data regarding the number of nurses in active practice. The total number of licenses issued to nurses is misleading in estimating available nurse power since many nurses maintain current registration in more than one state and others continue current registration even though not actively practicing nursing.

"Maintaining the census of nurses on a current basis will become a permanent routine procedure and will enable professional nurses to more effectively initiate measures for increasing nursing strength to meet all needs," said Miss McIver.

Paper-bound copies are available from the American Nurses' Association, 1790 Broadway, New York 19, N. Y., at \$1.00 per copy.

OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*

8104 Jenkins Arcade

Pittsburgh 22, Pa.

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

COLLECTION OF 1950 DUES

Reasons for the very considerable increase in society dues for 1950 were discussed in a letter dated Oct. 19, 1949, and signed by four officers of the State Society, which letter was addressed to every member of the State Medical Society (see page 1573, this issue).

The recommendation of the Board of Trustees and the action of the House of Delegates in fixing the amount of the 1950 State Society dues at \$23, and in anticipating A.M.A. dues at \$12 (subject to action by the A.M.A. House of Delegates, December 6-9), all to be collected by the county medical society, was clearly presented on page 1493 of the October PENNSYLVANIA MEDICAL JOURNAL.

One may gather from these sources that if his county medical society's dues remain the same as last year, \$10 for example, with State Society dues fixed at \$23; and, further (subject to action by A.M.A. House of Delegates, December 6-9), if 1950 A.M.A. dues are likely to be \$12, the three items to be acknowledged on one receipt will total, in this hypothetical case, \$45.

The secretary of each county medical society will receive from the office of the State Society in mid-December of *this year*, rather than in early November as in previous years, the usual notice and the triplicate receipts to be issued upon payment of each member's 1950 dues.

WISDOM FROM DISTAFF SIDE

The male members of The Medical Society of the State of Pennsylvania who are not completely aware of their hourly and daily contributions to or subtractions from the total of desirable public relations which stem from each doctor's ordinary activities may profit from reading the appended paragraph quoted from a delightful article on page 1589 of this issue prepared by

Mrs. Frank P. Dwyer, secretary (15 years) of the Woman's Auxiliary to our State Medical Society. (As you read, paraphrase by substituting *he* for *she*, *society* for *auxiliary*, etc.)

"Whether she wishes it or not, every member of the Auxiliary is a powerful public relations agent for organized medicine at her community level. The way she greets her neighbors or handles a telephone call, the way she dresses, the money she spends, the way she greets patients are all a part of the public's opinion of medicine."

VISIT HOUSE OF DELEGATES AT A.M.A. CLINICAL SESSION

Members of The Medical Society of the State of Pennsylvania who are planning to attend the Clinical Session of the American Medical Association in Washington, D. C., December 6 to 9, are urged to visit the sessions of the House of Delegates in the Hotel Statler.

A few hours spent listening to the deliberations of this democratic body will be very educational and enlightening to those who have never seen such a policy-making group in action.

The eleven delegates representing The Medical Society of the State of Pennsylvania include Drs. William L. Estes, Jr., Bethlehem; James L. Whitehill, Rochester; George S. Klump, Williamsport; Elmer Hess, Erie; James Z. Appel, Lancaster; E. Roger Samuel, Mt. Carmel; William Bates and Francis F. Borzell, Philadelphia; Harold B. Gardner, Pittsburgh; Charles L. Shafer, Kingston; and Howard K. Petry, Harrisburg.

Dr. Borzell is the speaker of the House of Delegates, Dr. Shafer will serve on the Reference Committee on Medical Education, Dr. Petry is chairman of the Reference Committee on Legislation and Public Relations, and Dr. Gardner is a member of the Reference Committee on Reports of Officers.

NEW SCHOOL OPENS IN 1950

The Graduate School of Public Health of the University of Pittsburgh, Thomas A. Parran, M.D., Dean, will not be prepared to take classes until the fall of 1950, and the number of students per class is expected to be between 30 and 40.

Recent assignments to the faculty are:

William M. Hammon, M.D., San Francisco, appointed professor and head of the department of epidemiology effective Feb. 1, 1950. He will also be responsible for the instructional and research interests of the school in the field of microbiology. At Harvard he received the degrees of M.D. (1936), M.P.H., and Dr. P.H., and then went to the University of California Medical School, San Francisco, where he was successively lecturer, assistant professor, associate professor, and professor of epidemiology at the George William Hooper Foundation.

Adolph G. Kammer, M.D., who was graduated from the University of Pennsylvania School of Medicine in 1928. Dr. Kammer practiced medicine in Belleville, Wis., for four years; he was medical examiner for the Montrose Mining Company, Montreal, Wis., medical director of the Inland Steel Company, East Chicago, and medical director of the Manhattan Project, at Oak Ridge, Tenn. Since 1947 he has been general medical director of the Carbide and Carbon Chemicals Corporation, South Charleston, W. Va.

The school will offer both the Doctor of Public Health and the Master of Public Health degrees, and is greatly interested in securing students of high caliber so that they may fill positions of importance in the public health field upon graduation. Prerequisites for entering the school will be made public in the near future.

INDIANA STATE MEDICAL SOCIETY CELEBRATES ITS CENTENNIAL

President E. Roger Samuel represented our society at the centennial celebration of the Indiana State Medical Association in September. He is enthusiastic in his praise of not only the dinner and program of the meeting, which he and a thousand others attended, but also of the many hospitable courtesies shown him.

The convention issue of the monthly *Journal of the Indiana State Medical Association*, with its handsome cover page in gold, black, and white, is replete throughout its one hundred and seventy-five pages with interesting historical articles, scientific papers, editorials, and pro-

grams which record medical progress, health and welfare responsibilities discharged, research, preventive medicine and public health—all done for the benefit of the people of Indiana as only an alert professional organization can do.

Eleven thousand members of The Medical Society of the State of Pennsylvania will echo the congratulations and good wishes which President Samuel expressed in person on Sept. 29, 1949, in Indianapolis.

A.M.A. WASHINGTON OFFICE STAFF VISITING STATE SOCIETIES

Three members of the staff of the Washington office, by direction of the A.M.A. Board of Trustees, will visit a number of states during the time that Congress is in adjournment.

Dr. Wilson, the deputy director, will visit some of the southern states; Mr. Foristel, the legal advisor, is planning a trip through the Middle West; and Dr. Lawrence will visit Texas and California. We shall call upon the officers of the state societies and will be glad to meet with such groups as they may select. Our mission will be to take a part in the very effective Educational Campaign being waged by the Association by telling intimately what is transpiring in Washington and what is likely to come before the Congress at its next session.

No Congress was ever so persistently and determinedly advised by its constituency as has the present, and that it is taking the voters' interests to heart is manifested in the efforts being made to answer letters. The Congress has voted a second time this session to increase the individual allotment for secretarial and clerical services. Communications opposing socialized medicine, stemming from our Educational Campaign, form no small part of the mail of the Congressmen. Every reader should be gratified with the part he has taken and continue the good work by personal conversation while the Congressmen are at home.

Summary Bulletin

We are engaged in finishing a bulletin in which will be given the present status of every one of the 291 bills we have reported out of the 10,627 bills introduced during the present session. This bulletin will be in the mail by the end of this week.

JOSEPH S. LAWRENCE, M.D.,
Director, Washington Office,
American Medical Association.

Oct. 24, 1949

VIOLATION

The Bureau of Narcotics, United States Treasury Department, has recently advised that "Dr. Carl H. Kivler, 295 East State Street, Nanticoke, Pennsylvania, entered a plea of guilty in the Middle District of Pennsylvania to Section 3224A of the Internal Revenue Code, and on August 26, 1949, he waived indictment

and requested transfer to the Southern District of Texas. On September 14, at Houston, Texas, he pleaded guilty and on September 27, 1949, he was sentenced to serve a term of nine months, and is incarcerated in the Federal Correctional Institution, Seago-ville, Texas."

Dr. Kivler is not a member of The Medical Society of the State of Pennsylvania.

SECOND ANNUAL CONFERENCE OF PHYSICIANS AND SCHOOLS

DR. WALTER F. DONALDSON, *Secretary-Treasurer*,
Medical Society of the State of Pennsylvania.

I wish to express my appreciation to Dr. Gilson Colby Engel, past president of our State Society, for my appointment as a delegate to the Conference of Physicians and Schools, held at Highland Park, Ill., Oct. 13, 14, and 15.

I believe that I was able to represent the State Society in a manner which will bring credit to our organization. I discovered that Pennsylvania is a tower of strength to the American Medical Association. I had a long talk with Dr. W. W. Bauer, Director of Health Education for the American Medical Association, and he informed me that many state medical organizations do not cooperate in a manner to bring credit to the profession.

I believe that I fully described the health service in the schools of Pennsylvania, and especially the fact that there is close cooperation between organized medicine, organized dentistry, and our school health service organization. I thoroughly sold the idea that there was absolutely no use in attempting to establish school health service in the various states without the complete and thorough cooperation of the medical association. This applies not only to the establishment of health services at the state level but also at the local level.

It was agreed by everybody that school health service is a screening process to discover conditions that are referred to family physicians for treatment; that no treatment of any kind is to be administered by school physicians other than first aid.

I described for this conference how Pennsylvania physicians and dentists met at the State Capitol and practically wrote the School Health Act 425 and Act 522, which have done much to curtail the idea of socialized medicine. Copies of these two laws were freely distributed to members of the conference.

I publicly made the statement that every school child in the State of Pennsylvania receives an examination every two years by a physician in the presence of a nurse, and that no child in the State is neglected medically or surgically because of a shortage of funds. I found that no other state has the type of service covered by Act 522, which provides for treatment of indigent school children through the Department of Public Assistance at state expense.

There were 162 delegates at the conference, representing some thirty-six states. At the close of the conference, I made a motion expressing our thanks and appreciation to the American Medical Association and Dr. W. W. Bauer and his associates for the excellent work they had performed in calling together this conference. The motion was amended by another delegate recommending that it be repeated every two years. I

feel certain that the country as a whole will benefit by this conference and a full report will be forwarded to you as soon as it is printed. I am enclosing herewith a partial list of participants and a sample of the questions that were discussed.

Again I wish to thank you for the privilege of acting as delegate for the State Society.

LAMONIER SMITH, M.D.,
Director of Pittsburgh Public
School Health Service.

Oct. 17, 1949

*Registrations from Pennsylvania at Second National
Conference of Physicians and Schools*

Samuel J. Dickey, M.D., Harrisburg, Pennsylvania
Department of Health

LeRoy E. Mercer, M.D., Philadelphia, University of
Pennsylvania

LaMonier Smith, M.D., Pittsburgh, Medical Society of
the State of Pennsylvania

Arthur F. Davis, Pennsylvania State College, School
of Physical Education and Athletics

John W. German, Jr., Harrisburg, Pennsylvania De-
partment of Health, School Division

Leona Woodward, Harrisburg, Pennsylvania Depart-
ment of Health

Mrs. Paul C. Craig, Reading, Woman's Auxiliary to
American Medical Association

William L. Hughes, Philadelphia, Temple University

Elmer B. Cottrell, Harrisburg, Pennsylvania State De-
partment of Public Instruction

INCREASED MEMBERSHIP DUES

*To the Members of The Medical Society of the State
of Pennsylvania:*

During the 1949 session of the House of Delegates of The Medical Society of the State of Pennsylvania, the delegates voted unanimously on September 28 to increase the 1950 state society dues from \$15 to \$23. This does not include your county society dues, nor does it have any reference to the very probable inclusion of annual A.M.A. dues.

In our last fiscal year the administrative expenditures of the State Society were \$66,684 greater than the administrative receipts. See page 1385, September 1949 PENNSYLVANIA MEDICAL JOURNAL.

Your society has rapidly expanded while trying to meet the local and national problems confronting the organized profession in the past eight years. Its Board of Trustees diligently searches for methods of economy and the chief increase this year over last year's budget is \$10,000 for public relations. This increase and the above-mentioned deficit total \$76,684. The \$8 increase in 1950 dues from each of our 10,500 active members will thus eliminate deficit spending in the new fiscal year.

We must meet these expenditures to become a factor in the preservation of American medicine. Truly there are considerable sums in our invested funds, but such can be used only for the specific purposes defined by our constitution, and the interest they earn must accrue to each fund and may not be expended for general operating costs. There are today twelve or more state medical societies whose annual dues are \$2 to \$27 higher than our own dues of \$23.

Each member of our society may verify the need for this increase in 1950 dues by studying pages 1385-87 of the September issue of the PENNSYLVANIA MEDICAL JOURNAL.

This communication has been prepared and distributed at the request of the Board of Trustees of The Medical Society of the State of Pennsylvania.

Very truly yours,

E. ROGER SAMUEL, President

GEORGE S. KLUMP, Chairman of

Board of Trustees

JAMES L. WHITEHILL, Chairman of

Finance Committee, Board of Trustees

WALTER F. DONALDSON, Secretary-Treasurer

Oct. 19, 1949

APPRECIATION

DR. E. ROGER SAMUEL, *President*,
The Medical Society of the State of Pennsylvania,
Harrisburg, Pa.

Dear Dr. Samuel:

At a meeting of the Executive Committee of the Emergency Aid of Pennsylvania held on Friday, October 7, a resolution was passed expressing the deep appreciation of this organization for the great honor it has received in being made the recipient of the 1948 Benjamin Rush Award of the Pennsylvania Medical Society.

This honor brings satisfaction to all of our committees and members who have been engaged in the health program of the organization, and the plaque will be a treasured record of the recognition your organization has given us.

Please extend to the members of your Society our deep and sincere thanks.

Yours very truly,

(MRS. HENRY A.) ANITA M. E. ADAMS, *Secretary*,
The Emergency Aid of Pennsylvania,
Philadelphia, Pa.

Oct. 10, 1949

A.M.A. SECRETARY'S LETTER

Two additional state societies and four more county societies have been made targets of the F.B.I., bringing to 22 the number under investigation by the Anti-Trust Division of the U. S. Department of Justice.

While six F.B.I. agents were still at work in the A.M.A. headquarters building, we were informed that the following six additional societies received "calls" from government agents: California Medical Association, Michigan State Medical Society, Ingham (Michigan) County Medical Society, Cleveland Academy of Medicine, Columbus Academy of Medicine, and the Summit (Ohio) County Medical Society.

It is still a bit difficult to say exactly what the government agents are looking for. The chief boss in Washington, J. Howard McGrath, former chairman of the Democratic National Committee and co-sponsor in the senate of the administration's compulsory health in-

surance bill, told the press that the Justice Department wanted to know if any monopoly existed in connection with prepaid medical care plans. Yet the agents at the A.M.A. are planning to look over the files and records of nearly every council and bureau at headquarters, even though the work of many of them is far removed from medical care plan operations.

Meanwhile, the A.M.A. Board of Trustees charged in a second statement given to the press that "the rapid spread of this epidemic of investigations demonstrates that a carefully calculated campaign of political terrorism is being waged against medical societies which have opposed the government's program of socialized medicine."

"There no longer can be any pretense," the Board added, "that it is simply a coincidence that all of these medical groups have been brought under investigation in a period of a few weeks. This is a politically inspired attack on those who differ with an administration-sponsored program."

Judging from the number of newspaper editorials, letters, and statements which have been issued from many sources, public protest is mounting against this vicious misuse of the police powers of the government.

A circuit judge at Eldorado, Arkansas, Gus W. Jones, handed the *Eldorado Times* a statement in which he assailed Attorney General McGrath's action. His statement follows:

"I sincerely regret the recent action of Attorney General McGrath in ordering the Department of Justice to investigate numerous state and county medical societies, including the Arkansas Medical Society.

"Mr. McGrath, as an individual, has the right to think as pleases him on the issue of socialized medicine, but he does not have the moral right to use the facilities at his disposal by reason of his office to harass any individual or group for having or expressing an opinion different to his own.

"There is no means of livelihood more useful or honorable than the medical profession. There is no group of individuals in this state more sincere or more honorable than the men and women of the Arkansas Medical Society. These individuals have the right to organize and govern their own affairs free from interference. Such societies are existent in almost every walk of life. The lawyers have their bar association; the preachers, their ministerial alliance; and the workers, their labor unions. These groups not only have the right but it is their duty to take a position on any question affecting their calling. Not only this, but each group has the right to publicize its position and lay its case before the American people.

"I have always had the greatest respect for the F.B.I. This organization is composed of highly trained, intelligent, and honorable men. Until this time, I believe that Mr. Hoover has kept the F.B.I. out of the political mire. Until this time, this fine organization has had the confidence, and very justly so, of the overwhelming majority of the American people. I regret any action that would or could have a tendency to destroy this confidence and respect.

"The F.B.I. is not a court, but it is very closely associated with courts. It is very definite and certain that politics have no place in our courts. When politics enter our courts, justice and right will no longer be found there.

"From every point of view, it impresses me that Mr. McGrath has taken a serious step in the wrong direction."

Conference of Physicians and Schools a Success. The Second National Conference of Physicians and Schools at Highland Park, Ill., October 13-15, was a big success. The conference, sponsored by the Bureau of Health Education of the A.M.A., drew more than 160 physicians, educators, and public health officials interested in school health problems. They came from 35 states and three territories.

It was the conclusion of the conference that:

1. The family physician is a key figure in a solution of the problems and should be brought into the school health programs at the planning stage.

2. Greater community and professional recognition of the role of the school physician is needed.

3. School health services should be considered a part of a total community health program and be integrated into such a program.

4. Medical schools should give additional training on school health to medical students.

It was the opinion that the greatest long-pull advantage to the pupil is when the traditional family-physician relationship exists.

Dr. Roscoe G. Leland Dies. Dr. Roscoe G. Leland, who was director of the A.M.A. Bureau of Medical Economics from the time it was organized in 1931 until his retirement in 1944, passed away in Chicago on October 17. Death was due to a heart ailment.

He was the author of many articles which appeared in *The Journal* and of many separate publications of the bureau, which has since been named the Bureau of Medical Economic Research.

Grass Roots Conference to Stress Local Leadership. The value of local leadership in the medical profession's fight against socialized medicine will be spotlighted at the Sixth National "Grass Roots" Conference which will be held on Thursday evening, December 8, at the Hotel Statler in Washington. All doctors and their wives who will be in Washington at that time for the A.M.A. Clinical Session are invited to attend.

Takes Job with Commission on Chronic Illness. Office headquarters for the Commission on Chronic Illness will be established in the A.M.A. headquarters building November 1 and, at that time, Peter B. Meek, of Washington, will take up his duties as assistant to the director of the commission. The office of director has not yet been filled.

The commission's projects include studies of well-rounded chronic disease programs, the administration of home-care programs as part of hospital service, the organization of rehabilitation centers, the establishment of units for the chronically ill in or adjacent to general hospitals, and the development of coordinated programs by state and local communities.

Leonard W. Mayo, formerly vice-president of Western Reserve University, Cleveland, and presently general director of the Association for the Aid of Crippled Children, New York, is chairman of the commission, which includes a long list of members and technical advisers.

Rural Health Conference on February 3-4. The Committee on Rural Health of the A.M.A. will hold its fifth annual rural health conference in Kansas City, Mo., February 3-4. Chairmen of the state rural health committees will meet February 2. This will mark the first time that the rural health meeting has been held away from Chicago.

Dr. F. S. Crockett, LaFayette, Ind., chairman of the committee, announced that there would be five topics

for discussion: (1) rural medical facilities at the local level; (2) relation of agricultural extension service to rural health problems; (3) community responsibility for health service in rural areas; (4) methods for prepayment for health services in rural areas; (5) the responsibility of the medical schools in the rural health program.

Arline Hibbard, acting secretary, said the conference would bring together physicians, farm organization leaders, agricultural educators, farm editors, and others concerned with rural health problems. The previous meetings produced a great deal of good and the coming conference, she said, should contribute materially to the health welfare of farm areas.

GEORGE F. LULL, M.D.,

A.M.A. Secretary and General Manager

Oct. 24, 1949

1949-1950 COMMITTEES STANDING COMMITTEES

COMMITTEE ON SCIENTIFIC WORK

Ralph L. Shanno, 1174 Wyoming Ave., Forty Fort, *Chairman*

SECTION ON MEDICINE—John H. Willard, 334 S. 15th St., Philadelphia 2, *Chairman*; Wendell J. Stainsby, Geisinger Hospital, Danville, *Secretary*.

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Resignations (4), Transfers (5) Deaths (9)

ALLEGHENY: *Deaths*—John W. Ildza, Pittsburgh (Temple Univ. '15), August 28, aged 71; Glenn H. Heilman, Tarentum (Univ. Pgh. '23), September 5, aged 53; Samuel Harris Johnson, Pittsburgh (Univ. Pgh. '06), September 8, aged 67.

ERIE: *Resignation*—William E. Barratt, Erie.

INDIANA: *Transfer*—Forrest F. Smith, Indiana, from Susquehanna County Society.

LACKAWANNA: *Death*—James D. Lewis, Scranton (Univ. Mich. '09), September 2, aged 69.

LUZERNE: *Resignation*—Joseph R. Sgarlet, Kingston. *Transfers*—Anthony J. Kameen, Wilkes-Barre, from Lackawanna County Society; Stephen E. Matsko, McAdoo, from Berks County Society.

McKEAN: *Death*—Samuel R. Huff, Eldred (Med.-Chi. Coll. '08), August 27, aged 65.

MERCER: *Transfers*—William A. Beatty and Edward C. Falk, Sharon, from Allegheny County Society.

MONTGOMERY: *Death*—Barton K. Thomas, Pottstown (Jeff. Med. Coll. '13), September 18, aged 62.

PHILADELPHIA: *Resignations* — Charles W. Day, Seattle, Wash.; Paul H. Schraer, Detroit, Mich. *Transfer*—H. Stephen Gallagher, Philadelphia, from Delaware County Society. *Deaths*—John H. Gunter, Philadelphia (Temple Univ. '17), September 23, aged 61; Henry P. Boyer, Philadelphia (Univ. Pa. '91), August 25, aged 81; Alfred Hand, Philadelphia (Univ. Pa. '92), September 1, aged 81.

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since August 29. Figures in first column denote county society numbers; second column, State Society numbers.

Aug. 29	Chester	118	10604	\$7.50
31	Allegheny	1650	10605	15.00
	Philadelphia	3179-3188	10606-10615	150.00
Sept. 8	Dauphin	255-256	10616-10617	15.00
	Lawrence	82	10618	7.50
12	Jefferson	59-61	10619-10621	22.50
	Delaware	296-297	10622-10623	15.00
14	Cambria	170-171	10624-10625	15.00
16	Washington	149	10626	15.00
22	Dauphin	257	10627	7.50
23	Luzerne	366-368	10628-10630	22.50
30	McKean	55	10631	7.50

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The following requests were filled during the month of September:

Gangrene	Penicillin
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Exfoliative dermatitis	Renal insufficiency
Retroperitoneal tumors	Tetraethylammonium
Thymol turbidity test	Choline
College health service	Electroshock therapy
Scleredema	Climate and disease
Glaucoma	Treatment of asthma
Erythema multiforme	Vision
Fluoroscopy	Pelvic infections
Rh negative infants	Acne therapy
Sex education	Bowleg
Rh factor	Automobile accidents
Vitamin E	History of malaria
Siamese twins	Cancer research
BCG vaccine	Arteriosclerosis
Medical economics	Thyroiditis
Childbirth	Riedel's struma
Scleroderma (2)	Struma lymphomatosa
Cryotherapy	Chemotherapy of cancer
Rh incompatibility	Boeck's sarcoid
Joint disturbances	Hiccough
Recurrent peptic ulcer	Ophthalmology
Diseases of the veins	Internships
Embolism	Diseases of the ovary
Angina pectoris	Psychosomatic medicine
Radioactivity	Use of priscoline
Atomic energy	Cancer clinics
Poliomyelitis immunity	Child welfare
Hysterectomy	Fibroids of the uterus
Antibiotics	Treatment of eclampsia
Streptomycin	Lithium intoxication
Treatment of alcoholism	
Diabetes and pregnancy (2)	
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*Werner, A. A.: The Climacteric in Women and Men, Postgrad. Med. 4:102 (Aug.) 1948.



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Atomic disaster protection
Convalescent homes in Pennsylvania
Treatment of acne with dry ice
Treatment of poliomyelitis

DONORA AIR POLLUTION STUDY

. . . The Public Health Service was called into Donora the first week of November last year immediately after the five-day smog. The first requests came from the town of Donora and the United Steelworkers of America (CIO) and they were followed by formal requests from the Pennsylvania State Health Department.

Donora is in a small valley on the Monongahela River about 40 miles southeast of Pittsburgh. It is a town of some 14,000 residents, and most of the wage earners work in a big steel and wire plant.

The 25-man field team that the Public Health Service sent into Donora to make its investigation included physicians, engineers, chemists, nurses, dentists, statisticians, and other technicians. In addition, specialists from the U. S. Weather Bureau played a key role in the study.

During the study in Donora, the members of the team visited a third of all the houses in the area, interviewed 1500 families, studied hundreds of medical records and individual histories, and collected and tested more than 4000 samples of the air in and around Donora for all types of chemical substances that might be present.

"The intensive study of the medical and weather history of the town," Dr. Scheele said, "indicated, among other things, that Donora might have gone through another serious smog period in April, 1945. The vital statistics for Donora show that there were almost twice as many deaths in the town for that month as in any ordinary April or any ordinary month."

At the same time the weather history that was uncovered indicated at least a possibility that there was an extended weather inversion and smog in that same month. The death certificates issued at the time named cardiovascular diseases or heart ailments as causes, which supports the possibility that they may actually have been "smog" deaths.

A weather inversion, like the one which lasted five days in Donora in 1948, occurs when a layer of warm air settles over the ground air, preventing the usual up-drafts. Because the upper air is warmer, the lower layer remains stable as long as the upper air fails to move.

"The fact that almost 6000 persons in the community had shown some signs of affection during the smog last fall was a surprising one to the investigators," Dr. Scheele said. "Although news of the deaths swept through the town, at the time most persons were unaware of the number of illnesses outside of their immediate neighborhoods, and the factor of illness was not

known to be important when the investigation began. It was discovered, furthermore, that about one-fifth of the people affected were seriously ill, many of them for as long as two weeks after the smog lifted."

The extent and severity of illness revealed itself early in the study, however, and the scientists remained in Donora for nearly six months following leads. After the field investigation, the team returned to Washington for another six months of analyzing the chemical samples and correlating all the data recorded. The complete findings of the survey are contained in the 200-page report released by Mr. Ewing.

The report is divided into two major investigations—medical and engineering. A major part of the engineering study was the meteorologic investigation, which was done by experts from the U. S. Weather Bureau. Each of the investigations carries separate conclusions, and the two sections are correlated in the report.

Analysis of the chemical samples along with a study of the processes used in the big plant brought the conclusion that there was not a sufficient concentration of any one substance in the air during the smog to have caused the deaths, although there were considerable amounts of sulfur dioxide coming from the plants as well as from the homes, the railroads in the town, and the steamboats passing on the river.

"The conclusions of the scientists, based on all available evidence, suggest the probability that a number of chemicals acting in combination or simultaneously caused the illnesses," according to the report. "This whole question," Dr. Scheele said, "will require a great deal of additional observation and research."

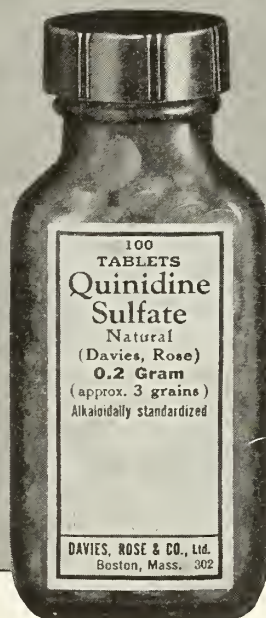
He pointed out that the burning of coal produces sulfur dioxide and that coal burned in homes as well as in industrial plants can be a source of considerable chemical residue going into the air.

In explaining the unusual significance of the Donora report, Dr. Scheele pointed out a number of important questions indicating the need for immediate research in the whole field of air pollution.

"For instance," he said, "the report shows that thousands of persons were affected during this acute period. But what do we know about the chronic effect over a period of several years on persons living in towns like Donora—persons who are constantly breathing less polluted air than that which blanketed Donora for five days last year? We need to know the answer to that question."

"Or, to go further, we know that those who died in Donora were chiefly older persons or those previously suffering from respiratory ailments or cardiovascular diseases. But does long-range exposure to air pollution only aggravate already present ailments, or does it also

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bring them on? And what effect does contaminated air have on persons with diseases not closely related to the respiratory system?

"A great part of our medical research in this country today," Dr. Scheele said, "is bent toward lengthening the life span. Our work is only half done if we help people to reach longer life and then allow them at the age of 65 or so to fall prey to contaminants in the air they breathe."

Dr. Scheele said that the report also gives some indication that Donora and other nearby towns have a significantly high rate of bronchial asthma and heart disease. This raises a question, he pointed out, as to what extent these diseases can be blamed on air pollution. It is apparent that they can be aggravated by air pollution.

"An entirely separate question arises as to the possible effects of continuing air pollution on the health of children," Dr. Scheele pointed out. "Even though the health records of Donora and the surrounding towns did not show any increase in the common illnesses among children, above other parts of the country, it is a known fact that particulate matter in heavily contaminated air can keep out or deflect the germicidal rays of the sun, the beneficial effects of which are beyond dispute."

"It seems to me noteworthy that the survey showed definite indications that persons in the homes of poorer construction in Donora were more seriously affected by the smog than those residing in homes of better construction and maintaining a higher living standard. This is only one of the many aspects of the problem which call for further study."

"Another new question is what possible effect a long period of living in air pollution can have on the mental health of individuals. Although the effects of constant air pollution have not been studied, there is a possibility that the mental effect over a long period of time—in terms of reduced alertness and efficiency—may be quite considerable."

"And finally," Dr. Scheele said, "we need to know what effect air pollution has in lowering the resistance of previously healthy persons so as to predispose them to infectious diseases, particularly of the respiratory tract."

"While medical research into the health aspects of air pollution is going on, the work of controlling contamination through better engineering should be continued. Industry already has done a great deal in this direction. The work should be pressed forward as rapidly as possible."

"Meantime, there are a number of precautions that can be taken. Chief among them is that a strict watch be kept for possibilities of weather inversions. Should such a condition appear possible, it was recommended that the plants either be shut down or curtail their operations sufficiently to reduce sharply the amount of contamination going into the air."

Dr. Scheele said that he fully recognized that the engineering problems involved are by no means simple ones. He explained that the engineering solution to air pollution is made doubly difficult because each city or area will have its own individual kind and degree of pollution—the sum total of contaminants of all the industry in that area.

So, before a city may begin to correct its air pollution, Dr. Scheele said, chemists must determine, as only one example, whether the air contaminants from

industry—gases, fumes, and particulate matter—always act singly on human beings, or act in combination, or act on each other to produce an agent which is more poisonous than any of the single substances or than the total acting in combination.

Public Health Service engineers at Donora were in such unexplored territory that they had to devise new methods and instruments in many cases for testing particular processes and for gathering samples of some of the substances suspected of being present in the air.

"We must first do research," Dr. Scheele continued, "to achieve some conclusive data on what concentrations of substances are necessary to produce either acute or chronic effects."

In industry today there are many hygienic standards for controlling the maximum concentrations of substances that may be allowed in the shops. These standards are established, however, for an eight-hour day and for the healthy age groups working in plants. Now the problem is to establish similar standards for air pollution in the surrounding communities where the exposure is to all age groups and on a 24-hour basis.

Since the Donora episode, Dr. Scheele said, the Division of Industrial Hygiene has received a number of requests from other cities and states for aid in studying air-pollution problems. Charleston, W. Va., and Whiting, Ind., for instance, are concerned about the air contamination in their areas, and both New Jersey and New York have asked that a study be made of air pollution around Staten Island.

Three engineers of the Public Health Service have returned to Donora, Dr. Scheele added, to take additional air samples during the coming fall months and complete other studies for a final report to be published.

"In view of the seriousness of the problem, these additional demands for help from the cities and states, and the need for more information," Mr. Ewing said, "the Public Health Service is now forming plans for an expanded program in this field of air pollution."—U. S. Public Health Service.

Oct. 14, 1949

NEW TYPE OF INSULIN AIDS DIABETICS

A long-acting insulin which reduces the number of injections needed by diabetics has been developed, according to an article in the October 1 issue of the *Journal of the American Medical Association*.

Duration of blood sugar lowering action of the new modified protamine insulin (NPH-50) is 28 to 30 hours, while that of other kinds of insulin is 6, 8, 15, and 72 hours, says Dr. Priscilla White, of Boston.

In 95 per cent of the 336 persons with severe diabetes to whom the new insulin was administered, results were as successful as, if not more so, than those from separate injections of crystalline and protamine zinc insulin, Dr. White reports.

In 5 per cent of the group a single injection of the new insulin was less successful in controlling diabetes than were separate injections of these two insulins. These failures included insulin-sensitive adults, diabetic children under five years of age, and patients whose requirements for long-acting insulin were small compared with their requirements for quick-acting insulin.

Regulation of diet and exercise is a necessary adjunct to treatment with the new insulin, Dr. White points out.

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TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the co-operation of the Pennsylvania Tuberculosis Society
and The Medical Society of the State of Pennsylvania

THERE is a great need for a trustworthy set of rules to protect the people in contact with tuberculous patients and an even greater need for a more general application of existing methods in sanatoriums, in hospitals, and in homes.

A CRITICAL ANALYSIS OF ASEPTIC TECHNIQUE FOR TUBERCULOSIS

The Essentials of Asepsis

"Aseptic technique" is a routine for protecting the contacts of tuberculous patients. It consists of a number of logical methods to prevent the spread of infection which are applied to the patient, to his contacts, and to his environment. It involves facilities for isolation, placement of the patient, and care of the patient. According to the circumstances, the routine may be limited to a few obvious essentials, or include a complete list of all possible methods.

The usual source of infectious material is the respiratory tract. Contamination may occur in three ways—*direct*, by contact with the patient; *indirect*, by the handling of contaminated materials; and *air-borne*. The newer analyses of air-borne transmissions have shown that bacilli may travel by: *droplets*, larger than 0.2 mm., which quickly clear from the air by gravity; *droplet nuclei*, less than 0.1 mm., which quickly evaporate, continue to float, and are a dangerous cause of infection; and *dust*, which may contain dried droplets.

Isolation technique is not the only means for control of tuberculosis in general hospitals. Other approaches include routine chest x-ray examinations of all patients and personnel to uncover all active cases of tuberculosis and the provision of facilities for the care and isolation of cases of tuberculosis when found.

Principles of Protection

The ways to avoid contamination are to reduce the number of bacilli expelled by the patient, to reduce contact between attendants and patients, and to apply a routine of aseptic pre-

cautions. One must plan to: immobilize the bacilli near their source, collect the secretions, protect the contacts, and cleanse the environment by appropriate means.

Education and training must reach not only the patient and his visitors but the staff and all employed personnel in the hospital whose duties bring them into contact with the patient or with material contaminated by his secretions. A detailed routine must be arranged for their care and protection, and carried out without deviation.

Excessive Hazards

There are a number of places in a precautionary routine where the hazard of contamination or the chance of non-observance is greater than others. In part, these hazards are due to the nature of illness, but in part to human failings. They include: lapses in self-care by the patient, personnel, or visitors, and the uncovered cough, sneezing, laughing, talking, and throat-clearing.

Some of the hazards are relatively unimportant, but a few of them represent notable *flaws or weak spots*. The *habits of the patient* are probably the most important factor in an aseptic routine. The patient must understand the theory of contamination; he must be willing to help; he is responsible for catching the bacilli near their source and disposing of them; he must practice the methods until habits are formed; and the habits must be constant and invariable.

The *respiratory tract of persons in contact with the patient* must be considered exceptionally vulnerable. Since attendants must care for the patient and also must breathe, the entry of bacilli

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should be prevented by all possible means. The correct wearing of masks and their construction and composition are of utmost importance.

The uncertain value of several antiseptics and methods is a weak spot in the technique. Among the antiseptics, only the alcohols, cresols, and formaldehyde have any appreciable effect on the tubercle bacillus, and only the first two are practical. The value of cresol compounds is at present a matter of dispute. They are being tested by modern methods in order to determine their efficiency and limitations.

Whether soap is simply an aid to ablution or is bacteriostatic is not known. Detergents (including soaps) are used for cleaning of rooms, yet they are not considered to be antiseptic for tubercle bacilli by authorities. Hand-washing is a stand-by in aseptic technique. In the washing of clothes, soap acts only as a remover of dirt. Sterilization depends upon the recurrent exposure of white clothes to temperatures above 140° F. for a total of at least thirty to forty minutes. This formula is generally used in standard laundry practice.

Vacuum cleaners have recently been suggested for cleaning rooms containing tuberculous patients, but have not been sufficiently tested for efficiency.

Face masks have not been completely studied. They have two uses—for the patient and for the person in contact. Masking of those in intimate

contact with patients is necessary, especially when they are grossly infectious, liable to cough, or careless.

The disinfecting value of ultraviolet light is in dispute, chiefly due to the variation in sources, intensities, and the quality of contaminated surfaces.

New and Valuable Methods

Several methods and materials have only recently been proved valuable and put into use. The use of oil to reduce the dust and the use of alcohol as a skin antiseptic are the most notable. Certain "odorless cresols" (which actually are phenols) have shown promise and are being tested.

Summary and Conclusions

The majority of protective methods and materials are good. They are logical, efficient, and can be easily applied. There are several valuable new procedures. A limited and incomplete application is the greatest deficiency which has been noted. A correction should not wait until perfection of the precautions; it should be made now, in every hospital and sanatorium, and pushed to wide usage in the care of patients at home.

A Critical Analysis of Aseptic Technique for Tuberculosis, William H. Oatway, Jr., M.D., Arizona Medicine, May, 1949.

LINKS DEAFNESS TO BODY'S PRODUCTION OF SEX HORMONE

Deafness of a type that affects more than 10,000,000 persons in the white population of the United States appears to be related to fluctuations in the body's production of the female sex hormone, estrogen, says a New York physician.

The condition, known medically as otosclerosis, is characterized by formation of spongy bone in a section of the inner ear.

"Certain sex-linked episodes frequently coincide with the onset or an increase of deafness caused by otosclerosis," Dr. Edmund Prince Fowler writes in a current issue of *Archives of Otolaryngology*, published by the American Medical Association.

"Estrogens are manufactured by both sexes, but in different proportions. Growth, pregnancy, lactation, and the menopause are periods of changing activity in the sex glands, often accompanied with disorders and diseases of bone coincident with known changes in estrogen levels.

"And, since the menstrual cycles likewise involve coincidental changes in estrogen levels, it is suggested that

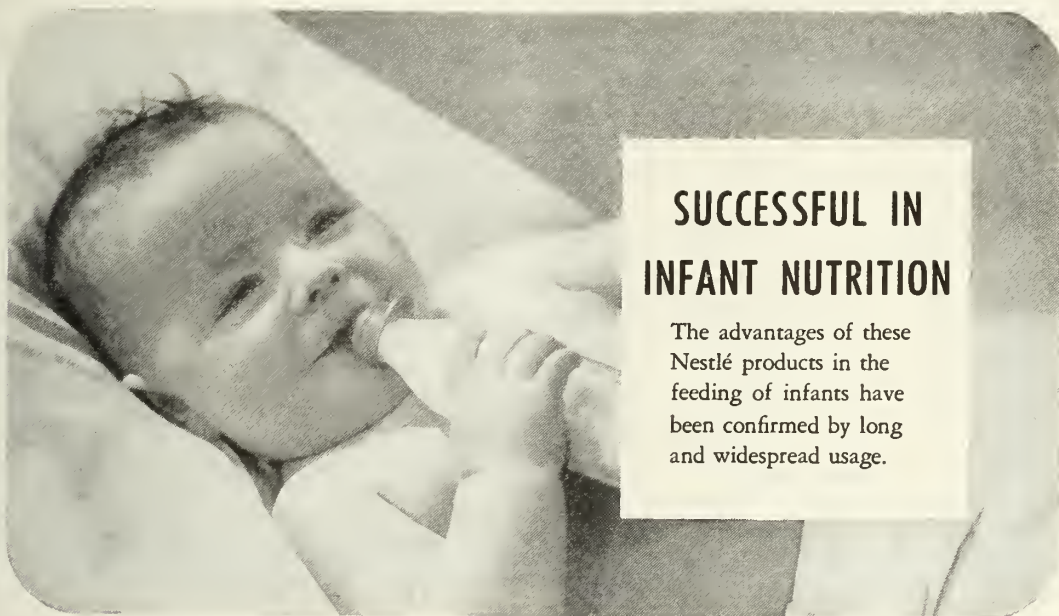
variations in estrogens may be one of the reasons for the distinctly higher incidence of otosclerosis in women than in men (the ratio is about two to one), and for the decidedly high incidence of activity and variations in the lesions during the years of greatest activity of the sex glands.

"It is well known that otosclerosis frequently increases during any of the longer periods mentioned and often after emotional upsets related to them.

"Negroes are noticeably less susceptible to otosclerosis than are white persons. Metabolism in the Negro is normally more stable and therefore less disturbed by the sex hormone tides than in the white person.

"Administration of estrogens has been observed to cause replacement of the marrow cavities of the femurs of mice, birds, dogs, and guinea pigs with bone. Studies in many laboratories have shown that essentially similar laws of inheritance and comparable types of endocrine action exist in birds and man.

"The thesis is advanced that estrogen is so closely associated with calcium and bone metabolism that it is permissible to assign to it a part in the causation of otosclerosis, at least in persons with receptive hereditary backgrounds, and perhaps it plays a major part in the changing activity of otosclerotic lesions."



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THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

547 Water Street

Indiana, Pa.

FIFTEEN YEARS OF SERVICE

The secretary of any organization leads a very dull, prosaic club life, writing down current data, filing materials and signing vouchers, with no chance at all for any originality or initiative. The Woman's Auxiliary to The Medical Society of the State of Pennsylvania has been served for fifteen years by the same secretary, and by all the rules of organizational procedure the routine should have become deadly by now, and even the efficiency of the group destroyed by such long service in one office.

As this officer of such ancient vintage, I have to admit that I have never had a moment of boredom nor have I found any measure of monotony in the routine. Each year's work has been a separate link in a long chain of friendliness, endeavor, and success. Even the projects that are common to every year's program have been approached in varying fashions by the different presidents, each making her contribution to the Auxiliary in the terms of her own individuality. As the secretary to each I would find it difficult to single out any year as better or more effective than any other. Each year county groups have widened and increased their services to their communities and to the Medical Society. Programs have followed the patterns of the times or the needs of the parent organization.

In the past fifteen years many changes have come into auxiliary planning and many things once urgently advanced in counties are no longer found necessary or important. This period covered two depressions, a major flood, and a great world war, all of which touched us deeply as an organization. The accompanying restrictions of each catastrophe brought us grief and hard work, but the losses and trials were all outweighed by the spirit of loyalty and the collective endeavors of the auxiliary membership.

Once county groups worked very hard on periodic health examinations, and family groups and lay club members went along with our program by the thousands. The growing awareness of health matters in communities has made this program of little use and it is no longer in force. Public health education, as a part of our pro-

gram for many years, was merged with public relations and approached in different fashion. We once had exhibits and posters and displays of medical implements of other years at the convention, but that is no longer done. The medical treasures gathered through the years—ancient books and instruments and records of priceless value—are now the property of the State Museum. The war work of countless defense programs at home, in camps, and base hospitals is now happily no longer necessary, nor is the War Participation Committee any longer in force. The post-war programs of local groups are no longer needed. Records of war service of county doctors are all finished and filed. Nomination of committee members by telephone hookups is no longer used. Members do not now provide the entertainment of conventions from their own membership. The government restrictions on convention numbers and even conventions are now in the past. Annual rosters, once the envy of other states in national convention, have been abandoned for several years. Four annual meetings of the executive board have been reduced to three, and on some occasions two, through the years. The common plea for more interest from medical societies in auxiliaries at the county level is also happily past. We, as an organization, are noticed by the men in a big way. The Auxiliary has progressed in a legislative fashion from our once frantic interest in nothing more deadly than the late Dr. Schireson's diploma to the powerful legislative force which now serves the Medical Society and which through its collective zeal has buried hundreds of legislators knee-deep in letters, telegrams, and petitions from every possible lay source.

The tangible profits in the auxiliary ledger, as the secretary has observed them, follow a pattern of growth in the Auxiliary and in the vast extension of its influence. Perusing, through the years, thousands of reports and letters and hearing millions of words on auxiliary programs, there are some things that stand out in my mind, all very simple but things that have wrought the progress in auxiliary life and the ever certain change.

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Diplomate in Psychiatry

Whether she wishes it or not, every member of the Auxiliary is a powerful public relations agent for organized medicine at her community level. The way she greets her neighbors or handles a telephone call, the way she dresses, the money she spends, the way she greets patients are all a part of the public's opinion of medicine. Members have long given this angle their attention.

Most auxiliary members are home-makers, office assistants, and all the countless things that a doctor's wife can be in one day. Most of us have no particular talents for crusading nor are we experts in any fields. But our closeness to the problems of medicine and the current threats to it and our knowledge of the results of those dangers to the patient make us aids of the best kind to discretely advance the things that the Auxiliary wants put over. We need not do spectacular work, but each of us at the community level can do some effective part of the county program. The reports which have reached me through the years total this individual service in countless ways.

Every auxiliary member can be an agent for Blue Shield and against compulsory health insurance, right in her home or office or lay club. Each of us can know both sides of the health insurance business and keep our husbands informed. Too rushed to study these angles themselves, the doctors rely upon us to help them learn the answers that they will need to give over and over again on the controversial issue. Lay clubs are fine places to actually advance sales of Blue Shield. This is a simple approach to good public relations and has been practiced widely by auxiliary members wholly apart from their county auxiliary work.

Women, even auxiliary members, are the creators of public opinion. We have done our share to make legislators at least aware of our side of the issue, and medicine and medical ideals have never suffered through the years as noted in my acres of auxiliary reports and programs.

At the community level, reports show outstanding service in projects needing our help. In groups and as individuals we have made the Auxiliary a practical, useful force in organizational life.

From the State Auxiliary I have seen four of our members elected to the highest post in the National Auxiliary. Twenty of us have served on the national board in the past fifteen years with distinction and honor. Our medical benevolence plan, our annual rosters, our work in *Hygeia*, and our conference successes have highlighted national conventions. Other states have

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sent their presidents and other officers to meet with us, so the friendliness which started us off as an organization twenty-five years ago continues to grow and grow. Through the years no lay club in Pennsylvania's women's organizations has ever had to vote on a state board resolution against organized medicine. That meant one of us or many of us were at work in the home clubs and state boards of lay groups.

I might go on and on with the things I remember that rate as successes. The failures somehow, many as there were, have made no deep impression upon me. Mellowed by the years they have melted into the pattern of worthwhile service and advancement. On the personal side of the secretary's ledger, I have become an expert in gathering in the reports. It is strange how very reluctant many county presidents are to tell me how wonderful they were during their year. When my annual reports for each of the fifteen years say "one hundred per cent reports filed," it sounds so simple and easy. But it often means that some twenty kinds of persuasions over a period of weeks were necessary to make that annual goal of complete reporting in the state group possible.

I have acquired a knowledge of counties and towns and cities that a geographer might envy. I have learned to know and to love the families of all fifteen presidents and a vast number of executive board families as well. The daily doings in all these homes are as familiar to me as the doings in my hectic household are to all of them. These fifteen years have been a great experience in my life and the memories are worth a king's ransom.

If my remembrances of the organization for the past fifteen years of auxiliary service are all happy ones, it is only because I have had the affection, assistance, and confidence of the auxiliary membership to help me to keep the records, to help me to preserve the story of our progress, and to help me to go along with the ever changing form of auxiliary endeavor.

(MRS. FRANK P.) MARY H. DWYER,
Recording Secretary.

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Mary H. Dwyer is pictured above presiding at the tea held in her honor as she was made an honorary life member of the Auxiliary at the Silver Anniversary convention. Mrs. Dwyer was presented with the lapel watch which she is wearing as a token of appreciation for her unselfish service to the Auxiliary.

The Auxiliary has benefited through her faithfulness in service.

When such a person brings to an office great executive ability, keen judgment, intrepid honesty, and an ability to win friends, she should receive our full commendation. Mrs. Dwyer has exhibited all of these virtues in the fifteen years she has served as recording secretary to the Woman's Auxiliary to The Medical Society of the State of Pennsylvania.

In recognition of this faithful service, the Woman's Auxiliary to the MSSP conferred upon Mary H. Dwyer the honor of being made its second honorary life member, during the twenty-fifth annual meeting at Pittsburgh, Sept. 28, 1949.

A true helpmate to her husband and exceedingly capable in her own right is Mary Dwyer, wife of Frank P. Dwyer, M.D., of Renovo. She has the delightful and unusual combination of organization and executive ability. The long list of her activities is an adequate reminder that her competence has been recognized in the Auxiliary for several years.

Were her service limited only to the Clinton County Auxiliary, Mrs. Dwyer's achievements would be enough to permanently enshrine her in our hearts. But she has gone on where others would have been satisfied to halt for rest.

She was educated at Indiana Teachers College and Columbia University and taught two years. Her activities include social work in the Federation of Women's Clubs, Community Chest, Red Cross Board, Renovo Monday Night Club (president), and the Clinton County Auxiliary (archives chairman and a past president). She has also been a district councilor in the State Auxiliary and a public relations chairman of the Woman's Auxiliary to the American Medical Association.

The Dwyers have two sons and one daughter: Dr. James R. Dwyer, a surgeon at Hagerstown, Md.; Dr. Frank P. Dwyer, Jr., a resident at St. Agnes Hospital, Baltimore, Md.; and Constance, a sophomore in St. Joseph's High School, Renovo.

Truly, Mary Dwyer's exemplary life bears the message, "They build too low who build beneath the stars."

(MRS. DAVID W.) GRACE E. THOMAS,
Clinton County.

AN ACKNOWLEDGMENT WITH REQUEST

For the past several years the officers and hundreds of members of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania have been exceedingly helpful in the development and advancement of the Society's public relations and legislative activities. Their helpful cooperation has never been equaled by any accessory group. They have indeed been an ally and their current officers have expressed a willingness to continue this arrangement indefinitely.

On behalf of our Committee on Public Health Legislation I wish to thank you for your past help and your offer of future assistance.

At a joint meeting between the State Medical Society Advisory Committee to the Woman's Auxiliary and state officers of the Woman's Auxiliary, the following subjects were assigned to the Woman's Auxiliary, with all present agreeing:

1. Animal experimentation.
2. Registration of doctors and the voting members of their families in order that they may vote in Primary and General elections, local, state, and national.
3. Functions of the State Board of Medical Education and Licensure regarding licensing limited practitioners of the healing arts.



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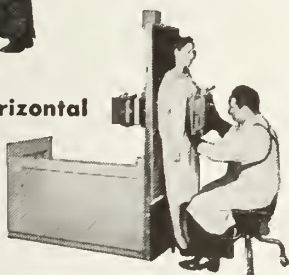
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head and torso)

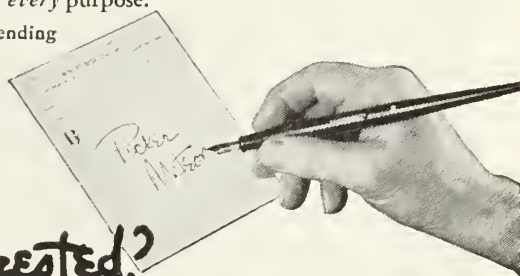


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4. Functions of the Department of Health and factors necessary for the improvement of health services to our citizens through the State Department of Health.

Animal experimentation is an extremely important legislative subject. For several years animal experimentation bills have been sponsored and introduced by the Committee on Public Health Legislation of The Medical Society of the State of Pennsylvania. During the past session of the Legislature, the Committee on Public Health Legislation and officers of the Woman's Auxiliary were very active in attempting to obtain passage of a bill providing for humane and sanitary regulation by the State Department of Health of all institutions using animals for experimental purposes. This would further medical progress and benefit not only our citizens but animals as well.

The State Society Committee on Public Health Legislation in conjunction with the Committee on Defense of Medical Research contemplates introducing a similar bill in the next session of the Pennsylvania Legislature.

There should be no question in the minds of intelligent individuals that animal experimentation, under proper, humane and sanitary conditions, is essential to medical progress.

It will be necessary to plan a well-organized, comprehensive campaign to inform the citizens of Pennsylvania individually and in large groups of the absolute necessity for animal experimentation. This will require two activities:

1. A large public relations program through the medium of newspapers, magazines, radio, and addresses before lay groups to persistently inform them of the benefits that have previously been and surely will in the future be derived from proper animal experimentation.
2. An intense legislative program involving support of many groups favoring such a procedure, and then persistently and intensely urging members of the House and Senate to adopt a measure regulating animal experimentation.

This entails personal contact with many individuals to get them to communicate personally—also by letters, telegrams, and postal cards—with their representatives in the General Assembly when the bills are introduced.

The antivivisectionists are professionally organized with full-time personnel who persistently, intensely, and even vituperously write, telegraph, and telephone members of the General Assembly opposing such measures.



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Registration of doctors and the voting members of their families will be a difficult but necessarily comprehensive program. There must be organized throughout the entire State Medical Society and Woman's Auxiliary small committees in each legislative district who will phone, write, or through personal contact urge doctors and voting members of their families to register from December 3 to about the middle of March in order that they may vote in the coming Primary Election in May and the General Election in November, 1950.

Functions of the State Board of Medical Education and Licensure regarding licensing limited licensees. The general public does not have a proper understanding of the attitude of the medical profession concerning this question. Limited licensees, namely, osteopaths, chiropractors, naturopaths, and others, are continuously distributing information to the effect that the medical profession is endeavoring to discriminate against them and hold them down and is fearful of competition from them.

Many persons seeking treatment for an ailment do not inquire whether or not individuals professing to treat them have conformed to legal

educational requirements and become licensed. All they are likely to be concerned with is whether or not benefit is derived from the treatment administered. The medical profession does not fear competition and has no argument against any form of treatment that benefits anyone with an ailment or injury. We only ask all who attempt to treat the human body in any way to conform to the State's legal educational requirements and be licensed by the State to practice the form of healing art for which they have duly qualified. All limited practitioners have been able to obtain a license in Pennsylvania since 1914 provided they conform with the legal educational qualifications. Many of them have conformed and have been licensed; however, there is a large group who are unable or unwilling to take the necessary training courses to conform to these qualifications and therefore, through political influence and false propaganda, continuously endeavor to obtain a license without conforming to present legal educational requirements.

This requires that continuous and emphatic information be disseminated to the public and to our legislators.



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A combined surgical course comprising general surgery, traumatic surgery, abdominal surgery, gastro-enterology, proctology, gynecologic surgery and urologic surgery. Attendance at lectures, witnessing operations, examination of patients preoperatively and postoperatively and follow-up in the wards postoperatively. Pathology, roentgenology, physical therapy, anesthesia. Cadaver demonstrations in surgical anatomy, thoracic surgery, proctology. Operative surgery and operative gynecology on the cadaver.

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State licensed, Belle Vista offers complete sanatorium care for convalescents, senile cases, nervous and mild mental patients. The most advanced ideas in treatment, including hydrotherapy, electroshock therapy, and metrazol are available. Ambulatory cases accepted. Physicians are invited to retain charge of their patients. Reasonable rates.

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Functions of the Department of Health. The State Department of Health and all the various municipal health departments are charged by law to act in the interest of the health and welfare of the people of this state.

Governmental services in health, as well as in any other line, depend entirely upon the ability and willingness of the individual citizens to pay the taxes required to provide such services. In other words, we receive service that is commensurate with our willingness to pay.

Sufficient funds are needed to increase the facilities and personnel of the State Department of Health and further to assure properly trained individuals a salary commensurate with their qualifications in order that they may be willing to make public health service a career.

Under the present law, the Pennsylvania Department of Health can do anything the health departments of any other state can do, provided (1) there are sufficient funds and (2) some system of security is developed for at least the trained professional personnel in the Department of Health.

These are the two greatest needs for improvement and for more widespread efficient health service on the part of our Pennsylvania Department of Health.

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technique, two weeks, starting November 28, January 23, February 20. Surgical Technique, Surgical Anatomy and Clinical Surgery, four weeks, starting November 7, February 6, March 6. Surgery of Colon and Rectum, one week, starting November 28, March 6. Esophageal Surgery, one week, starting April 17. Breast and Thyroid Surgery, one week, starting June 19. Thoracic Surgery, one week, starting June 12. Fractures and Traumatic Surgery, two weeks, starting April 17.

GYNECOLOGY—Intensive Course, two weeks, starting February 20. Vaginal Approach to Pelvic Surgery, one week, starting November 7, March 6.

OBSTETRICS—Intensive Course, two weeks, starting November 7, March 6.

PEDIATRICS—Intensive Course, two weeks, starting April 3.

MEDICINE—Intensive General Course, two weeks, starting April 3. Gastroscopy, two weeks, starting March 6.

DERMATOLOGY—Formal Course, two weeks, starting May 1. Informal Clinical Course every two weeks.

ROENTGENOLOGY—Diagnostic and Lecture Course first Monday of every month. Clinical Course third Monday of every month. X-Ray Therapy every two weeks.

UROLOGY—Intensive Course, two weeks, starting April 17. Cystoscopy, Ten Day Practical Course, every two weeks.

General, Intensive and Special Courses in all Branches of Medicine, Surgery and the Specialties
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A number of specific recommendations have been made in the survey recently made by the American Public Health Association. All these recommendations are of the highest type and deserve our earnest consideration. However, it is necessary in all types of service, whether it be governmental or otherwise, to be practical.

The question which the State Department of Health must decide is which recommendations are practical under present conditions and which can be laid aside until the general public is sufficiently informed and willing to pay the taxes to pay for them.

C. L. PALMER, M.D., *Chairman,*
Committee on Public Health Legislation,
The Medical Society of the State of
Pennsylvania.

MUSINGS ON THE "PRESIDENT'S NEW NATIONAL HEALTH BILL"

It's Sunday evening and I am weary of trying to figure ways and means to promote a larger budget for the Riverside County Health Department, so I pick up the May 7 issue of the *J. A. M. A.* and promptly fall from the frying pan into the fire. The cause of the difficulty is a summary of the "President's New National Health Bill." Following are the conclusions of an M.D. who has a smattering of statistical training:

First, I admire the rough sketch I make of the organizational chart for committees set up in S. 1679. It's a honey but would require too much county paper to reproduce it.

Then I while away the time trying to determine the number of persons involved in administering the proposed program. I come out with something like this derived from the organizational chart:

Item	Persons
Truman	1
Federal Security Administrator	1
National Health Insurance Board	5
National Council on Education for Health Professions	24
National Advisory Council for Research on Child Life (estimate)	20
National Advisory Medical Council	17
48 State Advisory Committees (estimate at least 7 members per committee)	336
Approximately 3200 counties with a specified maximum of 16 on the local administrative committee	51,200
3200 local professional committees allowing only one committee for each county (although there may be more committees) with an estimated membership of 7 per committee	21,400
Since it requires a minimum of one nurse to 2500 people for an adequate bedside program, the home nursing program would require nurses	60,000
Total	133,004

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SAME SIMPLE TECHNIQUE FOR BOTH

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My calculation of more than 130,000 committee members, administrators, and nurses in the country at large does not include an estimate of the numbers involved in the special advisory and technical committees at the Federal level. The bill provides for any number of such committees.

It is simple so far. When I try to estimate items *not* in the bill, the number of clerical personnel needed to process forms, bills, checks for doctors and so forth, besides someone to double-check the checks, at the county level, and a duplicate set at both the state and Federal levels (that is the way EMIC worked), I am about to quit, although I do come up with an estimate of a minimum of 40,000 additional personnel.

Then, I think, what's to prevent further decentralization by setting up intermediate personnel in each of the regular USPHS district offices? The possibilities are endless.

Can there be any advantage in an organization of such magnificent proportions? There must be, or the Washingtonians wouldn't have thought of it in the first place. There must, according to an unwritten law of nature, be some good in everything. I cudgel my brain and, lo, light appears. Come the depression there will be committee men, administrators, clerical personnel (we'll even have to have more janitors to carry out the wastepaper) et al. to the tune of a minimum of about 175,000 (says my statistical training) who will not be out of work.

Then, too, for some time I am worried that the local health officer might be designated as the local administrator of the so-called Health Plan. Imagine my relief to find that the sponsors of the bill are kind enough to remember to specify the duties of the local

administrator. Judging from those specifications any health officer who is worth his salt and does anything to earn his pittance won't have the time to be the local administrator.

Note: Guess the whole business is a waste of time, but the possibilities for employment and hitching a ride on the gravy train are fascinatingly fantastic.

P. S.: They should give physicians preference on some of these fancy jobs.—ROBERT WESTPHAL, M.D., *California Medicine*.

BUSINESS IS BUSINESS

Notice to All Duly Licensed Practitioners and County Health Commissioners

On June 6, 1949, the City of Toledo opened its new Contagious Disease Hospital on Arlington Avenue, adjacent to the Maumee Valley Hospital, for the purpose of caring for cases and controlling contagious disease within the limits of the City of Toledo.

Effective as of June 6, 1949, the Contagious Disease Hospital of the City of Toledo will not admit a patient or patients from any other governmental unit unless they have first signed a contract with the City of Toledo guaranteeing payment to the City of Toledo for the care and treatment of patients who are non-residents of the City of Toledo.

The above-mentioned contract may be signed and put in effect by contacting the Law Director of the City of Toledo, located at room 327 Safety Building, Toledo.—(Signed) City Manager.

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FOUNDED 1825: A chartered university since 1838. Graduates 17,815.

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ADMISSION: For full particulars regarding admission requirements write to the office of the Dean, 1025 Walnut Street, Philadelphia 7, Pa.

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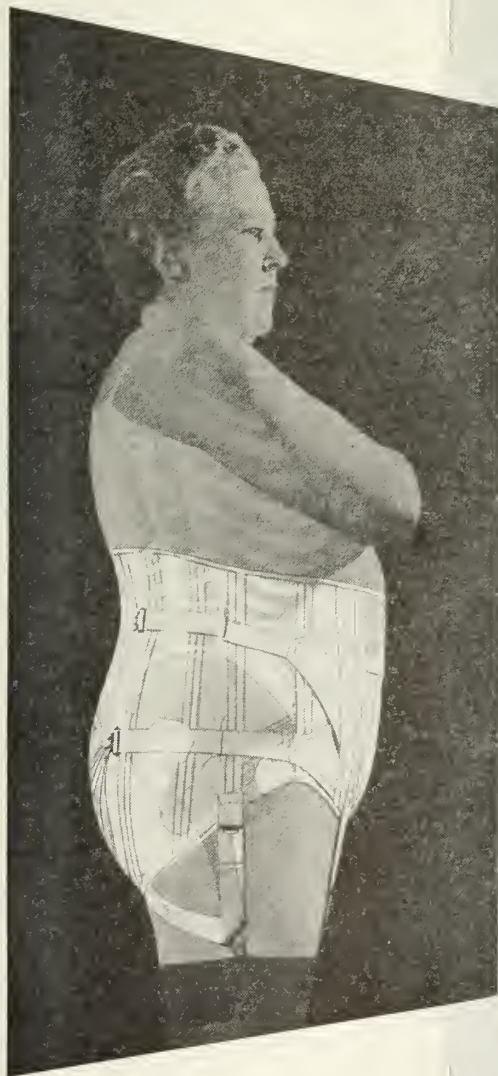
REQUIREMENTS

Four years of accredited high school work and two years of college work in a recognized institution of college grade, including one year of inorganic chemistry, one year of organic chemistry, one year of biology, one year of physics, these subjects to be taught in the laboratory, as well as didactically, and one year of English. Additional work in English, mathematics, modern language, history or political science: physical education or military science is recommended.

GENERAL—Sixty-fifth annual session began September 14, 1949. Catalog and information regarding courses on request. Address all communications to

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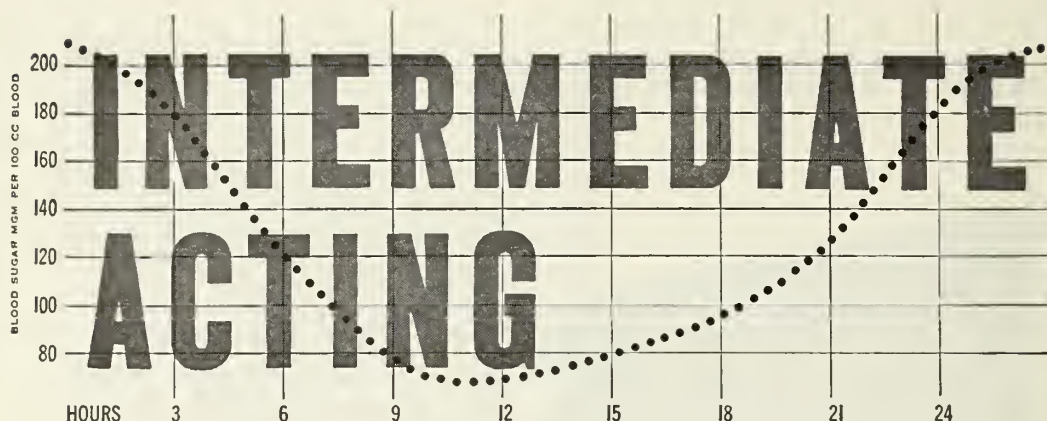
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1 Rohr, J.H., and Colwell, A.R.: Arch. Int. Med. 82:54, 1948.

2. ibid Proc. Am. Diabetes Assn. 8:37, 1948.



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MEDICAL NEWS

Birth

TO DR. AND MRS. JOHN H. HALL, of Philadelphia, a son, John Handy Hall, 3d, October 1.

Engagement

MISS MARY-HERITAGE WALKER, daughter of Dr. and Mrs. Dudley Pomp Walker, of Bethlehem, to Mr. A. Harden Coon, Jr., of Kingston.

Marriages

MISS RUTH MAY BROWN, of Berwick, to Russell G. Lindauer, M.D., of Montgomery, October 15.

MISS BESSIE A. DUTRO, of Harrisburg, to Charles Leroy Zimmerman, M.D., of Danville, October 22.

MISS FRANCES TABOR McDONALD, of St. Davids, to Mr. Jay C. Sands, son of Dr. and Mrs. Joseph E. Sands, 2d, of Rosemont, October 22.

Deaths

☉ Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

☉ Paul N. Jepson, Philadelphia; University of Pennsylvania School of Medicine, 1920; aged 56; died suddenly Oct. 24, 1949. From 1921 to 1927 Dr. Jepson was associate professor of orthopedic surgery at the Mayo Clinic. In Philadelphia he was chief of orthopedic surgery at Doctors Hospital and Fitzgerald-Mercy Hospital, Darby; St. Joseph's Hospital, Phoenixville; and Pottstown Hospital, where he conducted a clinic. He was also consultant at Warren Hospital, Philipsburg, N. J. He was a member of the American Academy of Orthopedic Surgeons and a fellow of the American College of Surgeons and the International College of Surgeons. Surviving are his widow, three sons, and a daughter.

☉ John H. Gunter, Wynnewood; Temple University School of Medicine, Philadelphia, 1917; aged 61; died Sept. 23, 1949. Dr. Gunter was director of the department of oral surgery in the University of Pennsylvania Graduate School of Medicine, also professor of oral surgery at the medical school and school of dentistry at the university. He was associated with the Philadelphia General, Jewish, Episcopal, Oncologic, and Jeanes Hospitals in dental surgical work during his career, and was an associate editor of *Philadelphia Medicine*. During World War I, he was a captain in the Canadian Army Dental Corps. Surviving are his widow, a son, a daughter, a brother, and three sisters.

☉ Joseph A. Coscarello, Philadelphia; Hahnemann Medical College and Hospital of Philadelphia, 1924; aged 50; died Oct. 15, 1949. Dr. Coscarello was chief of the department of women's diseases at Community Hospital for the past twelve years, and was an associate in gynecology at Women's Homeopathic Hospital, Broad Street Hospital, and St. Agnes Hospital. In 1947 he was admitted to the International College of Surgeons. During World War I, he served overseas with the U. S. Navy. He is survived by his widow, a son, a daughter, his mother, two brothers, and five sisters.

A. Victor Pelosi, Philadelphia; Temple University School of Medicine, 1926; aged 49; died Oct. 26, 1949, following a heart attack. Dr. Pelosi was chief

diagnostician of the Philadelphia Board of Health, and president and general manager of the Philadelphia LaScala Opera Company, to which he was devoted. He succeeded his brother, the late Francesco Pelosi, as head of LaScala. Surviving are his widow, a son, his father, and three brothers.

☉ Arthur C. Kalisch, York; Johns Hopkins University School of Medicine, 1932; aged 43; died suddenly of a cerebral hemorrhage Oct. 5, 1949. Dr. Kalisch was a specialist in the treatment of allergies and was chief of the dispensary allergy staff of York Hospital. He was a draft board physician before entering the Army in 1942 as a captain. He is survived by his widow, a son, and a sister.

John F. McGrath, Pittsburgh; University of Pennsylvania School of Medicine, 1901; aged 72; died Sept. 19, 1949. Dr. McGrath was a staff member of Mercy Hospital for twenty years and later was appointed police surgeon and served in that capacity until his appointment as city physician. He retired in 1945. Surviving are his widow, a son, two daughters, a brother, and three sisters.

☉ William G. Hess, Holtwood; University of Pennsylvania School of Medicine, 1898; aged 74; died of a coronary occlusion Oct. 5, 1949. Dr. Hess had served as plant doctor for the Pennsylvania Water and Power Company for more than twenty-eight years, retiring in 1946. In 1948 he was honored by the State Medical Society for having practiced fifty years. Two sisters survive.

☉ John P. Hegarty, Pittsburgh; University of Pittsburgh School of Medicine, 1902; aged 81; died Oct. 11, 1949. For many years he was a member of the courtesy staff of Mercy Hospital and attending obstetrician and chief of staff at Roselia Hospital. Dr. Hegarty retired in 1947. He is survived by a son, Francis A. Hegarty, M.D., of Pittsburgh, and two daughters.

Proctor T. Miller, Altoona; College of Physicians and Surgeons, Baltimore, Md., 1893; aged 78; died Sept. 28, 1949. Dr. Miller had practiced nearly forty years. His father and two brothers were also physicians. He was the last of his immediate family.

Henry F. C. Heagy, Cochranville; Jefferson Medical College of Philadelphia, 1883; aged 92; died Oct. 7, 1949. Dr. Heagy had practiced medicine for sixty-six years. He is survived by two daughters and one brother.

☉ Frank Womer, Clifton, N. J. (formerly of Reading); Jefferson Medical College of Philadelphia, 1889; aged 90; died Oct. 4, 1949, at the home of a daughter. He is also survived by another daughter.

James R. Care, Norristown; Jefferson Medical College of Philadelphia, 1886; aged 84; died Oct. 12, 1949, after a long illness. He is survived by his widow, three daughters, and a brother.

Robert P. Matthews, Philadelphia; Howard University College of Medicine, Washington, D. C., 1924; aged 51; died Oct. 6, 1949, after a long illness. His widow and a son survive.

☉ Clarence E. Apple, Melrose Park; Jefferson Medical College of Philadelphia, 1904; aged 67; died Oct. 22, 1949, after a year's illness. His widow and two sons survive.

○ **Frank A. Clawson**, Meadville; Chicago Homeopathic Medical College, 1899; aged 71; died in September, 1949. He specialized in eye, ear, nose, and throat diseases.

○ **Walter F. Mylin**, Willow Street; Jefferson Medical College of Philadelphia, 1903; aged 71; died Aug. 2, 1949.

○ **Barton K. Thomas**, Pottstown; Jefferson Medical College of Philadelphia, 1913; aged 62; died Sept. 18, 1949.

○ **John W. Ildza**, Pittsburgh; Medico-Chirurgical College of Philadelphia, 1915; aged 71; died Aug. 28, 1949.

○ **Samuel R. Huff**, Eldred; Medico-Chirurgical College of Philadelphia, 1908; aged 65; died Aug. 27, 1949.

Miscellaneous

THE CHILDREN'S HOSPITAL OF PHILADELPHIA has been awarded a grant of \$373,450 by the National Heart Institute of the U. S. Public Health Service for the construction and equipment of a new building to house research work on rheumatic heart disease.

THE EIGHTH ANNUAL MEETING OF THE AMERICAN ACADEMY OF DERMATOLOGY AND SYPHILOLOGY will be held at the Palmer House, Chicago, from Saturday, December 3, through Thursday, December 8, it is announced by Earl D. Osborne, M.D., secretary-treasurer of the academy, 71 North St., Buffalo, N. Y.

EDWARD F. CORSON, M.D., a member of the teaching staff at Jefferson Medical College of Philadelphia since 1920, has been appointed head of the department of

dermatology at the college. He succeeds Dr. Clarence S. Livingood who recently resigned. Dr. Corson has been professor of dermatology since 1947.

THE SIXTY-THIRD ANNUAL BANQUET OF THE ASSOCIATION OF EX-RESIDENT AND RESIDENT PHYSICIANS OF THE PHILADELPHIA GENERAL HOSPITAL will be held on Tuesday, December 6, at 7 p.m. Reservations may be had by writing to the secretary-treasurer, Robert C. McElroy, M.D., Room 514, 133 South 36th St., Philadelphia 4, Pa.

WALTER F. DONALDSON, M.D., secretary-treasurer of The Medical Society of the State of Pennsylvania and editor of THE PENNSYLVANIA MEDICAL JOURNAL, was selected as Pittsburgh's "Man of the Week" on Saturday, October 8, by the Pittsburgh *Post-Gazette*. Each week the *Post-Gazette* selects an outstanding Pittsburgher as "Man of the Week" and devotes some thirty column inches to a feature story concerning the outstanding achievements of the person selected.

CHESTER G. CRIST, M.D., Gettysburg College physician for nearly thirty-five years, was awarded the "meritorious service award" for the past year by Gettysburg College. Dr. Crist is also jail and county home physician, a post which he has held for the past fifteen years, and has served as county medical director and chief of the State Tuberculosis Clinic for the past twenty-five years and county coroner for the past twenty-six years.

LOIS A. GILLILAN, M.D., a graduate of the University of Pittsburgh School of Medicine, who later received her Ph.D. degree in anatomy at the University of Michigan, has been appointed to the faculty of the

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Endo

Graduate School of Medicine of the University of Pennsylvania. She has also done extensive research abroad. Dr. Gillilan's post will be assistant professor of anatomy in the Graduate School. Most recently she has been on the medical staff of the University of Illinois.

MALIGNANT TUMORS, their diagnosis and treatment, will be the theme of the thirty-fifth annual meeting of the Radiological Society of North America to be held in Cleveland, Ohio, from December 4 to 9. The meeting with 11 major symposia, 37 refresher courses, a tumor conference, and several special sessions, will be a "postgraduate course" in cancer. It will be held in Cleveland's public auditorium. Seventy scientific and technical papers are to be presented. Convention headquarters for the society will be in the Hotel Statler.

THE PENNSYLVANIA DIVISION OF THE AMERICAN CANCER SOCIETY, at the October meeting of its board of directors, elected the following officers: president, Harold J. Harris, M.D., Wilkes-Barre; first vice-president, Ralph D. Bacon, M.D., Erie; second vice-president, Edward L. Sittler, Jr., Uniontown; secretary, Mary Baker Davis, M.D., New Castle; treasurer, Walter E. Burns, Harrisburg. John H. Harris, M.D.,

of Harrisburg, past president, asked not to be re-elected because of the pressure of other matters. Twelve directors were also elected, and a thirteenth will be announced later.

STARTING SEPT. 1, 1949, St. CHRISTOPHER'S HOSPITAL, PHILADELPHIA, became the pediatric department of the Temple University School of Medicine and Hospital. All instruction in pediatrics to medical students will be given in the wards and out-patient departments of St. Christopher's Hospital. Waldo E. Nelson, M.D., is medical director of St. Christopher's Hospital and is professor and head of the Department of Pediatrics at Temple University. St. Christopher's Hospital is an institution of 100 beds. It was founded in 1875 and is the second oldest children's hospital in the United States.

A NATIONAL CONFERENCE ON CARDIOVASCULAR DISEASES will be held in Washington, D. C., Jan. 18 to 20, 1950, under the joint sponsorship of the American Heart Association and the National Heart Institute of the U. S. Public Health Service. This will be the first national conference bringing together physicians, scientists, community service leaders, and members of allied



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The above studies should be supplemented, when possible, with courses in mathematics, qualitative analysis, physical chemistry, foreign languages (Spanish, French, or German), and sociology.

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professions to formulate a comprehensive program to combat the nation's leading cause of death. Harold M. Marvin, M.D., president of the American Heart Association, and Cassius J. Van Slyke, M.D., director of the National Heart Institute, will be co-chairmen of the conference.

THE EYE SECTION OF THE PHILADELPHIA COUNTY MEDICAL SOCIETY is conducting its 1949-1950 series of postgraduate conferences, in the society's headquarters building, on the first Thursday evening in November, December, January, February, March, and April. There are two conferences each evening, beginning at 7:15 and 8:15 p.m. and lasting forty-five minutes each. There is no charge to members of the society, nor to hospital residents, interns and postgraduate students, but tickets must be obtained by writing to John W. Deichler, M.D., secretary of the section, 301 S. 21st St., Philadelphia 3. Non-members of the Philadelphia County Medical Society may obtain tickets upon request accompanied by check for one dollar for each conference selected.

IN LINE WITH ITS ENDEAVORS TO ENLIST THE ACTIVE COOPERATION OF ALL PHYSICIANS, SURGEONS, AND PATHOLOGISTS IN THE STATE, the Department of Health of the Commonwealth of Pennsylvania is supplying each registered physician with report forms upon which to report to its Cancer Division all types of malignant neoplasms as required by Pennsylvania law.

A report should be filled out by each physician, surgeon, or pathologist on every diagnosed case of malignant neoplasm and sent immediately to the Pennsylvania Department of Health. Please print information in ink or use typewriter in filling out form.

The form should *not* be filled out in the presence of the patient.

Additional forms and franked envelopes will be sent on request. Please note the number of additional report forms and envelopes desired in the space provided at the bottom of the form.

A JOINT MEETING OF THE CAMBRIA AND BLAIR COUNTY MEDICAL SOCIETIES was held at Cresson Sanatorium on Thursday afternoon, October 20. The following program was presented, and a buffet supper was served thereafter:

Presentation of program—Morrison C. Stayer, M.D., director of Bureau of Tuberculosis Control.

Address of welcome—Norris W. Vaux, M.D., State Secretary of Health.

Recent Advances in the Surgery of Pulmonary Tuberculosis—Charles P. Bailey, M.D., associate professor of thoracic surgery, Hahnemann Medical College of Philadelphia.

The Public Health Aspects of Tuberculosis—Russell E. Teague, M.D., Tuberculosis Control Consultant, U. S. Public Health Service.

The Evaluation of Pulmonary Lesions Discovered on Mass X-ray Surveys—C. Howard Marcy, M.D., medical director at Tuberculosis League Hospital, and associate professor of medicine, University of Pittsburgh.

AT THE ELEVENTH ANNUAL DINNER MEETING OF THE PENNSYLVANIA PSYCHIATRIC SOCIETY which took place at the University Club in Pittsburgh, September 29, Manfred S. Guttmacher, M.D., chief medical officer of the Supreme Court of Baltimore, Md., spoke on "The Function of Psychiatry in the Courts."

The following physicians were elected to serve as officers for the year 1949-1950:

President—Harold L. Mitchell, Pittsburgh.

President-elect—Arthur P. Noyes, Norristown.

Secretary-treasurer—Philip Q. Roche, Philadelphia.

Councilors for one year: Robert S. Bookhammer, Philadelphia; Hamblen C. Eaton, Harrisburg; Robert H. Israel, Warren; Thomas A. Rutherford, Carbon-dale. Councilors for two years: Hilding A. Bengs, Harrisburg; O. Spurgeon English, Philadelphia; James M. Henninger, Pittsburgh. Auditors: (one year) Morris W. Brody, Philadelphia; (two years) Robert W. Staley, Pittsburgh; (three years) Lauren H. Smith, Philadelphia. Editor of transactions: Theodore L. Dehne, Philadelphia.

A SEMINAR ON THE TREATMENT OF SYPHILIS will be held at the Mellon Institute, Pittsburgh, on Thursday, December 1, under the sponsorship of the Venereal Disease Division of the Pennsylvania Department of Health. The seminar will begin at nine o'clock and continue all day. Edgar S. Everhart, M.D., chief of the State Venereal Disease Division, will preside.



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The program will include the following papers: Effect of Syphilis on Civilization, Thomas Parran, M.D., dean of Postgraduate School of Public Health, University of Pittsburgh; Past, Present and Future of Syphilis, Erwin C. Drescher, M.D., special consultant to Pittsburgh Department of Public Health; Penicillin Therapy in Early Syphilis, Richard C. Arnold, M.D., director of Venereal Disease Research Laboratory, U. S. Public Health Service, Staten Island, N. Y.; Treatment of Syphilis in Europe as Contrasted with that in the United States, Mortimer S. Falk, M.D., Institute for the Study of Venereal Disease, University of Pennsylvania; The Interpretation of the Serologic Report, George R. Lacy, M.D., director of State Department of Health Laboratory, Pittsburgh; Clinical Syphilis, Fred M. Jacob, M.D., associate professor of dermatology and syphilology, School of Medicine, University of Pittsburgh; Prenatal and Congenital Syphilis, Norman R. Ingraham, Jr., M.D., assistant professor of dermatology and syphilology, Graduate School of Medicine, University of Pennsylvania; Modern Diagnosis of Syphilis, Robert C. Hibbs, M.D., clinical director of Central Diagnostic Clinic, Pittsburgh Syphilis Control Program.

The program will be concluded with a round table discussion on Problems of Diagnosis and Treatment of Syphilis, including Central Nervous System and Visceral Syphilis. Harold R. Vogel, M.D., assistant professor of dermatology and syphilology, School of Medicine, University of Pittsburgh, will be moderator, and the discussors will be Drs. Richard C. Arnold, Saul R. Bergad, Mortimer S. Falk, Robert C. Hibbs, Norman R. Ingraham, Jr., and Fred M. Jacob.

New York University-Bellevue Medical Center Postgraduate Medical School

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School and Postgraduate Division of
the College of Medicine)

The following part-time courses will be given in seven or eight sessions, January 3 through February 24, 1950. These courses consist of complete surveys in the various fields of Internal Medicine, by means of lectures and case demonstrations.

Arthritis and Allied Rheumatic Disorders Tuesdays, 9 a. m.—12 noon
Allergy Fridays, 2 p. m.—4 p. m.
Cardiology Mondays, 2 p. m.—5 p. m.
Clinical Hematology Wednesdays, 2 p. m.—4 p. m.
Normal and Pathological Physiology:
Functional and Clinical
Aspects Wednesdays, 9 a. m.—11 a. m.
Problems in Diagnosis Tuesdays, 9 a. m.—12 noon
Acute and Chronic Diseases of the Chest Thursdays, 9 a. m.—12 noon
Endocrinology Fridays, 9 a. m.—12 noon
Diseases of the Liver and
Biliary Tract Wednesdays, 11 a. m.—1 p. m.
Gastroenterology Wednesdays, 2 p. m.—5 p. m.
Nephritis and Hypertension Thursdays, 2 p. m.—4 p. m.
Peripheral Vascular Diseases Tuesdays, 2 p. m.—4 p. m.

OTHER PART-TIME COURSES

Cystoscopy and Endoscopy, January 4–February 6, 1950.
Mondays, Wednesdays, and Fridays, 10 a. m.—12 noon
Gynecological Endocrinology, January 3–February 25, 1950. Tuesdays, Thursdays, and Saturdays, 10 a. m.—12 noon
Vaginal Cytology (for specialists), January 3–February 23, 1950. Tuesdays, 12 noon–1 p. m. Thursdays, 9 a. m.—12 noon

For information about these and other courses, and for application, address

The Dean, 477 First Avenue, New York 16, N. Y.

THE CHALLENGE

" . . . What doth the Lord require of thee, but to do justly, and to love mercy, and to walk humbly with thy God?"—Micah 6:8.

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No nation grows in greatness save through the wisdom, the determination, and the vision of individuals. Each victory of man over the tyranny of absolute authority in government is the triumph of leaders who know justice, are merciful, and are humble before God.

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Sometimes these present problems seem beyond the power of any single man to cure. Yet if each follows the simple truths of the prophet, we can all influence the outcome.—*This Week Magazine*.

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BOOK REVIEWS

CAMPBELL'S OPERATIVE ORTHOPEDICS.

Editor, J. S. SPEED, M.D.; Associate Editor, HUGH SMITH, M.D., Memphis, Tenn. Second edition, with 1141 illustrations including 2 color plates. Volumes I and II. St. Louis: The C. V. Mosby Company, 1949. Price, \$30.00.

The first edition of *Campbell's Operative Orthopedics* appeared in 1939 and was based on his experiences as professor of orthopedic surgery at the University of Tennessee and the Campbell Clinic. Dr. Campbell died in 1941. This second edition represents the combined efforts of his former assistants, now the staff of the Campbell Clinic, and a number of outside specialists. The two volumes totaling 1643 pages and 1141 illustrations grew from the single-volume first edition of 1126 pages and 845 illustrations.

A comparison of the two editions, chapter by chapter, discloses the advances made in orthopedic surgery during the decade.

Chapter I on pre- and postoperative care is new, stressing the importance of recognizing subclinical avitaminosis, hypoproteinemia, phlebitis, and antibiotic therapy, etc., many terms not employed in the old edition.

Chapter III—surgical technique. Additions include Luck's electric saw and reciprocating unit; instruments for skeletal traction; stainless steel suture wire; nails—Smith-Petersen, Knowles, etc.; no contact technique reaffirmed; Bunnell's pull-out wire sutures for tendons; bone bank and iliac grafts.

Chapter VI—traumatic affections of joints. Over fifty pages are devoted to a description of the modern viewpoint of the anatomy, traumatic pathology, and treatment of the knee joint, based on American and British experiences in World War II. This is a model presentation of the internal derangements of the knee.

Chapter VIII—fractures. "Developments in metalurgy, surgical technique, and antibiotic therapy have made open reduction with internal fixation the most practical solution to many previously difficult or unsolved problems." The intramedullary fixation of diaphyseal fractures is developed in six pages. In compound fractures, after the introduction of sulfa and antibiotic drugs, the use of metallic fixation is advocated. In fractures of the os calcis—regardless of type of treatment given—if functional results are evaluated after four or five years, they are surprisingly good; therefore, the authors pursue conservative measures.

The literature on patellectomy is reviewed and a conservative course is advised. As to the femur (38 pages), intramedullary fixation is recommended, especially for shaft fractures of the middle third. In fractures of the hip, internal fixation is practically routine in adults. The mortality of neck fractures is 9.3 per cent; bony union 86.5 per cent; moderate arthritis 19 per cent. Good results are obtained in 43.6 per cent.

Chapter X on non-union includes additions.

Phemister's onlay bone graft without fixation is included.

As to the neck of the femur (36 pages), a detailed account of the present attitude toward this controversial problem is given. Statistics show that 85 per cent obtain union after operation; 60 per cent are non-union cases, and 33 per cent of those with union later develop aseptic necrosis of the head or arthritic changes. "Consequently the approach in the future will place emphasis on the prevention of aseptic necrosis rather than upon the problem of non-union." The physiologic pathology is presented from the viewpoint of Santo, Phemister, Sherman, etc., followed by a discussion of preoperative

factors to be evaluated, and ending with an excellent detailed description of the various operations classified under (1) osteosynthesis, (2) reconstruction, (3) osteotomy, (4) arthrodesis.

Chapter XI, peripheral nerve injuries (51 pages), by Francis Murphy, M.D., formerly chief of the neurosurgical section, O'Reilly General Hospital, Springfield, Mo., is based on the wealth of material accumulated during World War II. "The diagnosis and treatment of peripheral nerve injuries are described as simply and practically as possible." This promise is well carried out, and the illustrations are excellent.

Chapter XII, amputations (49 pages), by Donald B. Slocum, M.D., formerly chief of the Amputation Section, Walter Reed General Hospital, gives an authoritative survey of the modern approach to this subject based on a wide experience during the recent war in which the amputee received vastly more consideration than in any previous conflict.

Chapter XIII, chronic arthritis, with low back pain. A detailed routine for history and physical examination, including procaine tests, is described, followed by an outline of (1) conservative treatment—bed rest, traction or flexion and (2) surgical treatment.

On rupture of intervertebral disk, the modern viewpoint is discussed and operative treatment is presented by text and excellent illustrations (some in color) by F. Murphy, M.D., a neurosurgeon, giving orthopedic and neurosurgical viewpoint.

Chapter XVII on arthroplasty covers 75 pages, including mold. Arthroplasty of the hip by Smith-Petersen method, choice of operation, and technique are described in detail.

Chapter XX on muscles and tendons and the supraspinatus syndrome gives a conservative presentation of the modern view.

Chapter XXII on infantile paralysis (177 pages) gives an excellent review of modern techniques. References number up to 1947.

Chapter XXIII on cerebral palsy is reviewed by W. M. Phelps, M.D.

This is an enlarged, well-balanced second edition, carrying forward the high standard set by the first edition. It is a "must" for all orthopedic and traumatic surgeons, covering the subject in a practical manner, with excellent illustrations, full modern references, and combining the basic experiences of the staff of the Campbell Clinic with specialists in arthroplasty, neurosurgery, and amputations.

CHILD HEALTH SERVICES AND PEDIATRIC EDUCATION.

Report of the Committee for the Study of Child Health Services of the American Academy of Pediatrics with the cooperation of the United States Public Health Service and the United States Children's Bureau. New York: The Commonwealth Fund, 1949. Price, \$3.50.

This is the much discussed book which aroused considerable interest and controversy in the socio-medical world this year. It is an analytical survey of the entire field of child care and pediatric education in the United States. The work is based on an analysis of questionnaires sent to the practicing doctors in the United States on a county by county basis. It required the cooperation of Federal down to local authorities and comprises a huge amount of data which is broken down, charted, and presented in a most lucid and revealing manner. The ultimate aim of the entire study is to improve child health and thereby the health of the nation.

The health services to children are considered from the point of view of private practice, hospital care, and the community health agencies. Pediatric education is subdivided into undergraduate and graduate education. The revealing facts about medical service for children in the South and in rural areas give one much food for thought. The many facts about pediatric education likewise give one pause in considering how variable are the backgrounds of the graduates of different medical schools in pediatric training.

This book must find its way into the hands of all pediatricians, medical schools, and public health departments so that constructive ideas can be derived and put into practice in those parts of the country where they are needed most.

BRITISH SURGICAL PRACTICE. Under the general editorship of SIR ERNEST ROCK CARLIN, F.R.C.S., F.R.C.P., Consulting Surgeon, Westminster Hospital, and J. PATERSON ROSS, M.S., F.R.C.S., Surgeon and Director of Surgical Clinical Unit, St. Bartholomew's Hospital; Professor of Surgery, University of London. Volume 5. 494 pages with 220 illustrations and 6 plates. St. Louis: The C. V. Mosby Company, 1948. Price, \$15.00.

This recent volume in this contemplated set of eight volumes (with index volume) includes material ranging from Hodgkin's disease to lymphogranuloma. Specifically, the contents are arranged as follows: Hodgkin's disease, hormones, hydatid disease, hyperhidrosis and allied states, hyperpiesia, immersion foot, impotence, infections and inflammation, injury and compression, intestines, intussusception, ischemia, jaundice, joints, kidneys and ureter, lacrimal apparatus, larynx, law in relation to surgery, lens, leprosy, ligatures and sutures, limbs, lipid metabolism, liver, lumbar punc-

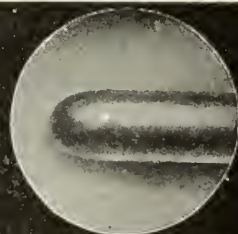
ture, lung tumors, lupus vulgaris, and lymphogranuloma inguinale.

As in the previous volumes, each chapter is well written so that no one chapter appears worthy of special mention. The illustrations are good generally, and the index of 38 pages is quite adequate. This book continues to uphold the fine standard set by the editor for this set of books.

OPERATIVE TECHNIQUE IN GENERAL SURGERY. Edited by WARREN H. COLE, M.D., F.A.C.S., Professor and Head of the Department of Surgery, University of Illinois College of Medicine; Director of Surgical Service, Illinois Research and Educational Hospitals, Chicago. Introduction by Frank H. Lahey, M.D., F.A.C.S. 951 pages and 521 illustrations. New York: Appleton-Century-Crofts, Inc., 1949. Price, \$16.00.

This new text edited by one of the best qualified surgeons and his collaborators describes in broad detail the accepted techniques in the field of general surgery which have proved their value in the clinical experience of busy practitioners throughout the United States. There are so many features in this book that no particular note can be made that any one chapter is more outstanding than the other. The contents of the book are arranged in the following 23 chapters: wound healing and the care of wounds; hemorrhage and shock; burns; pre- and postoperative care; amputations; face, mouth and jaws; esophagus; abdominal incisions; surgery of the stomach and duodenum; small intestine; pancreas and adrenal; gallbladder and bile ducts; liver and subphrenic space; colon and appendix; sigmoid rectum and anus; lymphatic system and spleen; hernia; breast; thyroid and parathyroid glands; muscles, tendons and bursae; blood vessels

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and varicose veins; hand and its tendons; skin and subcutaneous tissue. The index is good, also the paper, printing, and illustrations. This work is recommended for both specialists and general practitioners.

CARDIOVASCULAR DISEASE. By LOUIS H. SIGLER, M.D., F.A.C.P., Attending Cardiologist and Chief of Cardiac Clinic, Coney Island Hospital; Consulting Cardiologist, Rockaway Beach Hospital and Memorah Home and Hospital for the Aged. New York: Grune & Stratton, 1949. Price, \$10.00.

The text is basically devoted to a comprehensive coverage of fundamentals, differential diagnosis, prognosis, and treatment of cardiovascular disease. In writing this the author has drawn upon his experience from an extensive hospital and consulting practice of over twenty-five years' duration. Herein an attempt is made to cover all problems that the physician is called upon to solve in the course of his practice.

The volume is divided into thirty-one chapters and the material is appropriately punctuated by clinical illustrations, roentgenologic findings, and pathologic specimens including photomicrographic studies and many original drawings. In addition, the author discusses briefly such methods as roentgenkymography, electrokymography, angiocardiology, and cardiac catheterization. These are presented with the sole purpose of clarifying their significance and value.

As a text that has a practical clinical approach and presents the therapeutic aspects from a comprehensive viewpoint, this book is highly recommended to all physicians interested in heart disease.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

CLINICAL BIOCHEMISTRY. By ABRAHAM CANTAROW, M.D., Professor of Biochemistry, Jefferson Medical College; formerly Associate Professor of Medicine, Jefferson Medical College, and Assistant Physician, Jefferson Hospital, Philadelphia; and MAX TRUMPER, Ph.D., Commander, H.(S), USNR; Lecturer in Clinical Biochemistry and Basic Science Coordinator, Naval Medical School, National Naval Medical Center, Bethesda, Md. Fourth edition. Philadelphia: W. B. Saunders Company, 1949. Price, \$8.00.

OPERATIONS OF GENERAL SURGERY. By THOMAS G. ORR, M.D., Professor of Surgery, University of Kansas School of Medicine, Kansas City,

Kan. Second edition with 1700 step-by-step illustrations on 721 figures. Philadelphia: W. B. Saunders Company, 1949. Price, \$13.50.

ATLAS OF OBSTETRIC TECHNIC. By PAUL TITUS, M.D., Obstetrician-Gynecologist to the St. Margaret Memorial Hospital, Pittsburgh; Secretary, American Board of Obstetrics and Gynecology. Illustrations by E. M. Shackelford, formerly Medical Illustrator, John C. Oliver Memorial Research Foundation, St. Margaret Memorial Hospital, Pittsburgh. Second edition. St. Louis: The C. V. Mosby Company, 1949. Price, \$7.50.

A YEAR WITH OSLER 1896-1897. Notes taken at his clinics in the Johns Hopkins Hospital. By JOSEPH H. PRATT, a member of the class of 1898. Baltimore: The Johns Hopkins Press, 1949. Price, \$4.00.

BLOOD AND PLASMA TRANSFUSIONS. By MAX M. STRUMIA, M.D., Sc.D. (Med.), Associate Professor of Pathology, Graduate School of Medicine, University of Pennsylvania; Director, Laboratory of Clinical Pathology, and of the John S. Sharpe Research Foundation, Bryn Mawr Hospital; Member, Subcommittee on Blood Substitutes of the National Research Council, 1940-1945; and JOHN J. MCGRAW, JR., M.D., Instructor in Pathology, Graduate School of Medicine, University of Pennsylvania; Assistant Attending Pathologist, Bryn Mawr Hospital; formerly Commanding Officer of the Blood Bank for the Mediterranean Theater of Operations, Chief of the Blood Research Division of the Army Medical School, and Special Representative to the Surgeon General on Blood and Plasma Transfusion. 124 illustrations. Philadelphia: F. A. Davis Company, 1949. Price, \$7.50.

ESSAYS ON SEX. By HENRY MCCLURE YOUNG, M.D. Edited by Maud H. Young. Boston: The Christopher Publishing House, 1949. Price, \$5.00.

ORAL BACTERIAL INFECTION. Diagnosis and Treatment. By LYON P. STREAN, M.Sc., Ph.D., D.D.S., F.A.P.H.A., Director of Research, Novocol Chemical Mfg. Co., Inc., Brooklyn, N. Y.; formerly director of Bacteriology, Ayerst, McKenna & Harrison, Ltd., Montreal, Quebec, and New York; Associate Editor, *Dental Items of Interest*; Consultant in Bacteriology, Hebrew University, Jerusalem; Consultant in Bacteriology, Israeli Government Laboratories, Jerusalem. With 57 illustrations. New York: Dental Items of Interest Publishing Company, Inc., 1949.

CLINICAL NEUROLOGY. By BERNARD J. ALPERS, M.D., Sc.D. (Med.), Professor of Neurology, Jef-



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erson Medical College, Philadelphia; Neurologist to the Jefferson, Pennsylvania, and Wills Hospitals, Philadelphia. 240 illustrations. Second edition. Philadelphia: F. A. Davis Company, 1949. Price, \$9.50.

A TEXTBOOK OF PHYSIOLOGY. Originally by WILLIAM H. HOWELL, M.D. Edited by JOHN F. FULTON, M.D., Sterling Professor of Physiology, Yale University School of Medicine. Sixteenth edition. 1258 pages with 556 figures. Philadelphia: W. B. Saunders Company, 1949. Price, \$10.00.

A TEXTBOOK OF SURGERY. By American authors. Edited by FREDERICK CHRISTOPHER, B.S., M.D., F.A.C.S., Professor of Surgery, Northwestern University Medical School; Chief Surgeon, Evanston (Illinois) Hospital. Fifth edition. 1465 illustrations on 742 figures. Philadelphia: W. B. Saunders Company, 1949. Price, \$13.00.

MALARIA. The Biography of a Killer. By LEON J. WARSHAW, M.D. New York: Rinehart & Company, Inc., 1949. Price, \$3.75.

STEDMAN'S MEDICAL DICTIONARY. Edited by NORMAN BURKE TAYLOR, M.D., F.R.S.C., F.R.C.S. (Edin.), F.R.C.P. (Can.), M.R.C.S. (Lond.), University of Western Ontario, and formerly of the University of Toronto. In collaboration with ALLEN ELLSWORTH TAYLOR, D.S.O., M.A. Dictionary of words used in medicine with their derivations and pronunciation including dental, veterinary, chemical, botanical, electrical, life insurance, and other special terms; anatomical tables of titles in general use, the terms sanctioned by the Basle Anatomical Convention; the new British anatomical nomenclature; pharmaceutical preparations official in the U. S. and British Pharmacopoeias or contained in the National Formulary; and comprehensive lists of synonyms; biographical sketches of the principal figures in the history of medicine. Seventeenth revised edition with etymologic and orthographic rules. Baltimore: The Williams & Wilkins Company, 1949. Price: with thumb index \$8.50, without thumb index \$8.00.

MARIHUANA IN LATIN AMERICA — THE THREAT IT CONSTITUTES. By PABLO OSVALDO WOLFF, M.D., Ph.D., M.A., Buenos Aires, Argentina. Member of Expert Committee on Habit-Forming Drugs of the World Health Organization. Sponsored by Washington Institute of Medicine. Washington, D. C.: The Linacre Press, Inc., 1949. Price, \$1.50.

TEXTBOOK OF OPHTHALMOLOGY. By SIR W. STEWART DUKE-ELDER, K.C.V.O., M.A., D.Sc. (St. And.), Ph.D. (Lond.), M.D., Ch.B., F.R.C.S., Hon. D.Sc. (Northwestern), Surgeon Oculist to H.M. the King; Knight of Grace, Order of St. John; Consulting Ophthalmic Surgeon to the British Army and the Royal Air Force; Director of Research, Institute of

Ophthalmology, University of London; Fellow, University College, London; Consulting Surgeon, Moorfields Westminster and Central Eye Hospital; Ophthalmic Surgeon, St. George's Hospital, London. Volume IV, The Neurology of Vision Motor and Optical Anomalies. With 1081 illustrations, including 71 in color. St. Louis: The C. V. Mosby Company, 1949. Price, \$20.00.

EARLY CARCINOMA OF THE UTERINE CERVIX. Pathogenesis and Detection. Revised and augmented edition. By HANSJAKOB WESPI, M.D., Chief of the Obstetric and Gynecologic Department, Frauenfeld Hospital, Aarau, Switzerland. Translation by Marie Schiller, Ph.D. Foreword and survey by Walter Schiller, M.D., Pathologist to the Women and Children's Hospital, Chicago; Consultant Pathologist, Cuneo Memorial Hospital and Columbus Hospital, Chicago. New York: Grune & Stratton, Inc., 1949. Price, \$6.50.

MODERN PRACTICE IN PSYCHOLOGICAL MEDICINE, 1949. Edited by J. R. REES, M.D. New York: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers. Price, \$10.00.

TUBERCULOSIS IN HISTORY. From the 17th Century to Our Own Times. By PROF. S. LYLE CUMMINS, C.B., C.M.G., LL.D., M.D., Late Colonel, Army Medical Services; formerly Professor of Tuberculosis, Welsh National School of Medicine. With an introduction by Sir Arthur Salusbury Macnalty, K.C.B., M.D., F.R.C.P., F.R.C.S. Baltimore: The Williams & Wilkins Company, 1949. Price, \$4.50.

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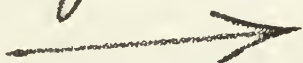
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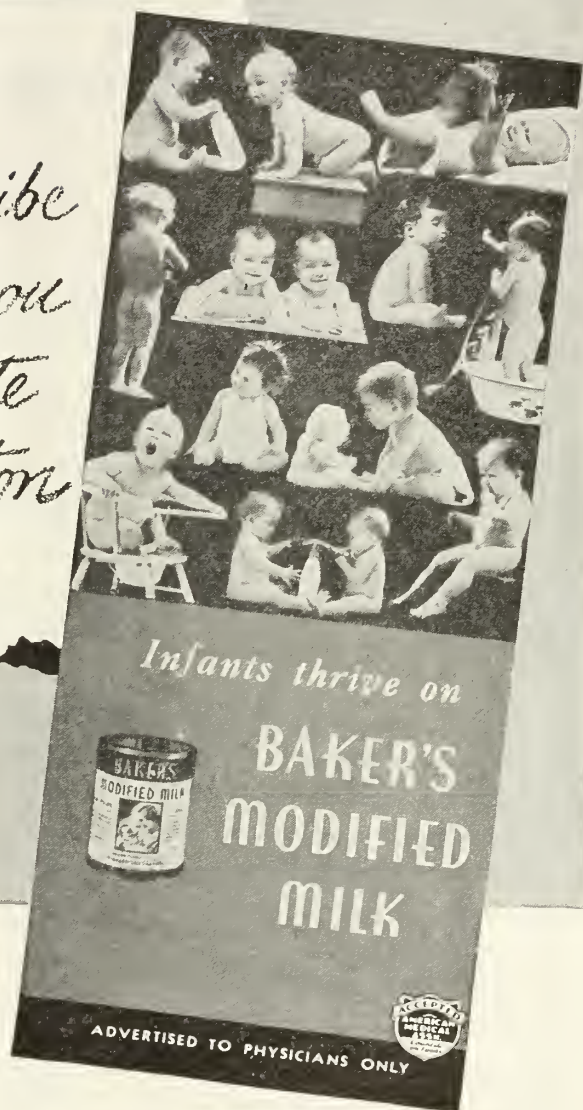
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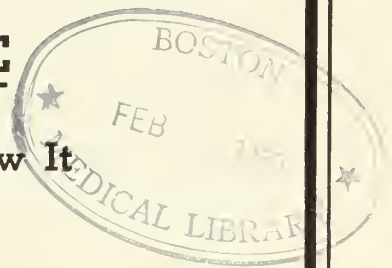
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¹ Flippin, H. F., and Bager, W. P.: Virginia M. Monthly 76:56 (1949).

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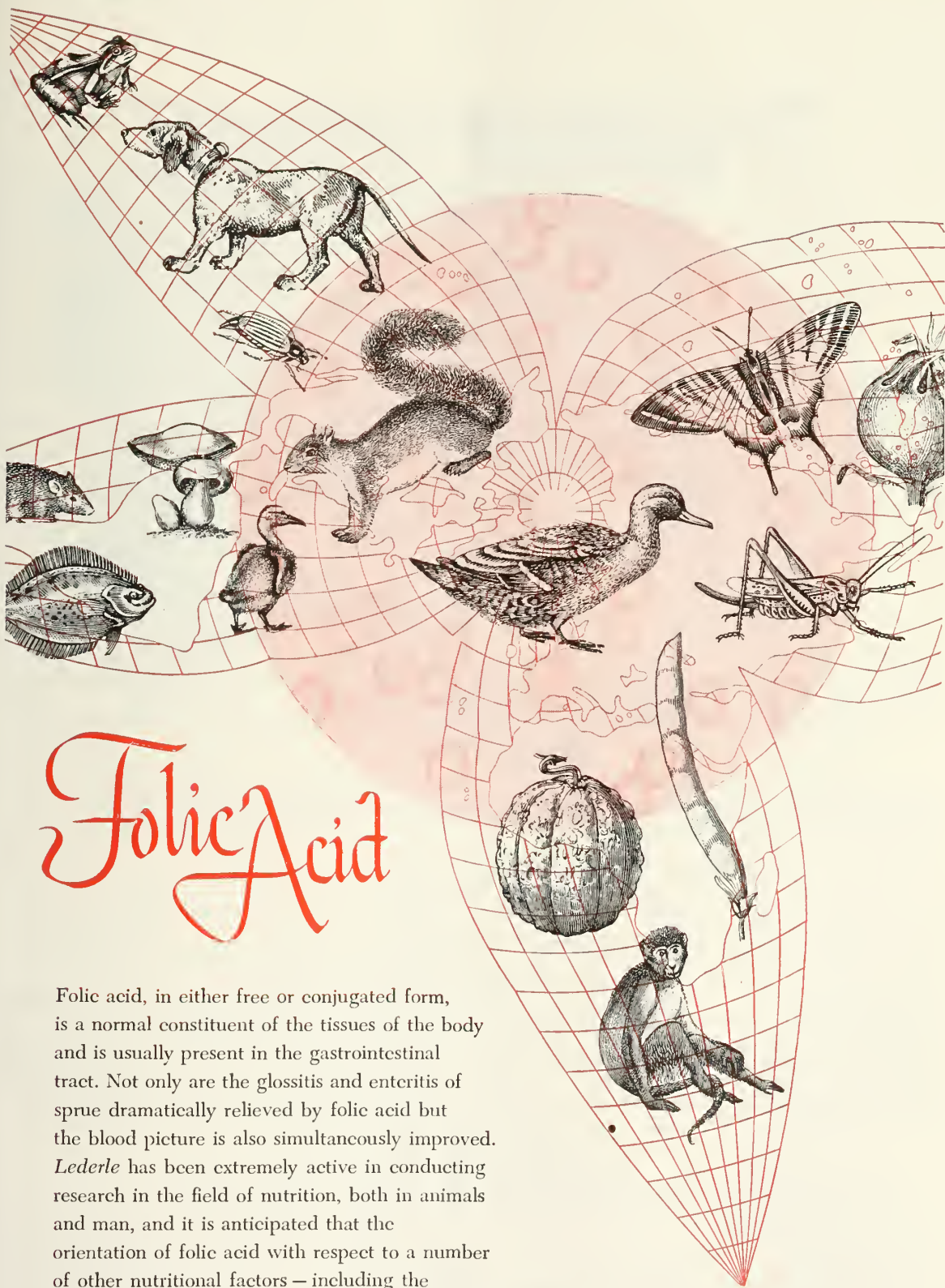
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Bedford	John A. Topper, Hyndman	Joseph A. Eyler, Bedford	Monthly
Berks	Archibald R. Judd, Hamburg	Clair G. Spangler, Reading	Monthly
Blair	Robert M. Keagy, Altoona	George R. Good, Altoona	Monthly*
Bradford	George E. Boyer, Troy	Stanley D. Conklin, Sayre	Monthly
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Butler	Charles B. Turnblacer, Butler	Joseph Van S. Donaldson, Butler	Monthly*
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McKean	Homer A. Wilson, Bradford	Persis Straight Robbins, Bradford	Monthly
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* Except July and August.

† Except June, July, and August.



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Folic acid, in either free or conjugated form, is a normal constituent of the tissues of the body and is usually present in the gastrointestinal tract. Not only are the glossitis and enteritis of sprue dramatically relieved by folic acid but the blood picture is also simultaneously improved. *Lederle* has been extremely active in conducting research in the field of nutrition, both in animals and man, and it is anticipated that the orientation of folic acid with respect to a number of other nutritional factors — including the anti-pernicious anemia factor and the animal protein factor — will soon be made clear.

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Adjusted doses of short-acting Nembutal can provide any degree of cerebral depression—from mild sedation to deep hypnosis. Dosage required is only about *one-half* that of many other barbiturates. Small dosage has several advantages: less drug to be inactivated, less possibility of "hangover," shorter duration of effect, greater safety and definite economy to the patient.

Short-acting Nembutal is available as Nembutal sodium, Nembutal calcium and Nembutal Elixir, all in easily administered small-dosage sizes. For the tab-indexed booklet, "44 Clinical Uses for Nembutal," write to ABBOTT LABORATORIES, NORTH CHICAGO, ILLINOIS.

In equal oral doses, no other barbiturate combines

QUICKER, BRIEFER,

MORE PROFOUND EFFECT than . . .

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(Pentobarbital, Abbott)

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Cardiovascular

Hypertension
Coronary disease
Angina
Decompensation
Peripheral vascular disease

Endocrine Disturbances

Hyperthyroid
Menopause

Nausea and Vomiting

Functional or organic disease
(acute gastrointestinal and emotional)
X-ray sickness
Pregnancy
Motion sickness

Gastrointestinal Disorders

Cordiospasm
Pylorospasm
Spasm of biliary tract
Spasm of colon
Peptic ulcer
Colitis
Biliary dyskinesia

Allergic Disorders

Irritability
To combat stimulation of
ephedrine alone, etc.

Irritability Associated With Infections

Restlessness and Irritability With Pain

Central Nervous System

Paralysis agitans
Chorea
Hysteria
Delirium tremens
Monia

Anticrampant

Traumatic
Tetanus
Strychnine
Eclampsia
Status epilepticus
Anesthesia

OBSTETRICAL

Nausea and Vomiting
Eclampsia
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Bosol Anesthesia
Postoperative Sedation

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Sedation for:
Special examinations
Blood transfusions
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fluids
Reactions to immunization
procedures
Minor surgery

Preoperative Sedation

LETTERS

A.M.A. Assessment

GENTLEMEN :

I am in my 84th year—not much longer to practice, but still feel that I must be loyal to my profession. Enclosed find my check covering the \$25 A.M.A. assessment.

Respectfully yours,

_____, M.D.
Pennsylvania.

GENTLEMEN :

You got me in a good mood today, so here it is (\$25 check for A.M.A. assessment). Hope the campaign will be effective, but I have my doubts. The politicians are riding high these days.

Sincerely yours,

_____, M.D.
Pennsylvania.

GENTLEMEN :

Please find enclosed check for \$15 to complete my A.M.A. membership assessment. I mailed you \$10 in April and am sincerely grateful for your kind understanding.

Sincerely yours,

_____, M.D.
Pennsylvania.

GENTLEMEN :

Enclosed is check for \$10 in partial payment of A.M.A. assessment. I do want to support the A.M.A.'s program, and regret that I cannot send the full amount at present, but will send more in the future.

_____, M.D.
Pennsylvania.

GENTLEMEN :

It gives me genuine pleasure to enclose herewith my check for \$25 to the great A.M.A. for their Fighting Educational Fund. They are doing a wonderful job for the physicians of this country and their patients.

Sincerely yours,

_____, M.D.
Pennsylvania.

Good Meeting

GENTLEMEN :

I would like to congratulate those responsible for the excellent manner in which the 1949 medical meeting in Pittsburgh was conducted. There was a very distinct improvement over the way the program was carried out two years ago.

As conducted the program enabled one to hear and to keep up with all the lectures. The papers were excellent and every doctor attending should have enjoyed the program.

_____, M.D.
Pennsylvania.

Van Meter Prize Award

GENTLEMEN :

The American Goiter Association again offers the Van Meter Prize Award of three hundred dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the association which will be held in Houston, Texas, March 9, 10, and 11, 1950, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten double-spaced copy in duplicate sent to the corresponding secretary, Dr. George C. Shivers, 100 East St. Vrain Street, Colorado Springs, Colorado, not later than Jan. 15, 1950. The committee which will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for presentation of the prize award essay by the author, if it is possible for him to attend. The essay will be published in the annual proceedings of the association.

GEORGE C. SHIVERS, M.D., *Corresponding Secretary*,
American Goiter Association.

Polio Costs

GENTLEMEN :

There have been many inquiries recently regarding the arrangements for covering the cost of care for poliomyelitis patients. There are a number of factors which will be of interest to your readers.

During 1949 a poliomyelitis incidence of unprecedented size (more than 37,000 stricken since January 1) has put serious financial strain upon the National Foundation for Infantile Paralysis. For the first time in its eleven-year history it was necessary to conduct a Polio Epidemic Emergency Drive, which although very helpful did not entirely meet current needs.

In its avowed purpose to lead, direct, and unify the national fight against infantile paralysis, the National Foundation undertook support of research and education, for in these areas lie the ultimate hope for eradication of poliomyelitis. These programs are not to be compromised in any way.

The greatest cost to the National Foundation, however, is payment for medical care to patients. It is urgent for all physicians to assist in the institution of measures which will reduce costs without prejudice to patients. The chief costs are for hospitalization. Many poliomyelitis patients are hospitalized when they can be cared for at home at a reduced cost.

Our experience in this year's epidemic, which has spared virtually no part of the country, suggests the following:

1. Abortive, non-paralytic and mildly paralytic poliomyelitis patients are being hospitalized because of the mistaken idea that the stated period of isolation must be spent in the hospital.

If she is one
of your patients



...Your help now may spell the difference between unprovided-for old age and economic security.

Women in business who are nervous, emotionally unstable and generally distressed by symptoms of the climacteric almost inevitably experience a reduction in efficiency as well as earning power.

"Premarin" offers a solution. Many thousand physicians prescribe this naturally-occurring, oral estrogen because...

1. Prompt symptomatic improvement usually follows therapy.
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3. The sense of well-being so frequently reported tends to quickly restore the patient's confidence and normal efficiency.
4. This "Plus" (the sense of well-being enjoyed by the patient) is conducive to a highly satisfactory patient-doctor relationship.
5. Four potencies provide flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg. and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).



While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens...estrodial, equilin, equilenin, hippulin...are probably also present in varying amounts as water-soluble conjugates.

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ESTROGENIC SUBSTANCES (WATER-SOLUBLE)
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COOK COUNTY GRADUATE SCHOOL OF MEDICINE

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technique, two weeks, starting January 23, February 20. Surgical Technique, Surgical Anatomy and Clinical Surgery, four weeks, starting February 6, March 6. Surgery of Colon and Rectum, one week, starting March 6. Esophageal Surgery, one week, starting June 5. Breast and Thyroid Surgery, one week, starting June 26. Thoracic Surgery, one week, starting June 12. Gallbladder Surgery, ten hours, starting June 19. Fractures and Traumatic Surgery, two weeks, starting April 17.

GYNECOLOGY—Intensive Course, two weeks, starting February 20. Vaginal Approach to Pelvic Surgery, one week, starting March 6.

OBSTETRICS—Intensive Course, two weeks, starting March 6.

PEDIATRICS—Intensive Course, two weeks, starting April 3.

MEDICINE—Intensive General Course, two weeks, starting April 24. Gastroscopy, two weeks, starting March 6.

DERMATOLOGY—Formal Course, two weeks, starting May 8. Informal Clinical Course every two weeks.

ROENTGENOLOGY—Diagnostic and Lecture Course first Monday of every month. Clinical Course third Monday of every month. X-Ray Therapy every two weeks.

UROLOGY—Intensive Course, two weeks, starting April 17. Cystoscopy, Ten Day Practical Course, every two weeks.

General, Intensive and Special Courses in all Branches of Medicine, Surgery and the Specialties

**TEACHING FACULTY—ATTENDING STAFF
OF COOK COUNTY HOSPITAL**

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For Nervous and Mild Mental Cases

**Restful, Quiet, Attractive Surroundings
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Diplomate in Psychiatry

2. Overly prolonged hospitalization is frequent. This is particularly true of the paralytic patient who has achieved maximum improvement from daily physical therapy. Home care with periodic office or clinic visits is then in order.

3. There still exists in some places a general attitude that poliomyelitis is a bizarre disease which only a few physicians can manage. This is not so. It is disturbing, for example, to find physicians leaning so heavily upon the guidance of physical therapists and nurses. The physician's assessment of the total patient is the best index in determining when a patient shall leave the hospital to receive home, office, or clinic care.

4. Patients hospitalized on general ward services are not charged medical fees ordinarily. When patients are hospitalized on isolation wards for poliomyelitis, however, bills for medical fees are at times submitted. Payment is frequently made by the local chapters of the National Foundation whose treasuries are now generally depleted.

It is hoped that your readers will understand clearly how urgent is our need for cooperation from all practicing physicians in the matters mentioned above.

HART E. VAN RIPER, M.D., *Medical Director,*
The National Foundation for Infantile
Paralysis, Inc.

TAXES ARE PRETTY HIGH, AREN'T THEY?

Following is the text of a small advertisement published in a Columbus newspaper by the Timken Roller Bearing Company, which tells a vital story in a few words and how necessary it is for Congress to put the brakes on spending sprees:

"Our company taxes are \$204,222 a week. Our company collects from employees \$86,673 in withholding tax a week. A total of \$290,895 for one week. Taxes are pretty high.—The Timken Roller Bearing Company. —Adv."

If you agree with the above, wouldn't it be a good idea for you to drop a note to your Congressman and let him know how you feel? If you think that's someone else's job, you're kidding yourself. Passing the buck to others is out of date.—*Ohio State Medical Journal.*

FOR PATIENTS WITH ALCOHOLIC PROBLEMS *The Baltimore Clinic*

A non-institutional arrangement in Baltimore, Maryland, for the individual psychological rehabilitation of a limited number of selected voluntary patients with ALCOHOL problems—both male and female—under the psychiatric direction of Robert V. Seliger, M.D., Fellow of the American Psychiatric Association.

City office:

2030 Park Ave.

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*Improved
Sulfonamide
Therapy...*



DIAMERZINE

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(BRAND OF SULFADIAZINE-SULFAMERAZINE COMBINED)

By presenting two of the most effective sulfonamide agents in a single dosage form, DIAMERZINE* tablets (quadrisectioned) offer definite advantages over single-sulfonamide therapy. Adequate antibacterial scope is provided, while smaller amounts of each drug may be given without diminution of total sulfonamide potency. Since the solubility of each drug is virtually unaffected by the presence of the other, the danger of crystalluria, concretment formation, and toxic reactions is greatly reduced. Sustained blood levels are rapidly secured.

Each quadrisectioned DIAMERZINE tablet contains:

Sulfadiazine.....0.25 Gm. (3.85 gr.)

Sulfamerazine.....0.25 Gm. (3.85 gr.)

SUPPLIED: Bottles of 100, 500, and 1,000 tablets.

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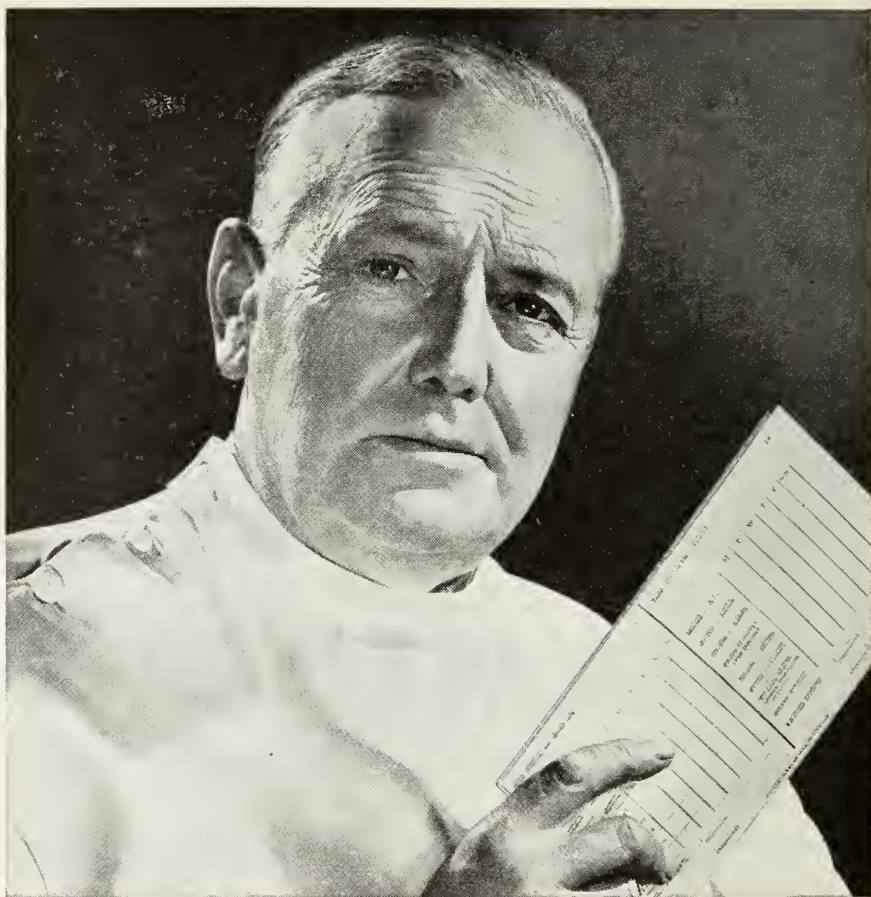
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*Throat Specialists
report on
30-Day Test of
Camel smokers—*

*"Not one single case of throat irritation
due to smoking **Camels!**"*

● Yes, these were the findings in a total of 2,470 weekly examinations of hundreds of men and women from coast to coast who smoked only Camels for 30 consecutive days! And the smokers in this test averaged one to two packages of Camels a day!



R.J. Reynolds
Tobacco Co.,
Winston-Salem,
N. C.

According to a Nationwide survey:

***More Doctors Smoke Camels**
than any other cigarette!*

Doctors smoke for pleasure, too! When three leading independent research organizations asked 113,597 doctors what cigarette they smoked, the brand named most was Camel!

THE PENNSYLVANIA MEDICAL JOURNAL

VOLUME 52

DECEMBER, 1949

NUMBER 15

SOCIALIZED MEDICINE AS I SAW IT

RALPH J. GAMPELL, M.D.
San Francisco, Calif.

I AM deeply appreciative of the honor you have paid me in inviting me to give you my experiences with socialized medicine as I saw it in Great Britain. You see, I was an intern nine years ago in Great Britain when I graduated and now I am an intern again in San Francisco. I can't be that bad. You are bound to finish your intern training in nine years!

What happened in the meantime? What is the background? What is the story? I should add at the beginning that I wouldn't presume to tell you ladies and gentlemen what you ought to do about your own affairs here in the United States. It would be both presumptuous and impertinent for a foreigner to come over here and tell you anything. You are all grown-up and over twenty-one and you can do what you like. But what I will tell you is what happened to me and what happened to my country, and if in places where I say "England" you make the mental alteration and put "America," you go ahead and do it, but don't say I said so!

I graduated in 1940 and I spent a year in hospital residence trying to learn my trade. Then I went into the Royal Air Force and I was kicking about in India and Burma and China up to 1946. I came back and was separated from the Air Force and I thought the least I could do for my future patients was to go back and learn some more medicine; so I went into a hospital to do some obstetrics because,

oddly enough, we don't have much obstetrics in the Royal Air Force.

When I finished my course in obstetrics, I went into general practice in Great Britain. It was a smallish town, quite small, of about 5000 souls. You can get a good idea of what sort of practice it was when I tell you that the vast majority of my patients were working in two coal mines and two cotton mills, and there was a small percentage of people who worked as fairly small farmers on the land. It was in every way a happy practice. I enjoyed life as much, I hope, as any hard-working doctor could.

Then came the National Health Service Act in 1946. That is the act of the British Parliament which instituted the National Health Service which was brought into operation in 1948. Now, this was put up to two referenda of the doctors. The British Medical Association said: "We, on a matter of this gravity, feel that we haven't the power, without a specific mandate, to decide a matter as serious as this to the future of medicine. We will put it up to our constituent members."

They put it up once and it was decisively rejected. The Minister of Health then made some very minor modifications, and it was put up again and it was decisively rejected; and so it came into operation.

Now, don't say "That is the British all over." It is no such thing. It came into operation as the result of one of the most elegant pieces of economic blackmail that it will ever be my good

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fortune to suffer. To tell you how that was, it is necessary to go back a bit to understand the method of medical practice in Great Britain before this scheme.

Over here, if you want to go into practice, you find a neighborhood which you think will support another doctor and you stick up your shingle, and you hope. That never was the method in Great Britain. We had the system of what was known as the buying and selling of the good-will of medical practices. I don't know why, but Britons by and large are very loyal to places. If they have always consulted Dr. Smith at such and such a place, even if Dr. Smith goes away and Dr. Jones comes, they will still keep on going there. That, I understand, is almost unknown in the United States.

As a result, the good-will of your medical practice was a salable commodity. In fact, when you went into practice in Great Britain, you bought the good-will of a man who retired. He introduced you to his patients and you both hoped the work that had been done by him would then be done by you. It may sound like an odd system, but that was a system hallowed by many years of custom.

Now, this was a very important commodity. For example, the practice I went into was grossing about \$8,000 a year, which for England is a lot of money. The value of that practice, to purchase it, was about \$12,000. I don't know how much money you made in the U. S. Army Air Force, but in the Royal Air Force you didn't make any \$12,000. The British Medical Association had a scheme by which you could go along to one of the big banks who looked at your face to see if it was honest, and if they thought it was, they lent you the money, the whole \$12,000, and you tied yourself up in shackles for the rest of your life! You know the way banks are. (I hope there aren't any bankers here tonight!)

You repaid the money actually over a matter of ten years, and you insured your life and gave the practice as security and sold your soul, and so on; but in fact it worked out very well. Lots of young men, the vast majority of young men in Great Britain, made their start that way. They borrowed the money; they went into practice; they worked like beavers for ten or fifteen years to pay off their indebtedness, and at the end of that time they were their own masters with no debt.

Came the National Health Service Act and it declared that the buying and selling of the good-will of practices was illegal—as simple as that. That meant that I, for example, a young man,

had \$12,000 tied up in my practice, not even my own money at that, and nobody to whom I could sell it; so I had lost \$12,000.

But, the Government, always being magnanimous, said, "No, of course, we don't mean to do that at all. We will appropriate a sum of \$260,000,000 from the general appropriation and that will be used as compensation for doctors. If you have lost so much money because you can't sell your practice, we will give you that money so you won't lose anything at all. But, of course, there is a small proviso. You must join the National Health Service on or before the appointed day."

It was as simple as that.

Up to July 4 the doctors protested and complained and said they would have no part of it. July 4, midnight, was the final time for joining. We all joined, because if we hadn't, we would have been made bankrupt. It was just as simple as that.

After July 5 the Minister of Health was able to go before Parliament and say that over 90 per cent of the doctors had already joined and more were to come. And now the figure is even higher than that. It is an elegant commentary on the way that a government can work against a profession when it uses all its resources. It was a perfectly simple financial proposition, but the sad part was that the people who were being ground down were the doctors. If you had enough money not to bother about \$12,000, you could keep out; but if you were just an ordinary doctor, like the British doctors, you joined. That is how the National Health Service came into being.

I don't want to weary you about this sum of money; but it is important, because over here a lot of people say, "The British doctors wanted it; now that they have it, what are they complaining about?"

The fact is they didn't want it; they decisively rejected it on two occasions, but they were coerced into it by forces far greater than themselves—the fact that they had wives and families, children to bring up.

So it came into operation July 5, 1948. By all the resources that the Government had of posters and radio and newspapers, the population was urged to cease being private patients and to join in the National Health Service. That wasn't very difficult, because people said, "Look, we have to pay this money anyway; we might as well get the benefits."

They were told to pick up white cards from the post office, fill them in, hand them to their doctor, and they were in the service. From then

on, the medical millennium would dawn. There were to be no further charges; it was all for free. The new day was here.

Well, they flocked to doctors. I had the delightful chore of filling in some 1400 or 1500 of these forms laboriously with my name on the back with a code number and my address and some other numerals. I remember it as such a wearisome chore that I telephoned this new body that was administering the scheme and said, "Can I use a rubber stamp?" "No," they said, "you can't."

I should add that several weeks after all the signing was done and all the forms were in there filtered down through the channels the information that a rubber stamp could be used. I thought to myself: "This is where I came in. I see the delicate hand of the Royal Air Force in this. This is the way it used to be when I was in the service."

Anyway, the people brought along these forms to the doctors and, once they were registered with a doctor, he was responsible for them. As a general practitioner I was responsible for the full range of general practitioner services, day and night, Sundays, Christmas, and during vacations; 365 days in the year I was responsible for those patients. That is fair enough.

The government gave a most magnanimous reward. For each patient who was registered with me, I received the sum of \$3.40 per year. It is not a lot of money; but they didn't want me to be reduced to penury, so they said, "Since we can only pay so little per patient, you can have a lot of patients." And they fixed a maximum number that one general practitioner could have. That figure, believe it or not, is 4000.

Now, I don't want you to think that I left my practice because I couldn't make a success of it. I probably look old, but at that time I was only thirty-two. I had registered with me 3200 patients, which means that when I got another 800, which wouldn't have been at all difficult, I would have hit the jackpot.

I could expect that within a year or two I would have reached the summit of medical ambition as a general practitioner and I would be earning 4000 times \$3.40, out of which I would have to pay all my own expenses, income tax, etc.

I have been asked over here, "What do you do about a secretary? What do you do about a nurse?" The answer is, of course, in that sort of deal you don't have any secretary; you don't have any nurse. You are your own secretary and you are your own nurse. It doesn't make

for the best sort of medical practice, but that was the way the government wanted it—a maximum of 4000 patients and \$3.40 per patient per year.

I told you that all the population was urged to register. At one fell swoop, 95 per cent registered. Now, how did I manage my 3200 souls? I used to do three office hours a day and I can say that many a day I saw an average of twenty people each hour. I assure you that I make no boast of this; it is nothing at all to be proud of. I have made thirty-six house calls in one day in addition to the office periods. You don't do a great deal for the people when you make thirty-six house visits in a day, but it takes time, even in going into the houses, going up the stairs, and laying a hand on to take the pulse.

What do the patients think about this sort of deal—three-minute medicine, thirty-six house calls a day? I regret, and I think it is probably to the shame of British medicine, that the vast majority of patients in Great Britain think it is wonderful. They have the impression that they need only to go to their doctor and keep on sitting and everything will come to them. They have been indoctrinated into believing that they don't need examinations when they are sick; what they need is a bottle of medicine. It is almost the fetish of the top shirt button. When they go to see a doctor, by and large, they don't like undressing. They undo the top button and the doctor puts his stethoscope on the windpipe and says, "Yes, Mr. Jones, your bronchitis is a great deal worse this morning."

I know most of you will think that I am exaggerating, but the doctors among you know that that is not so, because, in three-minute medicine that is all one can do. There is only time to fill in the patient's name on the top of the official prescription form and sign your name and the date on the bottom and fill in a standard formulary and the time is up. If that patient is given any more time, then either somebody else is going without attention or you are going to work on and on and pile up your visits because you are giving somebody more than their ration of time.

That is the sort of medicine that is being given—the quick sort, bottle-of-medicine type—because, you see, the one thing that you don't have enough of in this system is time. A patient can't have any of his doctor's time because he hasn't any to give.

How does the doctor get out of the mess? Let me take the example of a common enough thing—the man with a persistent cough. He comes into your office once and you examine him as much or as little as you think you will get away

with and you give him a cough mixture. He comes in the second time complaining of the same sort of cough and you change the cough mixture to another one. He comes in the third time and you say, "Oh, well, Mr. So-and-so, I think we had better get you investigated." That means you write a letter for him to the nearest hospital and you make an appointment for him to see a consultant. I assure you that this is not because you believe that he has need of consultation but because you *have* to get rid of him since he is taking up precious time.

You make an appointment with a consultant and in the district where I was, if you wanted to see a consultant in internal medicine, at the time I left the country, it took approximately eight weeks to get that appointment. At the end of the eight weeks the patient would go to the clinic at the hospital and there the consultant was faced with exactly the same problem. He was snowed under by a mass of unnecessarily referred cases. The important cases are buried under the morass of those that aren't important. So what does he do? He tries to take his way out—which is the laboratory—to get the investigations done and the x-rays taken, because he hopes at the end that the diagnosis will be given to him all wrapped up. He simply does not have time to take a careful history, make a careful physical examination, and perform other investigations which would be justified.

Now you know that taken by and large, if the patient lives long enough, you have a good chance of getting a result at the end of this, but it is a costly and vastly improper and cumbersome form of medical practice. It is the sort in which no self-respecting practitioner will have any part if he can see any other way out.

The hospitals are overloaded and the general practitioners are overloaded. I am going to quote you a figure which I am quite positive none of you will believe, but I am equally positive in telling you that it is a fact. The hospital that served the district where I was practicing had a waiting period for elective gynecologic procedures of no less than three years. Now they are not important conditions unless you happen to have one. If you are the person who is waiting for the "gyn" procedure, it is desperately important to you, and yet the waiting period for those procedures was three years.

As you see, the heat is taken off the general practitioner, but it is put onto the hospital. It is all a great mass of unnecessarily referred work.

What is it like working for a bureaucracy? You know the supposition is that working for

a government is sort of vaguely paternalistic. The government hidden away in Whitehall—that is the English Washington—is presumed to look after all our interests and I suppose in a theoretical and broad way that is true, but when you are dealing intimately with a department of government, you find it irritable and irritating, niggling, and bound up in red tape. I told you the story about the rubber stamp. It could be repeated one hundredfold by others. The great thing, you know, that keeps a scheme like this running is the forms, the paper work. If you come to your doctor's office with the right forms, you can have almost anything.

What can you get? You can get drugs and medicines, pills, tablets, dentures, and toupees. The Minister of Health, very rightly, says that you can have two toupees because it is a fact that at times one toupee would have to be cleaned. You can have spectacles. You can't have a monocle because the Act of Parliament specifies spectacles and does not specify monocles. I was reading in the medical press that some wretched woman wanted a monocle, and it was cheaper than spectacles, but she had to have spectacles because the Act said spectacles. You can have spectacles, toupees, surgical corsets, and the things that you wear higher up, which I won't go into. You can have dentures and hearing aids. Those are things that you can get officially; but over and above that are the mass of forms that the government has pushed onto you. If anything is in short supply, get a form from your doctor.

I filled in forms to get patients new houses on priority, vacuum flasks, malted milk, hot water bottles, for keeping children away from school, for priority milk, for priority eggs, for priority soap, and a host more. My table—and it was a big one—was covered with forms. I must be one of the best form-fillers in the United States. I don't know if any of you have a job for a good form-filler, but I really must be one of the best ones and I hope some day to put that doubtful acquisition to good use here when I am in practice. But I really can—I can fill out an elegant form. If you can fill out forms and write letters, and if you can deal with people quickly, get rid of them, and keep them from cluttering up your waiting room and office, you can't fail. Like me, you can have about 3200 patients and you can be a brilliant success.

Now, what about the cost? It was estimated that this scheme could be paid for by a withholding tax and everybody who is in work in Great Britain pays a withholding tax of approximately one dollar. I am talking now of

the good days before last week when there were four of them to the pound. I can't work it out now; all I know is that it is altered! But, in those days, you paid about a dollar a week and your employer paid about ninety-eight cents. It was said that those two sums of money together would run the medical service, provided the pump was primed by about 520 million dollars a year from the general appropriation. Fine! Well, they had to come to Parliament for more money at the end of the eighth month; the 520 million dollars had run out.

The sum of money they had appropriated for spectacles they overspent by no less than 600 per cent. That, I think, must be the best example of bureaucratic bad planning in history—to make an estimate and to be no less than 600 per cent wrong.

Anyway, the scheme now, they estimate, will cost something in the order of one thousand million dollars. It was going to cost about six hundred million dollars, and it will cost nearer double that each year.

Of course, the problem is this: the sort of medical care that they have been given in Great Britain, the free medicine in Great Britain, would be unthinkable here. If the doctors over here started doing that, the patients would come and break their windows. They just wouldn't have it. The sort of medicine I see practiced in San Francisco at the hospital I am at and the sort of medicine I was practicing in Great Britain are just not the same thing.

And, of course, all this bureaucracy is bound up in the fact that the National Health Service derives from the power vested in the Minister of Health and delegated by him to various nominated boards. As a physician, I bitterly resented the fact that I had to seek permission from such a body to practice in the Service, that

certain areas of the country were completely closed if I wished so to move, that I could be removed from practicing in the National Health Service by a tribunal with minority medical membership, nominated by the Minister, and that from the decision of such a tribunal, I would have no appeal to the judiciary. In England, there has always been an excellent medical discipline by means of a General Medical Council, with the most rigorous disciplinary power exercised in all cases of malpractice and unprofessional conduct. It becomes increasingly difficult to determine why it was necessary to set up a politically appointed tribunal and why the Minister was adamant in refusing any appeal to the courts. One is, of course, left to draw one's own conclusions.

I decided that I had enough. I had had enough of bureaucratic medicine—the red-tape medicine and the three-minute assembly line consultations, the twenty patients in an hour, and the thirty-six house calls. I broke my ties. I brought my wife and small baby over here to the United States; but, believe me, ladies and gentlemen, it isn't an easy decision to make. I would do it again tomorrow, but it still isn't easy. The ties of home, friends, and alumni and your school and medical school are very strong; they are not easily broken. It is not an easy thing to come to a new country and start off from less than the bottom without even a license or permission to practice. That isn't easy at all. Yet I told you—and I say it in truth—that I would do it again tomorrow.

As a closing thought I would say this to you: I had hopes and ambitions and I have them now. I hope that no doctor of my age, my sort of background, over here will ever be placed in the same kind of position and have to make the same type of decision.

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Problems in Treatment of Diabetes Mellitus

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MOST of the diabetic problems encountered in clinical practice can be dismissed readily, in this discussion at least, with the comment that they are common knowledge and that nothing new or controversial has changed their treatment recently. I will review them briefly in preface to my main subject.

Forty to 50 per cent of all uncomplicated diabetes is so mild that good control can be obtained by simple diet restriction. In these cases the advantages of perfect control and weight reduction are often overlooked. Reduction of the glycosuria to a moderate level and abolition of diabetic symptoms are only the beginning of good treatment. Good chemical control, as indicated by approximately normal blood and urine sugar levels, is highly desirable in addition, because diabetes can be prevented from becoming more severe and infectious and probably also vascular complications can be delayed or prevented thereby. Reduction of the body weight is also important in many of these persons with mild forms of the disease.

About one-half of the remainder of the diabetic population, or about one-quarter of the total, can be managed well by a moderately restricted diet together with small or moderate doses of almost any type of insulin. In these, good chemical control and maintenance of the body weight at or a little below ideal are also advantageous for the same reasons. The treatment of these two common types of diabetes requires little elaboration and will not be discussed further on this occasion.

It is my intention here to take up several diabetic problems of a less common, more difficult, and in some respects controversial, nature. Specifically, I should like to discuss the problems in-

involved in treatment of severe and "brittle" diabetes, where details of insulin timing are of great practical importance; the problem of treatment of diabetes during infections and surgical complications; the question of pregnancy in diabetes; and the effect of good control of diabetes on the increasingly important vascular complications which are so difficult to manage.

Severe and "Brittle" or Labile Diabetes

A brief review of the timing characteristics of various insulins will help to provide insight into effective management of this group of diabetic patients. Fig. 1 shows the average timing characteristics of single large doses of three standard preparations, ordinary or regular insulin (solution of amorphous insulin), crystalline insulin (solution of zinc insulin crystals), and protamine zinc insulin. These represent the extremes in action of various preparations now available for treatment, ranging from the prompt, intense but brief action of the ordinary solutions of the hormone at one extreme to the slow, weak but sustained action of the most insoluble form of "depot" insulin available, protamine zinc insulin. On account of these timing characteristics regular and crystalline insulin are most useful in emergencies where intense action is required promptly. They must be injected several times daily to provide good coverage, of course, which is their chief disadvantage in routine treatment. They have therefore been largely replaced by depot insulins with more sustained effect. Protamine insulin is the best known of these. It never needs to be given more often than once daily before breakfast.

Because of its slow and sustained effect, on the other hand, protamine insulin often fails to provide good control in severe diabetes. In dosages large enough to stop glycosuria after meals it is likely to cause violent insulin shock during hours of fasting, especially during sleep. Or if the dosage is reduced to a level where this does not happen, waves of heavy glycosuria are likely to follow meals. The intermediate insulin preparations are most useful in these situations. Their time action, in large single doses, is illustrated

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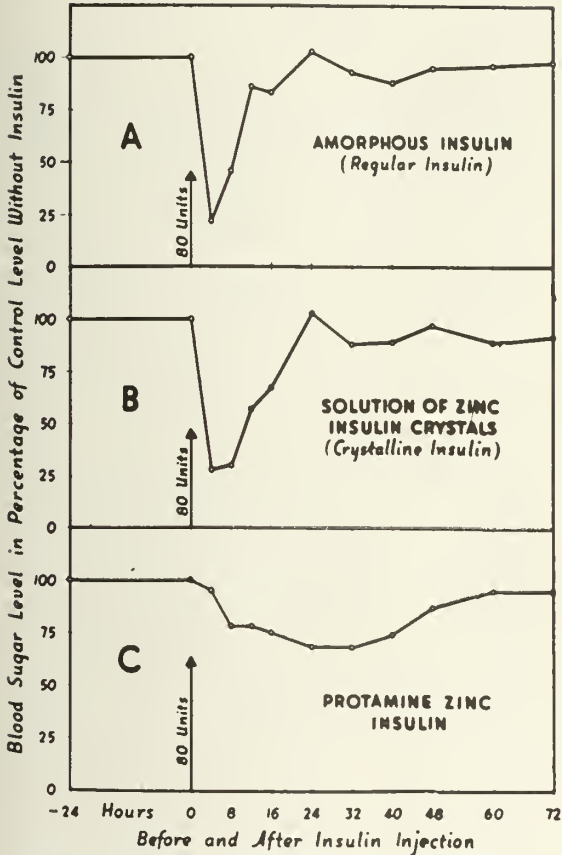


Fig. 1. Time-action of single large doses of regular, crystalline, and protamine zinc insulin in diabetes of moderate severity.

in Fig. 2, in contrast with that of the more common insulins shown previously. Mixtures containing two to three times as much regular or crystalline as protamine insulin, and globin insulin are very similar in the intensity and duration of their action. They are clearly intermediate between the unmodified and protamine insulins in all respects, with peaks of action during the feeding hours of the day, when injected before breakfast, waning of effect near the end of the 24-hour period during the night, and yet with sustained effect sufficiently heavy to carry the entire 24-hour period and overlap the next morning's dose.

These intermediate insulin modifications are most effective in severe diabetes when sudden shifts in sugar balance occur with ordinary techniques, when protamine insulin requires supplementation with regular insulin by separate injection, or when it allows glycosuria to follow meals and tends to cause hypoglycemia during the night. Good control and better health can often be gained with less inconvenience and danger to the patient by substituting one of them for protamine insulin or other insulins given by multiple daily injection.

There is not much choice between globin insulin and the protamine insulin mixtures. The most suitable one must be selected by trial and error in the individual case. Mixtures may be made in the empty ampule and must be completely mixed before using. They are stable enough for practical purposes. They should contain excesses of regular or crystalline insulin, ordinarily about twice as much as protamine insulin, and occasionally as much as three times as much. Globin insulin behaves nearly the same as a 2:1 mixture. The indication for more or less insulin in one of the mixtures is seen in the behavior of the late afternoon and evening sugar levels after injection in the morning, and the indications for more or less protamine insulin in a mixture are the sugar levels before and after breakfast. A 2:1 mixture and globin insulin will fit the needs of a majority of the cases with severe diabetes very well.

A good many young (and some older) patients with diabetes of long standing exhibit a pattern which defies almost all attempts at perfect control of glycosuria without insulin shock. On ordinary programs of management they behave unpredictably. A constant diet and insulin

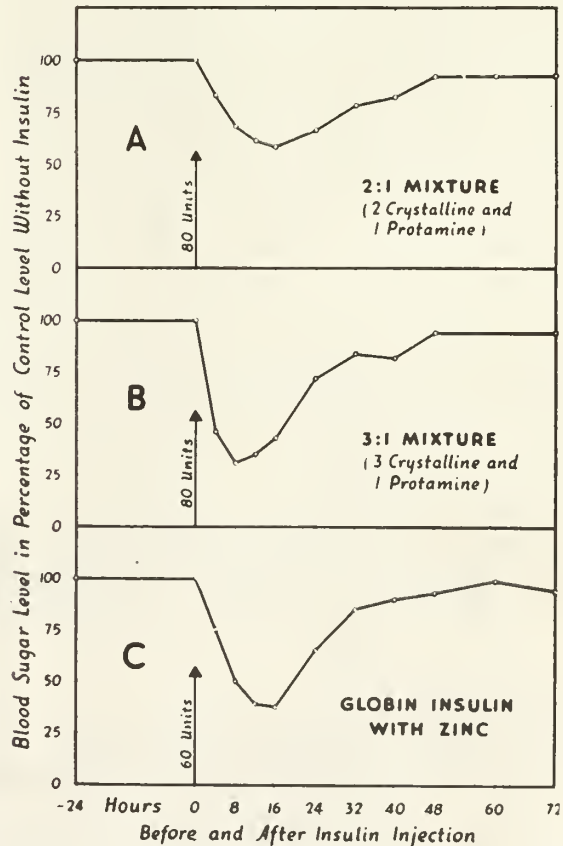


Fig. 2. Time-action of single large doses of protamine insulin mixtures and of globin insulin in diabetes of moderate severity.

régime permits sudden and unexpected shifts in glycemia from one extreme to the other for no apparent reason. These patients accept large waves of glycosuria alternating with severe insulin reactions with resignation and concern. Their number is increasing because of the lengthened life and greater duration of diabetes in young people with the disease.

A satisfactory balance is difficult to secure for these patients and is sometimes impossible. Ordinarily some degree of glycosuria must be accepted as the lesser of two evils, the other being frequent insulin shock. Compromise with ordinary standards of control is inevitable in some cases. The most satisfactory criteria for treatment involve: first, maintenance of normal nutrition; second, freedom from diabetic symptoms and all ketonuria; third, elimination of severe reactions from insulin; and finally, as little glycosuria as possible without great inconvenience in the diet or insulin routine.

The most satisfactory management of diabetes of this intensity compromises between convenience and perfect control. It involves the use of one of the intermediate insulins twice daily. Fig. 3 shows the improved control secured in one brittle case when this technique was substituted for one larger dose given once daily.

Specifically the method requires that the total daily insulin dose be divided into a larger dose (from two-thirds to three-fourths of the total) before breakfast and a smaller dose (from one-third to one-fourth of the total) at bedtime, along with a small lunch. Shifts in balance are minimized by this method. Slightly smaller amounts of insulin are needed, probably because of greater efficiency. The exact timing of the

insulin is not important provided one of the intermediate modifications is used. The effect of the morning dose is judged by the sugar levels in the late afternoon and evening; of the night dose by the levels before and after breakfast. Redistribution of food often improves the results after uniform patterns of insulin are apparent.

Acute Complications: Emergency Treatment

The most effective treatment of diabetes mellitus during acute complications differs radically from that applied routinely. The reason for this is that haste is essential. Acute illness puts sugar metabolism out of control; this, in turn, aggravates the illness, which again affects the diabetes adversely. This effect is illustrated clearly in Fig. 4. The vicious cycle thus initiated by acute disease cannot ordinarily be treated aggressively by routine methods involving diet adjustment and slow-acting insulins. Special methods must be applied which depend primarily on the use of ordinary insulin at frequent intervals.

Acute diseases which most frequently demand vigorous treatment by quickly effective methods are acidosis, acute infection, surgical interference, and trauma. All of these except severe forms of acidosis can be managed easily by a rational method of using ordinary insulin. The treatment of precomatose and comatose states requires much more aggressive methods which cannot be described here.

When heavy glycosuria, with or without ketonuria, exists as a result of any acute illness, it can be eliminated within 24 hours, as a rule, by judicious adjunctive use of ordinary insulin at six-hour intervals, together with six-hour tests and feedings of uniform size (Fig. 5).

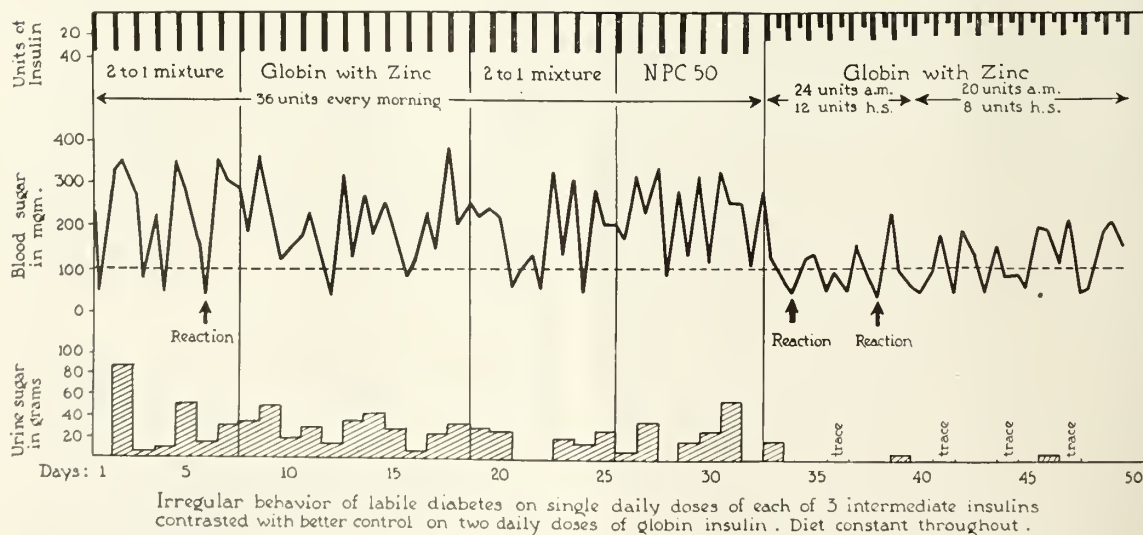


Fig. 3.

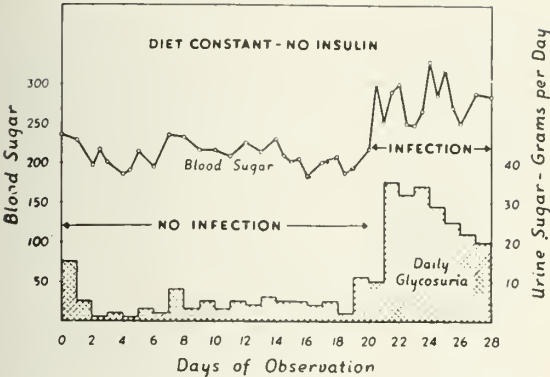


Fig. 4. Intensification of glycosuria and hyperglycemia in diabetes by mild infection (acute cystitis).

Every six hours the patient should receive 40 grams of carbohydrate by mouth or by injection, depending upon the alimentary capacity. This should be given during the night as well as the day. The uniformity of this sugar supply eliminates the food from consideration as a possible variable affecting the glycosuria.

Every six hours a dose of ordinary insulin is injected. The size of this dose depends on the intensity of the complicating illness as well as the severity of the diabetes and the degree of insulin sensitivity. Except in severe acidosis, 10 to 40 units every six hours will usually suffice.

The size of each insulin dose is judged according to the observed effects of previous amounts in the same patient under the same conditions. A simple urine test (preferably on a short collection near the end of each six-hour period) demonstrates the effect of insulin given previously. As long as heavy glycosuria exists, the dosage should be increased. Clearing of the sugar calls for caution, but does not indicate omission nor necessarily reduction of the next six-hour dose. Symptoms of insulin reaction or subnormal blood sugar values call for reduction but not necessarily omission of the next six-hour dose. Within 48 hours, as a rule, a constant six-hour dosage can be established which neither permits much glycosuria nor causes any hypoglycemia even when given repeatedly. On improvement in the patient's general condition the total 24-hour dosage can be replaced with a single large dose of one of the depot insulins and a diet of three meals served at customary intervals instead of four meals at six-hour intervals.

Pregnancy in Diabetes

More and more young diabetic women are becoming pregnant as a result of their better health and longer life spans due to insulin. Dr. Priscilla White, of Boston, has now observed some 400 cases and has been able to formulate rules of

management which should be observed by others until some equally impressive experience reveals better ones. A summary of her experience, as confirmed in our clinic and others, in smaller groups of cases, is as follows:

Pregnancy is somewhat less likely to occur and more likely to be interrupted spontaneously than in normal women. It does often proceed to term, however, and then requires special therapeutic precautions. It should be allowed to do so unless one of these contraindications exists: (1) strong diabetic tendencies on both sides of the family; (2) incompetent or uncooperative management of the diabetes, which is often severe and difficult, on the part of the patient or the physician in charge; (3) history of toxemia in any previous pregnancy; (4) stigmata of retinal, renal, hypertensive, or vascular disease prior to or during the pregnancy; (5) any other contraindication applicable to non-diabetic women. In addition, attainment of age 30 or diabetes of more than fifteen years' duration is often considered reason for interference. If the pregnancy is justifiably interrupted, it is ordinarily wise to sterilize the patient at the same time.

A pregnancy allowed to proceed should be treated with large doses of stilbestrol and progesterone unless sex hormone assays prove the individual to be normal. A large percentage of diabetic women have been found to be deficient in the estrogens: so where bio-assay methods are not available, it seems wise to give all estrogens routinely. Fetal survival rates have been almost doubled and the incidence of toxemias reduced radically by this procedure.

White advises increasing the daily dosage of stilbestrol and progesterone each to 30 to 50

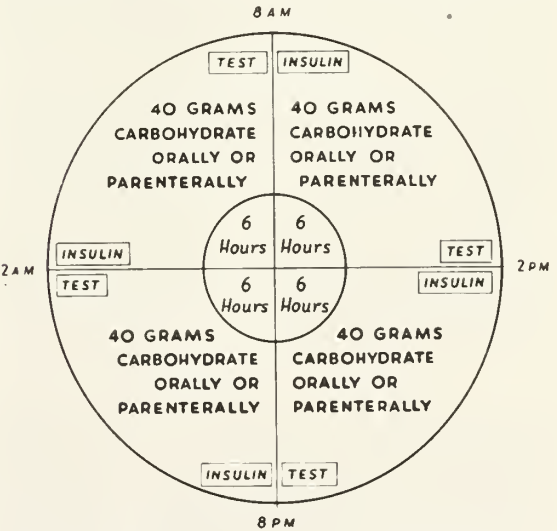


Fig. 5. Diagrammatic representation of six-hour emergency method of controlling diabetes during acute complications.

mg. daily during the pregnancy. Pregnant women tolerate it exceedingly well and it appears to do no harm to those who do not need it. The improved maternal morbidity and fetal mortality rates reported by White appear to justify this additional trouble and expense. In a smaller series of cases we can confirm them approximately.

Delivery should be accomplished two or three weeks before term on account of the frequent large size of the baby and the high stillbirth rate when allowed to proceed to term. Cesarean section is advocated because of the size of the baby and the difficulty in controlling the diabetes during prolonged labor and anesthesia. Induction of spontaneous labor is often successful, even so. Sedatives and anoxia should be spared as much as possible because of the frequent occurrence of respiratory difficulty and atelectasis of puzzling and even fatal character in the newborn baby. Hypoglycemic manifestations should be sought in the baby and glucose given on the slightest suspicion.

Management of the diabetes during pregnancy, at delivery, and during lactation differs from that outside of pregnancy only in a few respects, which are minor. The food allowance ordinarily must be increased in the last trimester and during lactation. Most often the insulin must be increased, sometimes radically, during pregnancy. When it does, it usually must be decreased rapidly immediately after delivery. Occasionally little change is necessary and it is not often possible to reduce it much during pregnancy.

The strong natural tendency to renal glycosuria in any pregnancy may lead to insulin shock if the urine sugar is used as the sole criterion for increasing insulin dosage near term. Blood sugar checks are indispensable to avoid confusion.

During anesthesia and delivery the diabetes must be managed with frequent injections of regular insulin as appropriate for any surgical episode.

Intelligent application of these rules now has made pregnancy almost as safe and successful as in non-diabetic women, provided none of the contraindications discussed previously is present.

Desirability of Good Control

Among the perplexing problems involved in modern treatment of diabetes mellitus, perhaps the most prominent one is the question of the origin of the vascular complications. The retinopathy, coronary disease, renal and hypertensive complications, and peripheral arterial oc-

clusive processes are so common, so unsatisfactory to treat, and so difficult to avoid that many of the benefits of insulin seem to be canceled by them as diabetics live longer with their disorder. The actual cause of these conditions is unknown. Their apparent progressiveness in spite of good control of the carbohydrate metabolism has led to great controversy over the benefits of good control, and much freedom in treatment has been encouraged on this account.

I should like to insert a plea for good control in an effort to help counteract the common current trend to treat diabetes the easy way because its complications are difficult to understand and avoid.

First and most important is the question of time. It seems elementary to point out that diabetes which is controlled well enough for a long enough period of time might result in far fewer vascular complications than if it were managed well intermittently or only for short periods of time. The fact, often pointed out by advocates of loose control, that many diabetic patients feel well and appear to be in just as good health in spite of persistently heavy glycosuria as those on more restricted programs fails to answer the question of the results of such treatment over long periods of time. The immediate benefits of insulin could be great enough to mask the early signs of degenerative complications caused by poor control of glycosuria and hyperglycemia. An entire generation of life and careful comparisons between well-controlled and poorly controlled groups of cases will be necessary to settle the controversy. The burden of proof is on the shoulders of the poor control enthusiasts to produce this evidence rather than on those who attempt to maintain normal conditions until proof that it is unnecessary is available. No such evidence has yet been produced.

Second, there is the obvious fact that even those who attempt to maintain perfect and meticulous control of sugar metabolism often are unable to do so consistently. This inconsistency may well be the reason why many conscientious diabetics appear to develop the same vascular complications as those who are not controlled so well.

Third, evidence is beginning to accumulate that good control may in fact be very important as a factor in preventing vascular disease. Jackson, of Iowa City, and his colleagues have reported convincing evidence showing progression in retinal and renal lesions with poor control and improvement with better treatment. They have an exceptionally fine opportunity to gather such evidence and have findings in addition to

those already reported to indicate that this is true. Examples of it are observed by every careful clinician who watches his diabetes cases studiously. Lukens' dog with pituitary diabetes which developed typical lesions of intercapillary glomerulosclerosis after five years of glycosuria provides much food for thought. Other experimental evidence is in the making.

Again, even though it should be granted that vascular disease is not related to good control of sugar metabolism, there are other reasons for maintaining normal conditions whenever possible. The undesirable influence of hyperglycemia and glycosuria on tolerance for sugar is common knowledge among those who see much diabetes and treat it well in its early stages. The improvement and even occasional disappearance of diabetes with good control and loss of excess weight is too striking to ignore. Both phenomena have been reproduced experimentally in various ways. The effect of good control on infection in the diabetic is also too obvious to require amplification. Insofar as infection so frequently complicates gangrene of the extremities the fact is pertinent in the vascular disease controversy.

THE PHYSICIAN'S SECRETARY

Never underestimate the power of a woman. When it comes to the importance of an efficient secretary to the average busy physician, a great deal can be said for the record.

In the saving of his time alone a capable medical secretary can contribute considerably to her employer. The methodical arrangement of office and hospital appointments and house calls will permit the physician to devote his energies most effectively to the many obligations on his time. Another contribution which the secretary can make is that of bringing to the doctor's attention matters requiring his immediate attention and relegating to the bottom of the pile the trivial things which can be disposed of at a later date. Such matters as important medical meetings and medical articles in the medical journals, particularly *Philadelphia Medicine*, and even medical articles in the public press should demand the interest of the secretary so that her "boss" can be alerted on those items in which he should be interested.

In the field of public relations, the secretary can play a very significant part. The personal relationship between physician and patient can be aided materially by the friendly interest in the patient of the young lady in the "outer office" who often spends more actual time with the patient than the physician himself. An attitude of appreciation for the payment of professional bills, the courteous making of appointments, as well as an interest in the patient's health and welfare should characterize the qualities of the secretary in her daily contacts with the public.

Finally, it would seem mandatory for all physicians to maintain conditions which are as nearly normal as possible, whatever the other arguments might be.

Most authorities agree that it is desirable to control abnormal hyperglycemia and glycosuria insofar as possible without unendurable inconvenience to the patient and danger of severe shock from insulin. In some instances these two qualifications make it advisable to permit minimal or transient glycosuria as the lesser of two evils. But, with proper care, the majority of diabetic patients can be maintained in approximately normal sugar balance without either of those penalties. This should be done whenever possible. The necessity for condoning some glycosuria in certain cases should not be permitted to encourage laxity of control in the majority. Established criteria for good routine management consist of the maintenance of normal nutrition and as good control of abnormal blood and urine sugar as possible without more serious penalties.

EDITOR'S NOTE: This paper is part of a Symposium on Diabetes Mellitus, discussion of which will follow the paper by W. Wallace Dyer, M.D., on "The Treatment of Juvenile Diabetes."

From a strictly business standpoint, the prompt sending out of bills to patients and the courteous handling by the secretary of complaints or questions regarding professional fees will make for more pleasant relations between physician and patient, and may eliminate certain misunderstandings which may prove embarrassing at a later date.

Of further importance to the physician is the handling of telephone calls. The impressions which a patient receives on the other end of the wire in talking with the physician's secretary are sometimes not to the benefit of the physician. Furthermore, the secretary should endeavor to take messages for the physician who is busy with a patient rather than attempt to bother him with matters which can just as easily be disposed of later.

The physician should not hesitate to give his secretary full responsibility for her share of the work of the professional office. He should turn over to her many details which she can handle more promptly and effectively than he can. His time should be given as completely as possible to the professional needs of his patients and not taken up with a lot of detail which his secretary can handle.

It is hoped that these few remarks will make the medical secretary more conscious of the important role she plays in the professional life of the physician, and that the latter in turn will recognize the potentialities of his medical secretary in terms of the efficient handling of his professional affairs.—*Philadelphia Medicine*, Nov. 12, 1949.

The Treatment of Juvenile Diabetes

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Philadelphia, Pa.

THE discovery of insulin in 1921 offered to most diabetics an increased longevity and a more normal life. For the children it meant life itself.

According to Joslin,¹ in the pre-insulin era the children under his care lived no more than two years. He reports that in studies carried through 1938 a child of ten had a life expectancy of forty years. I am sure that Dr. Joslin would agree today, more than ten years later, that the child's life expectancy now is even greater.

We are inclined to think that diabetes in children 15 years of age or under is uncommon, but this is not the case. According to Spiegelman and Marks,² there are at least 13,000 diabetic children in the United States under the age of 15 years.

Priscilla White¹ finds an equal sex distribution among the children, but points out that girls acquire diabetes on the average earlier than boys. The peak incidence is age 11 in girls and 13 in boys. The peaks in the age onset of diabetes are 3, 6, and 12 years.

The etiology of diabetes in children is unknown, but almost all authors are agreed that heredity plays a large role. Again, according to White,¹ at the onset of diabetes 25 per cent of the children have diabetic relatives, but *after* twenty years of diabetes 55 per cent have found the disease in their families. It is a common experience of the physician who is seeing any number of diabetic children to find the family utterly perplexed and confused as to the origin of diabetes in their child. Frequently they make the statement, "Why, doctor, there is no diabetes anywhere in our family." Often within the year these same parents will return and say that a grandmother, aunt, or uncle has just discovered that he or she has diabetes.

It has been pointed out by many authors, and especially well by Colwell,³ that diabetes manifests frequently the genetic phenomenon of "anticipation." This enables us to understand the clinical cases of diabetes appearing first in

the children and some time later in a near, older relative.

Obesity, the frequent companion or precursor of adult diabetes, is seldom found in children. On the contrary, Brown and Thompson⁴ found that most of the children they saw were 10 pounds or more below normal weight at the time of onset of the diabetes. White¹ found overweight in 86 per cent of 417 of the diabetic children seen by her. Wagner, White, and Bogan,⁵ found a definite precociousness in sexual development in their cases of diabetic children compared with the normal controls. In our experience *most* diabetic children continue to grow normally if their state of diabetic control is good. Barach⁶ emphasizes the fact that some juvenile diabetics fail to maintain a normal growth in spite of adequate nutrition and good control.

The American Diabetes Association is currently looking forward to the detection of the 1,000,000 unknown diabetics in this country. Relatively few of these unrecognized diabetics will be children, because usually in children the disease is fulminating and dramatic at its onset. Unless we are alert, many cases in children will not be recognized until they are seen in diabetic coma. We must suspect the possibility of diabetes in children who have diabetes in their immediate family.

Not all glycosuria in children indicates the presence of diabetes, but it is safer to consider it so until proved otherwise. The classical symptomatology is almost always present in juvenile diabetes — polyuria, polydipsia, polyphagia, weight loss, and weakness. Symptoms less commonly associated with diabetes, if correctly interpreted, may lead to the diagnosis. Such findings as persistent enuresis, superficial skin infections, pruritus, and fluctuations in visual acuity are not uncommon.

Positive diagnosis is best made by means of blood sugars. In our clinic a fasting sugar of over 120 mg. or a postprandial peak in excess of 180 mg. is considered as diabetic. In rare borderline cases, one of the standard glucose tolerance tests may be necessary.

In recent years we have begun to see a new

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type of diabetic. This is the person whose diabetes began in childhood and has continued for fifteen, twenty, or twenty-five years. Entirely too many of these patients are showing extensive degenerative vascular disease. Dolger⁷ called attention to this a few years ago. In 1948 White⁸ reported on her juvenile diabetics with a duration of the disease longer than fifteen years. While her findings were somewhat more optimistic than Dolger's, 93 per cent of her patients showed slight to severe retinal damage. Before the advent of insulin, children did not live long enough for these advanced arteriolar changes to develop. The fact that similar figures are being obtained in many clinics throughout the country emphasizes the fact that we have a greater responsibility than just maintaining life in our diabetic children.

There is considerable controversy as to whether the degree of control is related to the degree of vascular damage. Excellent papers have appeared on both sides of the controversy. It is my own feeling that the degree of control is definitely related to the amount of vascular damage. For this reason I believe that it is incumbent upon each of us to secure the best control possible in all of our diabetic cases and especially in the juvenile diabetics.

The "best control" means many things to many physicians. To me it means:

1. Diet adequate to maintain normal weight and growth.
2. Normal blood sugars whether they be fasting or postprandial determinations.
3. Minimal (10 grams or less) spill of glucose in the 24-hour urine.
4. Freedom from hypoglycemic reactions.
5. Psychologically well adjusted patients.

The diet prescription is not much of a problem. Suffice it is say that in the group 15 years of age and under we are likely to prescribe a 1000 calorie diet for a patient a year or under and add 100 calories per year of age thereafter. This will be so divided as to give them one gram of protein and one gram of fat for each two grams of carbohydrate. The rules for dietary prescription vary from clinic to clinic. Most important is that the child have an adequate amount of protein and sufficient calories to maintain weight and growth.

The prescription of insulin for the juvenile diabetic is perhaps the most difficult part of the whole régime. I wish to state emphatically that I do not believe any one insulin or insulin combination is necessarily best for children. Usually most children will require a long-acting insulin

and a rapidly acting insulin. There is no hard and fast rule about this. The most important consideration is that good control of the diabetes be secured regardless of the type of insulin employed.

Through the kindness of Dr. Joyce Sheridan, president of the Philadelphia Metabolic Association, and the Camp Committee consisting of Dr. Edward L. Bortz, Dr. Joseph T. Beardwood, Jr., and the author, I am able to present in summary the insulins employed in the treatment of the children at the last two camping sessions, 1948 and 1949.

CAMP FIREFLY

THE PENNSYLVANIA CAMP FOR DIABETIC CHILDREN

<i>Insulins</i>	<i>No. Boys 1948-1949</i>	<i>No. Girls 1948-1949</i>
Protamine zinc	5	5
Globin	4	2
Protamine zinc and regular ..	14	9
Protamine zinc and regular ..	12	5
Protamine zinc and globin ..	2	2
Globin and regular	..	3
NPH-50	..	1
No insulin	..	2
	18	24
	28	30

Most of these children are from Philadelphia or its environs. Some are from Pittsburgh, Harrisburg, Baltimore, Newark, Allentown, and elsewhere throughout the State. In 1949 the girls came from 9 different towns and 20 different physicians and the boys came from 11 towns and 26 physicians. Thus we have a fair cross-section of this part of the country. So far as possible the insulin régime started by the family physician is followed in camp. A variety of insulins or insulin combinations may be used effectively to control the juvenile diabetic. In the group of 100, control was regarded as good in 65 cases, fair in 34 cases, and poor in one. It is interesting to note the increasing popularity of protamine zinc insulin and regular mixtures this year as compared with last year.

A minimal number of insulin injections is desirable in the management of all diabetics, and this is especially true in children. For that reason in my own practice I usually try a mixture of protamine zinc insulin and regular insulin in the proportion of 1:2. If good control is not secured, and failure is not uncommon, I change to separate injections of protamine zinc insulin and regular insulin before breakfast, and sometimes a second injection of regular insulin is necessary before the evening meal. I have not personally used globin alone or in mixtures sufficiently to allow me to express a worth-while opinion.

In addition to the technical control of the diabetes, much else is of importance in the management of the patient. When possible, he is encouraged to go to the diet kitchen early in his period of standardization to watch the food being prepared and weighed and perhaps be allowed to weigh his own diet. A real interest in his disease is awakened by telling him the story of the discovery of insulin, the men and animals who contributed to its discovery. He is provided with a manual, of which there are many good ones, and he is given regular reading assignments. This never supplants personal teaching.

Early in his period of hospitalization he is taught to take his own insulin, and this can be done with children 5 or 6 years of age with patience and persistence. We do not require that all children inject their own insulin regularly, but it is desirable that they be able to do so in case of their parents' illness or if they are away from home. They are also instructed in the technique of determining sugar in the urine and are provided with one of the home kits now available.

Exercise is encouraged, as is participation in normal school functions. The hypoglycemic effect of increased physical activity is taught to the patient. He is encouraged to make exercise a part of his daily program and to avoid sudden unusual bursts of activity. Difficulties can usually be avoided by taking 10 to 20 grams of carbohydrate before beginning his exercise. As much time should be spent in making a friend and a confidant of the patient as in regulating the insulin dosage.

Good treatment and proper instruction of the juvenile diabetic will go far in preventing complications. It should help in the minimizing or postponing of degenerative vascular disease. Infections cannot always be prevented, but their early detection and prompt treatment will do much to shorten their course. Remember that every infected diabetic is a potential coma patient. Infections in diabetic children are to be treated exactly as in non-diabetics, but in addition it must be recognized that during the active phase and for some time afterwards increased amounts of insulin, especially the quick acting type, will be needed. Periodic chest x-rays should be a part of the long-range plan for the diabetic child.

Hypoglycemic reactions are more frequent in children than in adults, but they also are less alarming. A cause can usually be found for their occurrence in either (1) too little food, (2) too much activity, or (3) too much insulin. Many times the picture will resemble the insulin reac-

tions of adults. There is, however, no set pattern. Two good rules to follow are: (1) if in doubt, treat it as a reaction; (2) any sudden change in manner, mood, or behavior of the child should make you suspect an insulin reaction.

Diabetic acidosis and coma are also more common in children than in adults. The management of these patients differs little from that of the adult. Total insulin doses will usually be less. There is no set amount of insulin to be given, but a quick acting insulin must be used and in amounts that are sufficient to relieve the acidosis.

Less important complications are those arising from the injections of insulin. Children more frequently than adults will develop "insulin atrophy" (lipodystrophy) and "insulinoma." The former is a depression of the skin at the site of injection as a result of wasting of the subcutaneous fat, and the latter is an indurated raised area in the skin at the site of injection. The practical importance of the insulinomas is that continued injection here seems to produce a variability in insulin action. Both tend to improve with discontinuance of injections in the area. These emphasize the importance of teaching the patient in regard to an "insulin map"—changing the site with each injection.

The management of the surgical juvenile diabetic differs very little from that of the surgical non-diabetic child. The diabetic should have the same opportunity for surgery as his non-diabetic brother so long as he is not acidotic. His usual carbohydrate 24-hour intake is given by mouth or parenterally as the situation demands and insulin is provided "around the clock" using repeated injections of a quick acting insulin or protamine zinc insulin supplemented by a quick acting insulin. In the diabetics we have not seen a greater incidence of non-healing wounds or prolonged convalescence.

An often overlooked aspect of the treatment of the juvenile diabetic is the management of the family. To do this adequately it is necessary to visualize how our own domestic economy would be disrupted or altered were one of our children to become diabetic. It is a problem which I have considered many times because I have diabetes in my family and I have often wondered how well I could make the adjustment were one of my boys to become diabetic. The parents must be told *all* the facts. It is my practice to go over all the complications with them, but at the same time to stress the importance of good control in avoiding trouble. They must be warned of the danger of being over-solicitous and over-indul-

gent of their child simply because he has diabetes. This way is the best to insure that the children will be psychologically well adjusted. There are any number of outstanding men and women in our own field and in all walks of life who have grown up from juvenile diabetics. I urge the family to consult me frequently concerning their fears and their questions and I try to answer them honestly.

In summary, the large and increasing number of juvenile diabetics must be recognized and given the best possible control by diet and one or more of the available insulins separately or in mixtures. Most of the complications can be avoided by proper treatment of the patient and honesty with both patient and family.

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DISCUSSION

The following is an abstract of the discussion which followed the presentation of papers by Dr. Arthur R. Colwell, Chicago, Ill., and Dr. W. Wallace Dyer, Philadelphia, with Dr. George F. Stoney, Erie, chairman of the Commission on Diabetes, acting as moderator.

J. WEST MITCHELL (Pittsburgh): It is essential that we have good control of diabetes. The mixed insulin gives us a new tool which can be effectively used in gaining such control of difficult cases. We have seen too many examples of poor control. At the Falk Clinic the registration has run into the hundreds of thousands. We have seen individuals out of control who willfully maintain themselves in that condition because of lack of intelligence, or their economic state, or just obstinacy in not following the doctor's instructions. We have urged those same patients to come back to us so that we may observe the effects of diabetes in individuals who willfully keep themselves out of control for a period of years. So we have two groups: we have some very good patients and we have others who are excellent voluntary guinea pigs for the newer trend in the treatment of diabetes. We have not yet analyzed our charts completely and developed the statistics, but it is certainly my impression that the individuals who stay under good control for long periods of time have far fewer complications and are least difficult to handle.

The mixed insulins offer another tool in the acute degenerative processes of diabetes, namely, the destruction of the basal cells in acute recent diabetes where insulin requirements may not be too high. Certainly there is a smoother curve, and the disappearance of the diabetic symptoms is quite dramatic. There is no question but that now we have some cases on mixed insulin for as long as five years. Certainly they have gotten on better, and the evidence of arteriosclerosis is less frequent in that group.

I should like to emphasize one thing about the use of mixed insulins which I think is very important. Not all patients are able to comprehend the technique. It is a little difficult. However, by patience and repetition we have been able to get a good many on it. If the selection of patients is made on the basis of their co-operativeness and the amount of intelligence they have about running their case, many times the mixed insulin will be the answer.

THADDEUS S. DANOWSKI (Pittsburgh): We, too, in assuming the responsibility for a roster of some 160 juvenile diabetics practice the general principles so clearly enunciated by Dr. Dyer. A few of our customs are somewhat different. These as often as not, however, represent attempts to arrive at new truths or to apply established truths in specific and perhaps special situations. During the past year, for example, we have tried putting all our diabetic children on extemporaneous mixtures of crystalline and protamine insulin. These almost always exceed the 2:1 ratio employed by Dr. Dyer. To date it would appear that such a régime can provide adequate control, save that moderate glycosuria is usually present before lunch. Another possible result of this program may be the decreased incidence of diabetic acidosis and coma. In our hospital the admission rate for this complication has declined during the past two years to one-half of its previous level. However, since many factors are undoubtedly operative in the occurrence of coma, this must remain only a speculation.

I agree heartily with Dr. Dyer that the psychological aspects of this disease must not be neglected. This is important not only for the patient but for the family as well. The generosity of the Renziehausen family, the Children's Hospital, and the University has given us a practical tool for preventing and treating the emotional and personality problems which may arise in diabetic children. It is obvious that the restrictions necessarily placed on such children by virtue of their illness makes them feel out of place in their social group. Furthermore, I believe that intellectually and emotionally they mature more rapidly because of the need for assuming responsibility early. This creates problems. We therefore bring them into the Renziehausen Ward where they congregate amongst their diabetic peers. They accept diabetes and its needs as a way of life. Their families are indoctrinated in their responsibilities and taught to meet them. As a result we probably forestall or remedy personality problems which would otherwise assume significant proportions. It would be my impression that in the uncomplicated diabetic state this is one of the chief ends in entering a unit such as ours. I wonder whether there is general agreement on this viewpoint.

GARFIELD G. DUNCAN (Philadelphia): This has been an excellent survey of the outstanding problems connected with diabetes, and anything that I might add would just be to emphasize certain features which time did not permit covering. One is the safety factor in juggling the diet. Patients taking regular insulin are most likely to have hypoglycemic reactions before lunch; those taking globin insulin are more likely to have reactions before supper; those taking protamine zinc insulin are more likely to have reactions before breakfast. Therefore, nourishment in the late afternoon will permit taking a bigger dose of globin insulin, and nourishment at bedtime will permit a bigger dose of protamine zinc insulin. This will facilitate smoother control of the diabetes.

The second point is that the rate of action and the duration of the effect of globin insulin varies tremendously with the size of the dose. The effect of a dose of 10 units may not be manifested for two, three, or four hours; but as the dose gets larger and larger, the more quickly the reaction is noted and the longer it lasts.

I have a patient at the moment with active tuberculosis whose diabetes I was unable to control satisfactorily with a dose of protamine zinc insulin and regular insulin before breakfast and a dose of regular insulin before supper. She is now nicely controlled with 100 units of globin insulin given before breakfast. A test made at two-hour intervals throughout the twenty-four hours shows that the blood sugar falls as quickly with that size of dose as with regular insulin.

The last point is to emphasize what Dr. Dyer has said regarding the guidance of children in their adjustment to the new problem. I think that is of utmost importance, and I think it is just as important that this guidance should be by a general practitioner or internist and under no circumstances by a psychiatrist.

CHARLES S. MORROW (Butler): Recently in the newspapers there appeared a statement by Dr. Somogyi of St. Louis, who is a biochemist. He states that physicians are using too much insulin and that much less insulin is required in the control of diabetes. I wonder if one of the speakers would answer that question.

JOSEPH H. BARACH (Pittsburgh): I have been very much interested in the report by Dr. Somogyi before the American Chemical Society. First of all, I should like to say that if he had something important to tell us, he should have said it before the American Medical Association rather than before the American Chemical Society, because after all we are the ones who need the latest and best information on the treatment of diabetes.

As I read the report on this discussion by Dr. Somogyi, I was quite impressed with the fact that he himself is a doctor of science and not a doctor of medicine. He has only stood over the shoulders of the practitioners of medicine in a hospital and given them some interesting advice. He brought into the argument certain physiologic facts that are known to all workers in diabetes as a science. It is true that diabetes is a disharmony between the endocrine hormones involved—insulin on the one side, and the pituitary, thyroid, and adrenals on the other. It is true that if you give massive doses of insulin you can alter or depress the normal functions of the adrenals, thyroid, and pituitary. It is also true that when these three glands are overactive, the insulin function is suppressed. That has been known in medicine for the past ten years. It is the basis of the work of men such as Sostek and others who have worked in this field. The result is that Dr. Somogyi has emphasized something that everyone knows, only he has said it in a popular fashion. That is my first objection to his report.

The second objection is that he starts out with the 50 per cent proportion of our diabetics who get along very well without insulin. That has been clearly stated this morning by Dr. Colwell, and I am sure that it is the experience of Dr. Dyer, Dr. Danowski, Dr. Mitchell, and everyone else who treats diabetes sensibly.

Now, then, how are you going to guess when your patient's pituitary, thyroid, or adrenal glands are overacting? There is no way of knowing. Dr. Somogyi has created a situation that no one can answer. His theory may be true for the laboratory, but it does not

work in the human guinea pig. I will give him all the patients he wants and let him reduce those who require 60 units a day to 10 units of insulin, or 15, or 20, but I defy him to reduce my patients and have them free of glycosuria and hypoglycemia. He cannot do it, and no one else can do it. He might have emphasized the importance of the group who can get along with a very small dose of insulin or perhaps none at all. That is the actual situation.

That report has not brought forth anything new to the men who are treating diabetes intelligently, and I do not see any great value to it. The one thing it has done is that it has made a great many patients very unhappy. They have come running to their doctors, saying, "Doctor, are you overtreating me?" The doctor, being on the defensive, has no way of answering the question. My answer to them is: "All right, reduce your insulin to 10 units and see what happens. If you are just as well off with 10 units less, I am willing that you should have smaller doses of insulin." However, that report does not negate everything that has been done constructively by the men who have been treating diabetes over the past twenty-five or thirty years.

DR. COLWELL (in closing): I have not had a chance to read Dr. Somogyi's data or evidence except in that number one scientific journal of the country, *Time Magazine*. I should like to see his evidence rather than judge by his conclusions. As we all know very well, there is often a striking difference. I would suspect, however, that Dr. Somogyi has managed to observe a group of diabetic patients who have been fed too liberally and been given too much insulin unnecessarily. By restriction of their diets and reduction of their weight, he has found what we all have known for a long time, namely, that in such cases it is possible to reduce, and in some instances even omit, their insulin. Those data have been exaggerated to the point of the spectacular and sensational. It may be that the diabetics in St. Louis are different from those in Chicago or Pittsburgh.

It seems significant to me that all of the discussants and essayists this morning have emphasized the importance of good control in diabetes as a matter of preventing vascular and other complications. It looks as though the pendulum is swinging back to the rational again after a brief period of publicity from the city where the streets are paved with sugar. It is a healthy sign. Certainly there is every reason why we should adhere to the principles which have been established over many years and not pay too much attention to those which have developed fairly recently in the interest of obtaining an easy way to treat diabetes and also perhaps in the interest of sensationalism.

Just one final word on insulin mixtures. It should be unnecessary for us to worry about mixing a couple of incompetent insulins for the use of the patient. Those steps should be taken over by the experts and by the manufacturers. It looks as though that will be true in the case of protamine insulin within a few months, or a year, or perhaps a little longer. There is a crystalline form of protamine insulin which is now being used for clinical trial under the manufacturer's research term, NPH-50. It is a recrystallized protamine insulin with about two-thirds as much protamine as in the standard amorphous suspension. It has the desired time reaction exhibited by the most widely used mixtures which require about twice as much slow-acting insulin. It has about the same reaction as globin insulin which is already on the market, and it looks as though it might

be marketed before very long to replace ultimately the standard protamine insulin preparation on the market, thus making it unnecessary for us to worry about mixing two insulins.

DR. DYER (in closing): I want to say amen to everything that Dr. Danowski said. We are not quite so for-

tunate as he is in having the excellent facilities at the Renziehausen Clinic. We try in a small way to do the same thing through the camp for diabetic children in the summertime, and invariably the children leave camp with a better knowledge of their disease and a much better adjustment to their social and school background.

SHORT SCIENTIFIC PAPERS

Your editors have occasionally harped upon the subject of suitable material for publication in this JOURNAL. A principal theme has been the need for shortening papers. The problem is becoming more acute with soaring costs of printing, more societies and members to serve, and plenty of good scientific material worthy of printing. An excellent article upon the subject of good medical writing has just appeared in the *Staff Meetings of the Mayo Clinic*, by Dr. Walter C. Alvarez. His experience is well known and he speaks authoritatively. His ideas have inspired us to renew our editorial comment upon medical writing.

The articles which are read, talked about, and which are of most educational value are the ones which are short and interesting. Many readers glance first at the summary and conclusion. If these have a "punch," they return to the beginning to sort out the meat.

Few papers are injured by being abridged. Most useful messages can be practically conveyed within ten minutes' reading time. Our good writers rarely are the ones who write easily; they are rather the authors who apply themselves laboriously, set the work aside, sleep on it, returning after a few weeks to see if they still feel the same way about it. The material is then reviewed, modified, changed and—fortunately—shortened. When the author asks himself whether his message fills a gap in the world's knowledge or whether it settles a controversy, he may decide that it does not. If such is the case, the wastebasket should receive another contribution.

The article should start in such a manner as to incite interest, which is maintained through the absence of uninteresting material. Historical comment, inconclusive statistics, and minor technical details are the first to dispel reader interest. Dr. Alvarez agrees with our convictions that few bibliographies should be published, especially the large ones. Some authors are disappointed if readers are not impressed by innumerable articles the author seems to have studied.

In case reports, there is no need for patients' initials, hospital number, exact date of admission, or irrelevant family or personal history. Likewise findings at operation or at autopsy should be positive findings only. Voluminous case reports do not impress readers with an author's thoroughness but rather that the author is inefficient and that his brain is muddled.

Work your material over several times; cut out all irrelevant and negative data; shorten your sentences; delete most adjectives and all superfluous words. Speak in plain English and use the shortest generally accepted spelling. Impress your readers with your clear thinking, practical interpretation of your problem, efficient management, and sensible approach—not your erudite background and worldly perspective.

Your summary should state more than that such and such has been reviewed, or this and that conclusion drawn. It should be a true, but brief and pointed, abridgement of the paper for the benefit of readers who read no more and to show students what they may expect to find in somewhat more detail in the body of the article.—*Rocky Mountain Medical Journal*, October, 1949.

STATE MEDICINE AS CONTROLLED BY RUSSIA

A recent letter came to a Johnstown man from a surgeon in Czechoslovakia the translation of which says in part, "There isn't any good news of which I would be permitted to write. For me and others, life is very difficult and miserable; never did it occur to me that at my age I would meet up with such hardships and sacrifices—financial sacrifices that today I would be unable to even support my family—self and family of three.

"I work 100 hours per week but get paid for 48 hours only. Where there were - of us there are but half now working. For my three months' pay I am able to buy one suit of clothes; and for one month's pay I am able to buy two (2) pairs of shoes for myself. At times, I thought of leaving this place for betterment but it would be worse. . . .

"During the war, I was in the army at the Eastern front. We all returned home with different conflicting views. While I have amassed a fortune of one million crowns (kronen), yet I can't clothe my family of three.

"If you learn of anyone who might wish to send some money to their friends or relatives in the form of dollars, I could exchange the dollars for them at a greater rate than they would receive otherwise and the arrangement would help me and the recipient—thus I would be able to buy some clothing. Please do this for me if any way possible. . . .

"Soon I will be granted a vacation when I will be able to visit my old home at least. My mother is quite better since the operation. Sister has all of the material to build a home which has been her sole ambition, but the authorities will not permit her, even though there are two families cramped up in a small house. . . .

"My address is still the same although I am using a fictitious name and address because some of the mail is censored. . . ."

Until we meet?—*The Medical Comment*, Johnstown, Pa.

Viral and Rickettsial Infections of the Lung

Comments on the Problem of Specific Therapy

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IN discussing with some colleagues recently the question of the etiology of non-bacterial, or "atypical" or "virus" pneumonia, as the clinical entity is variously called, the remark was made that the newer antibiotics, which seem to be effective against this disease, may solve the problem without the etiologic agent ever being isolated. This remark was made facetiously, but it is an interesting commentary on the new era of chemical therapy. The remarkable discoveries in the field of the chemotherapeutic and antibiotic agents have had a profound effect not only on the practice of medicine but on the direction and channels of research. The various approaches to the solution of many problems have been abandoned for the rush of chemotherapeutic or antibiotic gold. Some are now seeking the preparation that will be effective against all microbes without the limitations that are imposed by the specificities of the presently available drugs. We hope that such research will be rewarded with success and that this may come soon.

The universal antimicrobial agent is yet to be found; nevertheless, from the stories that are told about the treatment nowadays of patients with febrile diseases, particularly those with respiratory disease, one might think that the day has already arrived. As these stories sometimes go—the patient or the anxious relative telephones the doctor's office to describe the reason for the call. The doctor, or perhaps even his nurse, suggests the dosage of one of the sulfonamides or of oral penicillin—or perhaps both to be sure—and the advice is then given to report back if the patient is not well in 24 to 48 hours. Failure to respond in another day may bring forth the confident suggestion that the patient has a "virus" infection. This story is fictitious, and any resemblance to reality is merely coincidental.

Although things probably do not happen in ex-

actly this way, it is not infrequent for the therapeutic agents mentioned to be administered positively. More often than not these drugs are prescribed without an intellectual conviction that they are indicated. The thought is that they can do no harm—they may do some good—and if the patient does not respond, it is because he has a "virus" infection and the drug will prevent complications. If the patient gets well in 24 to 48 hours, the statement is often made that the drug was the responsible factor and that the illness was due to a drug-sensitive agent. I am sure that I am safe in saying that more often than not this is quite erroneous.

This state of affairs is a reflection, in part at least, of the incomplete state of our knowledge of the etiology of numerous febrile illnesses, particularly those of the respiratory tract. The incomplete and preliminary state of our knowledge of the etiology of respiratory disease is in striking contrast to the advances that have been made in the treatment of some of the bacterial infections as a result of the discovery of the antimicrobial agents. The difficulty imposed by our ignorance is compounded by the limitations in making a specific etiologic diagnosis in those diseases of which we know the cause, since positive diagnosis usually requires the application not only of careful bacteriologic studies but of some of the special methods for diagnosis of virus infections to which Dr. Werner Henle referred in a paper published in the *PENNSYLVANIA MEDICAL JOURNAL* in January, 1949.

Although we will discuss this problem as it applies to the virus and rickettsial infections of the respiratory tract in greater detail in a moment, I would like, at this point, to emphasize the tendency toward laxity in the application of the diagnostic skills and techniques, both clinical and laboratory, by certain physicians who are too quick on the chemotherapeutic trigger. It is pertinent to point this out in a discussion of the virus and rickettsial infections of the lung, since it is almost standard practice to arrive at such a

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From the Virus Research Laboratory, Department of Bacteriology, School of Medicine, University of Pittsburgh.

diagnosis by exclusion based upon failure to respond to antibacterial therapy.

Since the majority of the antibiotics and chemotherapeutic substances used today are less dangerous than the early sulfonamide derivatives, the worst consequence most frequently is the unnecessary expenditure of money. However, the remarkable advances in therapy have not altered the fact that the basis for treatment is accurate diagnosis.

We seem to have gone very rapidly through a succession of cycles. It was quite unimportant, in the days before specific therapy, to determine the exact nature of the etiologic agent in cases of infectious disease. This was altered with the advent of serum therapy which made it essential that an accurate and very specific diagnosis be made before administration of treatment. Knowledge of the precise type of the invading pneumococcus was a matter of life or death. The importance of specific diagnosis in diphtheria, meningococcic meningitis, and Hemophilus influenzae meningitis is still true. With the advent of the sulfonamides, penicillin, etc., there was a justifiable relaxation in the need and urgency for the same type of etiologic study prior to the administration of therapy. This relaxation has overshot the mark and has, at times, resulted in serious consequences. I am prompted to extend these remarks regarding the importance of etiologic diagnosis prior to therapy even though it may not seem pertinent to the subject that I am to discuss, because the time is rapidly approaching when the virus and rickettsial infections of the respiratory tract may have to be considered in terms of specific etiology prior to administering the correct suppressive drug. It is for this reason that I would like to cite two instances that come to mind even though they concern bacterial infections. They illustrate how wrong one can be in diagnosing virus infections by exclusions and also the danger of treatment that is not based upon accurate diagnosis.

The first example occurred in our troops overseas shortly after the war. In many instances a diagnosis of the presence of a virus infection was made in men, treated for sore throat with sulfadiazine or penicillin, who subsequently developed drop foot or other neurologic manifestations of diphtheria. I can recall investigating a series of cases of myocarditis that were called influenza virus myocarditis and attributed to the use of influenza virus vaccine. All too frequently diphtheritic myocarditis was diagnosed post-mortem in patients who in life were treated for sore throat with antibacterial agents rather than with antitoxin.

Then there is the case of a child with the classical signs of meningitis who was treated with penicillin for five days. The lack of clinical response by the fifth day caused the physician to examine the spinal fluid to determine the nature of the "virus infection." He found, however, that the reason for failure of the treatment was not because the patient had a "virus infection" but because he had Hemophilus influenzae meningitis and not the meningococcic meningitis for which the original treatment was given without diagnostic confirmation. The use of streptomycin suppressed the infection, but irreparable damage had occurred already.

The foregoing remarks, while broad and general in their implications, have an important bearing on the problem of the virus and rickettsial infections of the lung. The segregation of non-bacterial pulmonary infections has to a great extent been based upon failure to respond to the sulfonamide derivatives and penicillin. This is due in part to the fact that the diagnoses of the latter conditions are at present made not on the basis of positive criteria, but by exclusion. Now, however, the reports of success in the treatment of certain non-bacterial types of pneumonia with aureomycin or chloramphenicol shift the problem of diagnosis and of etiology of this group of infections from the academic to the practical sphere. These discoveries may actually hasten the day when the etiologic factors will be understood completely.

The virus and rickettsial agents which have been isolated and studied in the laboratory and that are capable of inducing pulmonary involvement are the viruses of psittacosis, influenza type A and type B, lymphocytic choriomeningitis, and the Rickettsia of Q fever. Although the principal organism responsible for the majority of cases of the clinical syndrome of non-bacterial pneumonia has not been isolated as yet, it has been established that at least one virus is involved. In 1938 Reimann speculated that this disease, to which he drew attention, was "probably caused by a filtrable virus," but decisive evidence was not had until 1944 when the Commission on Acute Respiratory Diseases showed that the infection could be transmitted to human volunteers by means of bacteria-free filtrates of sputum. These same filtrates were non-pathogenic for the various experimental animals that were tested and they had no apparent effect upon chick embryos.

In addition to the viruses of psittacosis, influenza, lymphocytic choriomeningitis, the Rickettsia of Q fever, and the unidentified viruses capable of causing atypical pneumonia, there have

been reported almost a dozen etiologic agents that are reputed to have been the cause of sporadic cases of this syndrome. The reason for the uncertainty, in some cases at least, of the etiologic relationship of the virus isolated to the patient's illness is the possibility that the virus isolated may have originated in the animals in which it might have been endemic.

For reasons of completeness I should like to mention other diseases, not caused by viruses or Rickettsiae, that simulate the pneumonia to which we have been referring. These other conditions are (1) bacterial pneumonia, (2) early tuberculous pneumonia, (3) coccidiomycosis, and (4) passive congestion of circulatory failure, to mention but a few.

The role played by the latter group as a cause of atypical pneumonia is quite insignificant in terms of the relative number of cases that they contribute to this syndrome. As for the known viruses and Rickettsiae psittacosis and Q fever can usually be suspected on epidemiologic grounds, and both of these can be proved by relatively simple laboratory tests. The role of the influenza virus has been investigated extensively in large numbers of cases of atypical pneumonia and the evidence indicates that it is not of major significance except, perhaps, during epidemics of influenza. Although in the differential diagnosis the possibility of (a) bacterial pneumonia, (b) the other conditions that may produce this syndrome, as well as (c) the known viruses that have been cited, must always be kept in mind, it is to be realized that the greatest proportion of cases are probably caused by one or more agents that have defied capture in the laboratory.

It was necessary for the Commission on Acute Respiratory Diseases to use human volunteers rather than experimental animals to prove that a filtrable agent was the cause of at least certain cases of atypical pneumonia because of the elusive nature of this virus. It first slipped away from the moderator of this symposium, Dr. Joseph Stokes, Jr., more than a decade ago and since that time a large amount of negative data has accumulated. Some hopeful results have brightened the horizon from time to time. A few years ago Eaton and his co-workers reported the isolation of an agent in cotton rats which was transmissible to chick embryos. Eaton's virus is of such low pathogenicity for experimental animals and appears to be so unstable that it is difficult to study in the laboratory. Nevertheless, Eaton presented what appears to be good evidence of an etiologic relationship between the virus he isolated and "certain" cases of primary

atypical pneumonia. It has been difficult to confirm Eaton's findings for technical reasons, and it is still not clear what relationship his observations have to the findings of the Commission on Acute Respiratory Diseases.

Workers in Horsfall's laboratory have brought forth evidence suggesting the possibility that an indifferent streptococcus may play a role in certain cases. This suggestion is based upon the demonstration of an increase in titer of agglutinins for streptococcic meningitis in about the same proportion of patients as one finds an increase in titer of cold agglutinins. Although the factors responsible for each of these immunologic reactions are separable and have not been explained entirely, the association of the two in many instances has raised the possibility that a combined virus and bacterial infection may be responsible for some cases of this syndrome.

Time does not permit me to go into further detail. I have attempted to indicate the diverse etiology of the non-bacterial pneumonias. The difficulties in diagnosis apply primarily when one tries to specify the etiologic agent. It is less difficult to name the clinical category to which the case appears to belong. Despite the difficulties, an effort should be made always to make an etiologic diagnosis. This then serves as a guide to management and specific therapy.

If this brief presentation has done nothing more than to make you wonder exactly what the cause is of the disease process in your patients, it will have accomplished part of its purpose. The remainder will have been accomplished if you seek, wherever possible, to establish the clinical diagnosis where doubt exists by methods other than the so-called therapeutic test. Until the clinical or laboratory diagnosis can be established *easily*, treatment *must* be based upon the best clinical judgment applied judiciously. This becomes all the more important when we realize that the various chemotherapeutic agents are not universally effective and some that are useful for one disease are useless in another, as in the instances cited. The addition of aureomycin and chloramphenicol (or chloromycetin) to the therapeutic armamentarium now brings pressure to bear for trying to separate the various pneumonias. Although the new drugs seem to be of value in the treatment of primary atypical pneumonia and are effective against the agent of Q fever and psittacosis (which is also sensitive to very large doses of penicillin), they are ineffective against experimental infections with the influenza virus and their value in the treatment of the bacterial pneumonias has not yet been explored adequately.

Viral Hepatitis—Progress and Problems

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THE occurrence of epidemics of viral hepatitis in many widely separated parts of the world during the past few years stimulated numerous investigations in this country and abroad. Much new information became available concerning the clinical course of the disease, its causative agents, and possible manners of spread and prevention. Integration of this newer knowledge with earlier clinical and epidemiologic observations resulted in a clearer concept of the natural history of the disease.¹ Historically, it is worthy of note that although the pathogenesis of viral hepatitis was well understood many years ago by several investigators, particularly in Europe^{2,3} but also in the United States,⁴ general medical opinion was slow to accept the fact that the essential lesion in this disease is hepatocellular necrosis rather than catarrhal obstruction of the common bile duct.⁵ It is largely as a result of work of recent years that the unequivocal evidence assembled during earlier periods has become more generally appreciated.

Advances in Knowledge

A certain number of facts and many speculations characterize the current concepts of viral hepatitis. These have been recently reviewed,^{6,7} and some of the observations are summarized in Table I. The available evidence suggests that there are at least two forms of the disease. One of these is called *infectious hepatitis*, the naturally occurring epidemic or sporadic disease, more commonly known as catarrhal jaundice; the second has been arbitrarily termed *homologous serum hepatitis*, which is that form of the disease produced artificially by the parenteral inoculation of human blood or its products containing a virus of hepatitis. The exact relationship between these two forms of hepatitis is not known. Although serum hepatitis may, at times, represent the artificial transmission of the naturally occurring disease there is good reason to

believe that this is not always the case. After onset, these two forms of hepatitis are identical clinically and pathologically although experiments with volunteers suggest that certain differences exist between them and between their causative agents. These differences are of such character as to indicate that, although the two diseases are not identical, they doubtless belong to the same general group.

Both forms of hepatitis are caused by viruses which are filtrable and resistant to a temperature of at least 56° C. for thirty minutes. The incubation period of the naturally occurring disease is short, ranging from 15 to 30 days, and contact cases are common. The virus is present in the blood and feces in the acute phase of the disease, and may be transmitted experimentally to volunteers by parenteral inoculation or feeding infectious materials. In contrast, the incubation period of homologous serum hepatitis is long (from 60 to 120 days) and contact cases are infrequent. The virus is present in the blood during the long incubation period and in the acute phase of the disease, and may apparently be transmitted only by parenteral inoculation. Both of these viruses evoke homologous immunity, but there is no demonstrable cross-immunity between them. The epidemic disease may be prevented by the administration of normal human gamma globulin during the incubation period,^{8,9} but similar attempts to prevent homologous serum hepatitis have been followed by equivocal results,^{10,11} suggesting the possibility that the virus or strains of virus causing this form of the disease may not be as widespread as the virus causing the epidemic disease.

Problems for Investigation

Serology. In view of the advances in knowledge made in recent years, it is not surprising that several previously little considered problems now press for solution. It is a matter of concern that no *specific* serologic test has been devised. Such a test would make it possible to make the diagnosis in the pre-icteric phase and in certain patients in whom differential diagnosis between obstructive jaundice and hepatocellular jaundice

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From Jefferson Medical College of Philadelphia.
These investigations were aided, in part, by the Commission on Virus and Rickettsial Diseases and the Commission on Liver Diseases, Army Epidemiological Board, Office of the Surgeon General, U. S. Army, Washington, D. C.

is difficult. In addition, such a test might make it possible to measure the past experience of various populations with either form of hepatitis and thereby aid in investigating its epidemiology. The greatest hindrance to the development of a specific serologic test has been the failure to transmit successfully either virus to any laboratory animal or embryonating eggs. Colbert¹² recently reviewed and documented many of these experiments. Unconfirmed reports of successful transmission of strains of human hepatitis virus to rats, pigs, canaries, and embryonating hens' eggs have been made. In addition, the spontaneous appearance of hepatitis in colonies of supposedly healthy mice, puppies, and horses has been described. More recently, Lucké and Radcliffe¹³ reported the production of hepatitis in birds by inoculating them with material presumed to contain human hepatitis virus. The exact relationship of the agent or agents producing these affections in animals to hepatitis in man is not known.

Epidemiology. Although possible methods of transmission of both forms of the disease are known, the conditions which influence increasing or decreasing incidence are often poorly de-

TABLE I*
COMPARISON OF INFECTIOUS HEPATITIS AND
HOMOLOGOUS SERUM HEPATITIS

	<i>Infectious Hepatitis</i>	<i>Homologous Serum Hepatitis</i>
<i>Clinical</i>		
Incubation period . . .	15 to 30 days	60 to 120 days
Type of onset	Sudden	Insidious
<i>Epidemiologic</i>		
Contact cases	Common	Rare
Seasonal incidence	Fall-winter	Throughout year
<i>Virus</i>		
Filtrable	Seitz EK	Seitz EK
Resistance to heat	56° C. 30 minutes	56° C. 60 minutes
Susceptible host . .	Man	Man
Route of infection (experimental)	Parenteral or oral inocula- tion	Parenteral inocu- lation
Virus in stool . . .	Acute phase	Not demon- strated
Virus in serum . .	Acute phase	Incubation period and acute phase
<i>Immunity</i>		
Homologous . . .	Present	Present
Heterologous . .	None apparent	None apparent
Prophylactic value of human gamma globulin	Good	Equivocal

*Summarized from the reviews of Neeffe⁶ and Havens.⁷

HEPATITIS IN DENMARK 1928-1947
Total Cases

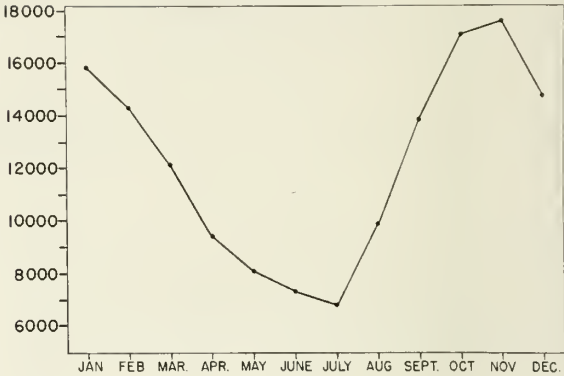


Fig. 1

fined. Attention has frequently been directed to the seasonal variation in incidence of infectious hepatitis with a predominance of cases in the fall and winter months, in contrast to the year-round occurrence of homologous serum hepatitis (Fig. 1). In this regard, the epidemic pattern of viral hepatitis in American troops in Germany during the past four years is of interest (Fig. 2). During this time, the seasonal variation of the disease has become less pronounced, and the incidence of the disease has steadily increased so that now the rate approaches in magnitude the epidemic rate of 1945. In addition, cases are widely scattered, and localized outbreaks are uncommon, suggesting that the virus is diffusely spread. An adequate explanation of this situation is not available, and the solution is made more difficult by the inability to distinguish between the *naturally occurring* and the *artificially transmitted* forms of the disease.

It would seem that in any area where hepatitis is widespread, the opportunity for transmitting the virus accidentally by improperly sterilized needles or syringes is substantial. Because of this, it has been suggested that a certain amount of hepatitis in Germany may have been artificially transmitted in the course of vaccinations against various diseases or therapy of venereal infections. If this is true, it would offer a partial explanation of the lessened seasonal variation in the incidence of hepatitis. The reasons for the steadily increasing amount of hepatitis among American troops in Germany since 1946 are not known. The repeated introduction of susceptible replacements and the increased fraternization between Americans and Germans are suggested as possible contributing factors. Although there is little available information about the incidence of hepatitis among Germans, there is good reason to believe that the disease occurs frequently. Closer contact between Americans and Germans,

Hepatitis in U.S. Troops in EUROM
Rate per 1000/Annum



Fig. 2

possibly under conditions favorable to transmission of the disease, might explain in part the increase in incidence. Of interest in this regard, however, is the fact that while hepatitis has steadily increased among American troops, it has diminished among British troops in Germany (Fig. 3). There is no knowledge as to whether there is any difference in exposure between the two groups.

Control. Among the important problems in the control of hepatitis has been the occurrence of homologous serum hepatitis following the reception of human blood or its products contaminated with the hepatitis virus. The incidence of hepatitis following transfusions of plasma has been variable, but has been recorded as high as 7.3 per cent in England. The severity of the disease in older and debilitated patients in both civilian and military groups has curtailed the use of pooled plasma in many hospitals, and caused to be limited the number of donors contributing to pools in other institutions. A recent survey of the potential icterogenic capacity of pools of plasma (made from blood from 16 to 25 donors) at the Pennsylvania Hospital indicated that between 8 and 16 per cent of 64 pools made in a 19-month period in 1946-1947 were presumably infected with the hepatitis virus as determined by their capacity to produce hepatitis with jaundice in recipients.¹⁴ The possibility that other recipients were infected without being jaundiced but serving as potentially infectious carriers must be considered. The importance, then, of devising an economical method of sterilizing plasma of the hepatitis virus is emphasized, and it is only recently that this has been shown to be possible economically on a large scale by irradiation with ultraviolet light.¹⁵ The development of simpler methods by the use of antibiotics or chemicals is now being explored.

Clinical Course and Therapy. Study of the clinical course of the disease has revealed wide variations in severity. A frequently fatal form of hepatitis was recently observed in Denmark among older women beyond the menopause.¹⁶ In World War II it was shown that when troops were exhausted by privation, battle, and wounds, the course of the disease was often severe,¹⁷ in contrast to a milder form of the disease which occurred in men not exposed to such hardships.¹⁸ During the past three years, hepatitis has been mild in American troops in Germany, and it has been suggested that one of the reasons for the benign course of the disease during this time has been the excellent physical condition of the men before contracting hepatitis.¹⁹ This is of importance in defining the management of patients with the disease, for up to the present time none of the chemotherapeutic agents or antibiotics employed has been of value.

The length of time that a patient must remain in bed and the type and amount of food such patients should eat have been the subject of investigation. It has been clearly shown that there is no reason to limit fats, particularly dairy fats; actually, the liberal use of such foods makes a palatable diet and insures a greater intake of calories, resulting in an earlier gain in weight and return to normal of tests of hepatic function.²⁰ In the light of earlier experiences, it was felt that prolonged rest and large amounts of food, particularly protein and carbohydrate, were necessary. The more recently observed milder forms of the disease have raised the question as to whether these precepts of management may not be modified. In this regard it is of interest that, during recent years in Germany, greater activity has been allowed to patients at an earlier stage of convalescence without appar-

Hepatitis in U.S. and British Troops in EUROM
Rate per 1000/Annum

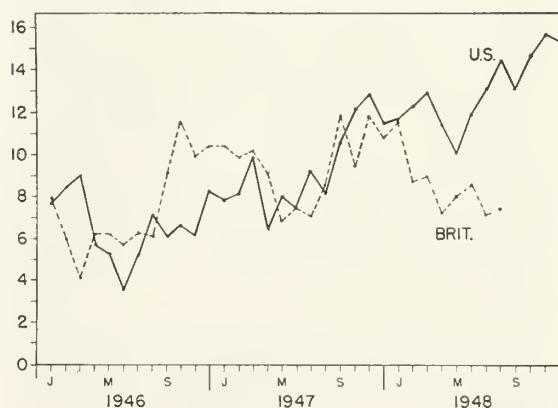


Fig. 3

ently protracting the course of the disease or increasing the number of relapses or recurrences.¹⁹

Chronic Hepatitis. Of particular importance is the determination of how often chronic hepatic disease follows viral hepatitis. The use of various tests of hepatic function, in conjunction with clinical observation and biopsy of the liver, makes it possible to show conclusively that chronic hepatitis and post-necrotic cirrhosis may follow the acute disease. The factors which favor such a sequence of events are not completely known, but it is believed that severe initial disease or relapses and an inadequate period of rest or diet may predispose towards chronicity. How often chronic disease follows acute hepatitis is a subject for further clinical investigation.²¹ The implications of earlier work are that viral hepatitis is not as innocuous as formerly considered and that residual functional impairment of the liver is a common occurrence. Later studies, however, suggest that residual hepatic damage is uncommon, and in one carefully controlled group of 350 patients with viral hepatitis, Kunkel et al.²² reported a relapse or delayed convalescence in 60 patients (17 per cent), although only 8 patients (2.3 per cent) had signs or symptoms of persistent hepatic disease one year after onset.

The use of biopsy makes it possible to observe the alterations in the liver during various phases of the disease, although it is often difficult to interpret and correlate the presence or absence of histologic changes, the results of tests of hepatic function, and signs and symptoms of the disease. Certain tests of hepatic function are of value in making it possible to predict the presence or absence of histologic alterations in the liver in patients with a history of acute hepatitis from which recovery has apparently not been complete. During the past year, the opportunity of observing a number of such patients at the Army Hepatic and Metabolic Center at the Valley Forge General Hospital made it possible to make certain correlations between histologic variations as determined by biopsy of the liver and tests of hepatic function. Preliminary observations suggest that in the patient without jaundice but with complaints of anorexia, pain, and fatigue, with or without hepatomegaly, one of the most sensitive tests of hepatic function is the measurement of the capacity to excrete bromsulfalein. The clinical course of two such patients is recounted in the following reports of cases:

D. J., a 21-year-old male negro, was admitted to a United States Army hospital in Germany with viral hepatitis, Sept. 6, 1947. He was discharged from the hospital apparently well Dec. 17, 1947, and seemed to

be in good health until April 1, 1948, when he observed the appearance of dark urine followed in three days by anorexia, malaise, nausea, and jaundice. He was readmitted to the hospital April 7, 1948. Physical examination at that time revealed that the liver and spleen were not palpable. The serum bilirubin measured 2.41 mg./100 ml. serum. The symptoms and jaundice improved rapidly, and the serum bilirubin became normal approximately eight weeks after the appearance of jaundice. However, although he was asymptomatic, he continued to have abnormal retention of bromsulfalein and positive thymol flocculation tests. Because of the evidence of persistent hepatic disease, he was transferred from Germany to the Valley Forge General Hospital Sept. 11, 1948.

Physical examination on admission to this hospital revealed a well-developed and nourished male negro who did not appear sick. The liver and spleen were not palpable. Laboratory data: The serum bilirubin measured 0.64 mg./100 ml. serum. Fifteen per cent of bromsulfalein was retained in the blood 45 minutes after the injection of 5 mg. of dye per kilogram of body weight. The thymol turbidity test measured 7 units, and the thymol flocculation was 2 plus. The cephalin-cholesterol flocculation test was negative. He remained asymptomatic and was granted several convalescent leaves of absence from the hospital. Biopsy of the liver performed Dec. 3, 1948, revealed periportal fibrosis and infiltration with round cells. Following his last convalescent leave of thirty days, the liver was found to be palpable 3 cm. below the right costal margin. The bromsulfalein dye retention test was still positive at the last examination, nineteen months after the onset of hepatitis.

S. C., a 49-year-old white male, received yellow fever vaccine (Lot No. 334) in February, 1942. Two months later he had epigastric distress, anorexia, easy fatigue, and malaise with intolerance to fatty foods. Approximately six weeks later in June (three and a half months after the reception of yellow fever vaccine), he became jaundiced. He was treated in a United States Army hospital for five weeks with a regimen of rest in bed for part of each day, and was discharged from the hospital before his jaundice had completely disappeared. He continued to have malaise and lethargy for several months after leaving the hospital. During the ensuing seven years, from 1942 to 1949, he had frequent intolerance to fatty foods with a sensation of abdominal fullness after meals. These symptoms became increasingly severe, and during the past eight months anorexia was present. The diet was apparently adequate during this period, and only moderate quantities of alcohol were consumed.

Physical examination on admission to the Valley Forge General Hospital revealed a well-developed and nourished middle-aged white male who did not appear sick. The skin and sclerae were clear. The abdomen was obese. The liver and spleen were not palpable, and there was no tenderness to percussion or palpation over the liver. No spider nevi were visible. Roentgenograms of the gastro-intestinal tract and cholecystogram revealed no abnormality. The serum bilirubin (1' direct and total), cephalin-cholesterol flocculation, thymol turbidity, prothrombin time, urine and fecal urobilinogen were normal in several determinations. Repeated determinations of the amount of retention of bromsulfalein revealed consistently abnormal degrees of retention ranging from 16 to 22 per cent (45 minutes after the injection of 5 mg. of dye per kilogram of body weight),

Biopsy of the liver performed April 12, 1949, seven years after the initial attack of jaundice, revealed mild periportal fibrosis and infiltration with round cells.

Residual periportal fibrosis and cellular infiltration early in the period of recovery have been described by several observers.²³⁻²⁵ The exact significance of such histologic changes is, as yet, undetermined. It has been suggested²⁴ that in most instances they ultimately disappear, and it has been shown that even severe hepatic damage may be repaired completely after twenty-one months. Sherlock and Walshe²⁶ have called attention to the fact that a certain number of patients complain of anorexia, fatigue, and abdominal discomfort three to twenty-four months after the onset of hepatitis when only an occasional test of hepatic function is abnormal. The term "post-hepatitis syndrome" has been used to describe this situation, and an analogy has been made to "effort syndrome." Biopsies of the liver of such patients and of patients making an apparently normal recovery within three to six months of the initial attack revealed similar changes, i.e., slight residual periportal infiltration with excess of fat in parenchymal cells. When patients with "delayed recovery" were examined by biopsy of the liver four to seventeen months after onset of the disease, Mallory²⁵ showed that 25 out of 40 patients were normal or had doubtful changes; the remaining 15 patients had periportal and intra-lobular inflammation and focal hyaline necrosis. That a certain number of such patients develop chronic progressive hepatic disease is borne out by general experience. How often this transition occurs is undetermined, but the preponderance of evidence suggests that it happens relatively infrequently.²⁷

Summary

The investigations of various aspects of viral hepatitis during recent years were productive of certain information which broadened our concept of the natural history of the disease. Considerable new knowledge is now available on the causative agents, possible manners of transmission, and prevention of disease. A more accurate concept of the clinical course and its relationship to chronic hepatic disease is emerging, although many points still require clarification. On the basis of information now available, it would appear that viral hepatitis is usually a benign, self-limited disease, with complete recovery in most cases. A small percentage of patients develop progressive chronic hepatic disease, terminating in cirrhosis of the liver. The size of this group will be better defined subsequently when the re-

sults of long-term follow-up studies are available. Other problems which press for solution are those concerned with the development of a specific serologic test and the transmission of the virus to laboratory animals. On such methods depend future advances in the epidemiology and control of the disease.

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A FUTURE FOR PREVENTIVE MEDICINE

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PREVENTIVE medicine as a somewhat abstract philosophy is well considered in current medical thought. Few discussions of medical care are entered into without it being appealingly discussed. It is a favorite topic which is well ventilated by politicians, newspaper editors, sanitarians, physicians, and the laity itself.

Three years ago,¹ after considerable thought on the subject, I recommended that the aim of a department of preventive medicine should be that of gradual self-extinction in every medical school and that its success should be considered complete when, owing to its efforts and its endeavors, the level of the instruction in, and the practice of, humanistic medicine has been raised to such a point in all departments in a medical school that the continued presence of a department of preventive medicine is unnecessary. I have now come to the conclusion that, while my original premise was correct, the possibility of self-extinction is remote and that, before it can become more than hope, a great deal of spade work must be done in the field of preventive medicine. My reason for this statement is based upon the present untenable position of preventive medicine which, in day-to-day medical care, is often barred from the clinic and forgotten, or is disregarded by physicians. It is only in the field of public health practices and in the confines of certain university health services that continuing efforts in certain areas of disease and prevention of disease are maintained. Likewise, as a subject in the medical curriculum, the content and philosophy of preventive medicine are as variable as are the titles of those who profess it. It may be designated as preventive medicine, public health medicine, public health, hygiene, or, as is beginning to happen with increasing frequency because of the catchiness of the title, it is called social medicine.

There is widespread confusion of thought and of design in the teaching of preventive medicine, which stems from the fact that, to date, neither

its practical role in over-all medical care has been satisfactorily defined nor is there a concerted effort in any large hospital or university medical center in this country to bring to its clients a planned program of preventive services. One must hasten to add at this point, to avoid the brickbats, that in certain areas of medical care such as obstetrics, pediatrics, orthopedics, ophthalmology, and mental hygiene comprehensive and excellent preventive services have been developed in some hospitals, some clinics, and some medical centers. This situation is both unfortunate and unrealistic.

Today, about one-fifth of the people of our country are members of Blue Cross. Forty-four state medical societies have inaugurated plans for the prepayment of medical care. Indemnity and casualty insurance is flourishing. Unions have or are in the process of establishing systems which will provide prophylactic and medical services for their members. About two-thirds of the people of the United States have some type of medical coverage, and a compulsory health insurance bill which has in its declaration of purpose "the inability of most of our people to benefit from modern preventive medicine" as one of the major reasons why it is needed, is in the legislative hopper. The evidence in hand indicates that the hospitals, medical schools, and indeed the medical and allied professions in this country must prepare themselves for a broad program of preventive services, the demand for which will continually increase as the base for the prepayment of health and medical care broadens.

The question may be asked at this point, "What has preventive medicine to offer and what is its concern in practical problems of medical care?" I would say that preventive medicine has been and should continue to be concerned with all problems having to do with the maintenance of health in the individual, in the family group and, under certain conditions, in larger aggregates of population. Then, I would add to this responsibility as more recent, accessible, and practical interests, the problems of minor illness, the prevention of serious impending illness, the rehabilitation of the sick and the disabled, and

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the maintenance of the disabled, and even the chronically ill, as functioning economic and social units at the highest level compatible with the infirmity encountered in the patient. This proposed definition of the functional activities of preventive medicine follows the philosophy which it is believed should in part govern general instruction in this field, and especially so if and when preventive medicine is permitted to play a practical role in over-all medical care. Instruction in preventive medicine by precept has been a sterile undertaking. Instruction by example would bring its benefits to the people of this country.

It may be argued, and I am certain it will be, that the acceptance of this definition of preventive medicine will produce head-on functional collisions between preventive medicine and the ever-expanding activities of the public health sciences on one hand and with the dynamic clinical sciences on the other. Actually, it would appear on careful analysis that, instead of a collision of ideas and philosophies, a logical community of interest exists between preventive medicine and the public health and clinical sciences.

Preventive medicine might well be considered the bond between these two major working groups in the broad field of medical care. To the philosophy and practice of public health, it can bring an understanding of the individual and collective problems of the sick and injured. It has been and should continue to develop techniques for the maintenance of health, which techniques, when once established by sound clinical experimentation, pass into the domain of public health practices. Preventive medicine is ideally situated for the conduct of pilot studies in techniques of medical care. It can assist in establishing adequate standards of medical care. It can interpret the effects of new developments in scientific medicine on future public health practices and policies, the role of technologic services in the provision of medical care, etc. On the practical side, preventive medicine should be permitted to correlate those activities in programs of medical care which have to do with the maintenance of health, the problems of minor illness, the prevention of impending serious illness, and the rehabilitation of the sick and injured for the purpose of providing those facilities, at the level of the individual or group, which are so necessary for the instruction and education of the health officer.

In most teaching institutions, the student of public health is subtly isolated from the clinical sciences during the time when he is taking his master's degree or doctorate. This arises in part

from a lack of understanding on the part of the clinical sciences of their responsibilities in the field of public health, and in part from ignorance, timidity, and possibly a feeling of inferiority of those responsible for the development of the public health sciences. Preventive medicine, with its interest in clinical as well as the public health sciences, is ideally fitted to bridge this gap and bring about the necessary correlations.

In the clinical sciences, preventive medicine enters (or should enter) into every branch of medical practice. It is an integral part of all aspects of medical care and should, as far as possible, be dealt with in relation to these wider subjects rather than as distinct and separate disciplines. As has been pointed out² so succinctly, diseases are not solely "clinical entities," but rather disturbances or disequilibriums in the structure and function of the organism, which arise from both internal and external causes. Protagoras has summed this up in the phrase, "Man is the measure of all things," and, as Trousseau so clearly stated, "There are no diseases, there are only sick people." In the teaching and practice of general medicine, we are concerned with the *how*, *why*, and *what* of illness. Major emphasis has been and is still laid upon the *what* of illness. Under this emphasis, and especially in teaching hospitals, the patient often becomes "the uninteresting vehicle of a fascinating disease process." It would appear to be within the scope and philosophy of preventive medicine to concern itself actively with the *how* and the *why* of illness.

Daily, in practice in the outpatient departments and in the wards of our hospitals, we see patients in whom the neglect of health has produced minor problems of disease, and patients in whom the neglect of the latter has produced major problems of illness. The *how* and *why* had been disregarded and the *what*, being minor, was not considered important. In the average teaching hospital outpatient or receiving room, it is well known that neither the senior nor the junior staff evince much interest in minor illnesses. This is unfortunate because it is in the early stages of illness, when complaints and findings are often minor, and at the time when the patient is often most ready to listen to advice, that a golden opportunity is offered for the initiation of preventive practices. This is one of the areas in which preventive medicine should be allowed to function.

A further extension of this type of practice concerns the desirable role of preventive medicine in ambulatory care in outpatient departments. Historically, the outpatient department

has been in a sense the stepchild of the clinic, generally manned by junior members of the staff who regard it as a stepping stone to service on the staff of the hospital. In many instances the outpatient department functions as a graded "sieve," which permits interesting cases to pass quickly through its mesh into the wards, while at the same time, by agile manipulation, the "undesirables," the minorly sick, the chronically ill, and other categories of patients are kept in a state of agitation which not only prevents them from slipping through the mesh but also, because of an improper realization of the function and responsibilities of ambulatory care, is downright bad for the patients. While this analogy is somewhat exaggerated, the question should be asked as to whether most outpatient departments are fulfilling their function as a major line of defense against illness.

It is in the outpatient department that preventive medicine can and should play its practical clinical role. In a further extension of this thought, extramural hospital service might be added. Under its influence would come the problems concerned with the maintenance of health, the treatment of the minor or ambulatory sick, the rehabilitation of the sick and injured, and the problem of maintaining the chronically ill as functioning social and economic units at as high a level as the patient's illness permits. In a sense, the mission of preventive medicine would be that of the general practitioner who has a special knowledge of human beings and of the early signs and symptoms of disease, who initiates prophylactic measures, who takes care of the minor or chronically ill, and who, if the need is such, refers the patient to a specialist.

In addition, under the guidance of preventive medicine, the outpatient department could be made an educational forum in which the fledgling student of public health could be brought into intimate contact with the latest developments in the clinical sciences, while the clinician would profit by his contact with the philosophies and practices of the public health and preventive medical sciences.

It is suggested that the time has come when preventive medicine should be asked (or forced) to abandon its academic aloofness and to test its theories and philosophies in a practical manner. Departments of preventive medicine should be

assigned the functional and administrative responsibilities and authority necessary for operating outpatient departments, and for developing plans and liaisons for the continuing education of students, interns, residents, and practitioners in its philosophies and practices. It seems reasonable to believe that this change in responsibility for outpatient services can be brought about without disturbing any of the relations, either academic or inpatient care, which now exist with the clinical sciences. The only change would be that emphasis in medical care would be more equally distributed between the various factors in illness rather than primarily on the problems of diagnosis and therapy.

A proposal such as has just been made is not revolutionary in character, and, despite possible thought to the contrary, does not represent a threat to the prestige, dignity, or integrity of the clinical sciences. It will relieve the clinical departments of the administrative burden concerned with outpatient management and permit them to concentrate upon the solution of fundamental and applied problems of disease. On the other hand, it provides preventive medicine with a *raison d'être* and permits it to expend its energies profitably for the general good rather than in sterile academic discussions.

In conclusion, if the program for preventive medicine which has been outlined in this presentation should be widely adopted, it must be said that the whole tenor of training, thought, and activities in many departments of preventive medicine in the country would have to be altered. This program cannot possibly be successful unless it is guided by those who, by training, have a deep insight into the problems of the clinical sciences and who, at the same time, have a sympathetic understanding of the methods and philosophies of the public health sciences. However, the future of the health and physical and mental welfare of this country, and indeed, possibly, the future of American medicine as we know it and as we like it, depends upon the rational and useful development of preventive medicine in the field of medical care.

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The Surgical Aspects of Congenital Heart Disease

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NOW, as never before, physicians are called upon to make an accurate anatomic diagnosis in patients with congenital heart disease. Cardiologists who have become specially interested in this field can usually do this by the clinical examination alone when dealing with the commoner congenital conditions. When common lesions do not produce typical findings, or when dealing with unusual anomalies, special studies such as the angiocardigram and cardiac catheterization may be necessary. Upon the accuracy of the diagnosis will depend one's ability to determine whether surgical intervention is indicated.

There are three congenital anomalies for which surgical treatment has been generally accepted. We shall confine our discussion to these three lesions, namely, (1) patent ductus arteriosus, (2) tetralogy of Fallot, and (3) coarctation of the aorta.

Patent Ductus Arteriosus

Bullock¹ and Shapiro,² on the basis of autopsy findings, placed the average age of death in patients with patent ductus arteriosus at 35 years. The cause of death was most often cardiac failure or subacute bacterial endocarditis. Certainly one seldom sees a middle-aged person with a patent ductus arteriosus. There have been only three such patients, over 40 years old, seen in the cardiac clinic of the Hospital of the University of Pennsylvania in the past 17 years. While the antibiotics have no doubt helped somewhat in the treatment of subacute bacterial endocarditis, it still remains a hazard with a considerable mortality.

Because of this decreased life expectancy in the untreated patient with patent ductus arteriosus, the operative treatment of the condition has been generally accepted since Gross⁵ performed the first operation in 1938. The mortality of the operation is insignificant when compared with the risk of the condition untreated.

In a collected series² of 643 cases operated upon by 42 different surgeons the mortality was

4.9 per cent. In our own series it is now 1.3 per cent. This would not appear to be too great a risk for an operation which increases the life expectancy from 35 years to the normal of about 70 years.

The optimum age for operation is from 4 to 8 years. We feel that the operation should be performed then as a matter of election, not waiting until cardiac failure or subacute bacterial endocarditis develops. The mortality of the operation is certainly greater in adults or in the presence of the above complications.

For those who may be interested in certain technical considerations, we, as well as Jones⁴ and others, prefer the posterolateral approach, feeling that if the ductus should be torn, we would be in the best position to deal with the problem. We, therefore, routinely use this position in the older age group or in the presence of subacute bacterial endocarditis or cardiac enlargement. The anterior incision has the advantage of leaving a smaller scar.

The patent ductus may be obliterated by two heavy silk ligatures or it may be completely divided. Gross⁵ places hemostats across the ductus, cuts between them, and then sews over the ends of the divided vessel. Crafoord⁶ places non-crushing clamps across the aorta and pulmonary artery so that the ductus may be divided and the ends closed without applying crushing hemostats. The reason for complete division is the fear that the ductus may not be completely obliterated by the silk ligatures. We have taken the point of view that the ductus will be obliterated if the ligatures are pulled tightly enough. We, therefore, pull the ligatures down as tightly as possible with the thought that if the ligatures should cut through the ductus we can then apply hemostats and divide the ductus by Gross's technique. If the hemostats should also cut through the ductus (as they did on one occasion), we then apply Crafoord's non-crushing clamps to the aorta and suture the ductus in a dry field.

In four of the first ten patients operated upon, although we have not been convinced that the ductus was not obliterated, at least one observer thought he heard a diastolic murmur at some

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TABLE I

Operation	Number of Operations	Deaths	Per Cent
Patent ductus arteriosus	78	1	1.3
Tetralogy of Fallot .	35	4	11.4
Coarctation of the aorta	11	1	9.1

time postoperatively. Since with additional experience we have felt that we could recover from the situation if the ductus were torn by the ligature, and have therefore had less fear of pulling it tightly, there has been no suggestion of a postoperative diastolic murmur in any of the patients.

In 77 operations for patent ductus arteriosus, we have used double heavy silk ligatures uneventfully in 71 instances. The ductus was divided and sutured in two instances as a matter of election. The ductus was torn in four patients. One of these was the third patient operated upon and accounts for our only mortality. In the others we used the methods outlined above.

When a patient with no other lesion has gone through a successful operation for a patent ductus arteriosus, we believe that he may be considered normal thereafter.

Tetralogy of Fallot

The congenital defect which leads to the "blue baby" syndrome is the overriding of the aorta with a high intraventricular septal defect so that venous blood goes from the right ventricle directly into the aorta without passing through the lungs. The amount of blood which takes this abnormal route is increased by the stenosis of the pulmonary artery. There are other defects which produce cyanosis, so that the cardiologist must be prepared to ascertain which patients in the cyanotic group can be helped by surgery.

The object of the operation for the tetralogy of Fallot is to increase the blood flow through the lungs. This was first done by Blalock,⁷ in 1944, by making a shunt from the systemic circulation to the pulmonary circulation and has since been shown to be an effective procedure.

The optimum age for operation is from 4 to 12 years, and the lowest mortality is in this group. The technical difficulties of doing arterial anastomoses on smaller infants make it desirable to wait until the child is about 4 years old if possible. However, if it is obvious that the patient will not survive to reach that age, operation cannot be deferred. The decision as to whether the operation can be deferred is based upon the

child's general condition, the arterial oxygen saturation, the degree of polycythemia, and the evidence of cardiac failure.

Because of the polycythemia, which most of these patients have, they should be transfused with plasma at the time of operation rather than with whole blood. This decreases the risk of thrombosis. Heparin is not used unless there is some evidence of thrombosis.

One of the greatest problems in the preoperative diagnosis of these patients is to ascertain whether there is a deficiency of blood going through the lungs due to pulmonary stenosis or whether the cyanosis is due to a mixing of right and left ventricular blood. Determination of pulmonary artery pressures by cardiac catheterization may be diagnostic. The pulmonary artery pressure can also be determined at the time of operation. If the pressure is under 300 mm. of water, one can be reasonably sure that the patient will be helped by a left to right shunt. At this time we are not prepared to say at exactly what level of pressure the operation should not be performed. At least two of our patients with pressures well over 300 mm. of water appear to have been considerably improved by the operation.

The operation involves the anastomosis of any available systemic artery, of adequate caliber, to the pulmonary artery. Blalock⁸ prefers to use the subclavian branch of the innominate artery. Holman⁹ and Paine and Varco¹⁰ have preferred to use the subclavian branch of the aorta for the anastomosis. Blalock feels that the angle made by the subclavian branch with the innominate artery is better than with the aorta, but agrees that in the older age group and in tall individuals the subclavian branch of the aorta may be preferable.

Potts, Smith, and Gibson¹¹ have done a lateral anastomosis between the descending aorta and the pulmonary artery by using a clamp which allows the blood flow to continue through the aorta during the anastomosis. In our hands, the Potts operation has seemed simpler to perform than the Blalock operation. We prefer it in children weighing under 30 to 40 pounds, but when they are over that size there is little to choose between the two procedures. Many patients with the tetralogy of Fallot have a right-sided aorta, so it is important to be certain of its location before operation. It is more difficult to do the Potts operation in the presence of a right-sided aorta. We feel that it probably should not be attempted in children over 40 pounds in weight. We are not aware that size is a limiting factor for the Potts operation on the left side.

In doing the Potts operation in infants, there is a real danger of making the anastomosis too large and throwing the patient into cardiac failure. This occurred in two of our patients who weighed less than 11 pounds, but they both responded to rapid digitalization. The opening as a rule is made about one-fourth inch in length.

The subclavian artery and the pulmonary artery can usually be brought together without undue tension. When the subclavian artery is unusually short, we have divided the pulmonary artery so as to bring it up for an end-to-end anastomosis as suggested by Blalock.⁸ In two patients, however, the subclavian artery seemed too short to do even this. In both instances, we¹² used a section of the superficial femoral vein as a graft to fill the gap. Gross¹³ has used refrigerated arterial grafts from fresh cadavers for this purpose.

The operative mortality has been in the neighborhood of 10 to 20 per cent in most series. It will depend to a considerable degree upon the state of the patients accepted for operation. Two of the four deaths in our series were due to massive pulmonary emboli. The other two were very poor risk infants.

It should be understood that the operation for the tetralogy of Fallot does not correct the cardiac defect but produces another one to compensate for that already present. Nevertheless, while the operation does not change the patient to a normal individual, there can be no doubt that most of these patients are greatly improved. The arterial oxygen saturation and polycythemia change toward the normal and the patient's activity can be greatly increased. Time alone will tell us what the life expectancy will prove to be.

Coarctation of the Aorta

Coarctation of the aorta is a congenital anomaly in which there is a constriction of the aorta at or near the ligamentum arteriosum. In the commonest variety there is an abrupt constriction and this is known as the adult type. Occasionally there is an elongated narrowing of the aorta and this has been known as the infantile type, according to the classification of Bonnet.¹⁴

Patients with coarctation of the aorta may reach the late teens or early adult life without symptoms. However, hypertension in the upper extremities develops, also the complications associated with it. Death is usually due to cardiac failure, cerebrovascular accidents, or actual rupture of the aorta due to degenerative changes in it. Maude Abbott¹⁵ found the average age at death to be 33 years.

The diagnosis is usually suspected because of

hypertension found perhaps during a routine physical examination in a young individual. It will be found that the pulses in the lower extremities are weak or absent. Pulses can usually be felt in large subcutaneous arteries in the interscapular region. They are a part of the collateral circulation. X-ray examination of the thorax usually reveals scalloping of the ribs by the large intercostal arteries and the aortic knob is small or may not be seen. The defect may be clearly shown by an angiogram, but this is not necessary for diagnosis.

The first operation for coarctation of the aorta was done by Crafoord¹⁶ of Stockholm in 1944. He placed non-crushing clamps across the aorta above and below the constriction, excised the constricted area, and brought the remaining ends together with a continuous silk suture. Gross¹⁷ did the first operation in this country shortly thereafter.

In order that such an operation may be successful, it must be done before there have developed in the aorta degenerative changes of such a degree that the sutures will not hold satisfactorily. It is important, therefore, to make a diagnosis and bring these patients to surgery before that occurs. Unfortunately, one cannot determine the extent of degenerative changes in the aorta preoperatively. In order to be reasonably certain that the operation is done before the degenerative changes occur, we feel that the time of election for operation is from 12 to 15 years of age. This is at a time when the patient has few or no symptoms. The operation may be done after that age, but in general the risk increases as the age increases. Most of our patients have been between 17 and 22 years of age. Blalock performed one successful operation in a 42-year-old man.

The technique of operation has not varied greatly among different surgeons. Crafoord¹⁶ has used the Carrel suture technique, while Gross¹⁷ and Blalock¹⁸ prefer the continuous everting mattress suture. The Carrel technique has seemed preferable in our hands. Every effort should be made to avoid sacrificing the large intercostal arteries. We have found this to be most easily done by placing the posterior row of sutures without turning the aorta over as originally suggested by Gross. If the patient has not already obtained his full growth, it is probably wise to use some interrupted sutures so as to allow the aorta to grow.¹⁹

When the constriction is a long one and it seems impossible to pull the ends together after excising it, there are two methods which may be used. We and others^{20, 21} have used the sub-

clavian artery by turning it down and anastomosing it to the aorta. Gross¹³ has used refrigerated artery grafts to bridge the defect.

Following operation there should be a bounding pulse palpable in the lower extremities. The blood pressure should be slightly higher in the legs than in the arms. This indicates a good anastomosis and one may expect the blood pressure to fall toward normal in due time. This fall is usually gradual over a period of two to three weeks.

The mortality of the operation should be less than 10 per cent. The risk obviously depends primarily upon the presence or absence of degenerative changes in the aorta at the time of operation. Our only death was that of a 24-year-old man with a blood pressure of 260/130 mm. Hg. There were such severe degenerative changes present in the aorta that an anastomosis was not possible. Such a case demonstrates the importance of operating upon these patients before such changes occur.

It is too early to know what the late results will be following this operation. However, if the patient's blood pressure returns to normal, we anticipate that it will remain so and that such a patient may be considered a normal individual.

Summary

1. We believe that patients with a patent ductus arteriosus should be operated upon as a matter of election without waiting for the complications of the condition to develop. The optimum age for operation is from 4 to 8 years. In the absence of other defects the patient should be a normal individual after operation.

2. Patients with the tetralogy of Fallot may be most safely operated upon at the age of 4 to 12 years. While these patients are not normal individuals after operation, there can be no doubt that they are greatly improved by the procedure.

3. Operation for the correction of coarctation of the aorta should be done as a prophylactic procedure before complications of the condition develop. It can probably be most safely done at from 12 to 15 years of age. We believe that if the operation is done successfully the patient will have a normal life expectancy.

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THE GRIM TRUTH

Until someone comes up with the results of a critical survey of the *really* sick Britons and their reactions to socialized medical care, the British "patient" will continue to be represented to us as one who is tickled pink with his "free" eyeglasses, his "free" dentures, and his "free" prescriptions for cough syrup.

The real British patient, the one with a major illness or disability, may not be quite as complacent. The *Bulletin* knows of one who isn't. She's a young married woman in a small town in Sussex, the cousin of one of the ACMA headquarters staff. For six months she has been virtually helpless, strapped into an orthopedic corset to prevent aggravation of a back condition which requires surgery. There have been no hospital beds available.

Her latest letter, dated March 17, 1949, says, in part:

"Well, am afraid we are down in the dumps about it all after the examination yesterday. In the first place there isn't a chance of a bed for many, many months, and the (London) specialist says I must go and see him again on *June 8th* as an outpatient! He may then consider me for another *corset*! I told him about the pain and he just waved it aside. He says that I must have complete inactivity for this three months, but can walk a little. What a blow!

"I sincerely hope that America will not follow in Britain's footsteps (nationalized health scheme), as whatever you may hear regarding its success *from the medical point of view* is thoroughly unfounded and is purely political.

"One has only to speak to one's own family doctor to realize what a mess it all is, and how overworked the poor practitioner is."—*The Bulletin* of the Alameda County Medical Association, California.

Angiocardiography and Cardiac Catheterization as Aids in the Diagnosis of Congenital Heart Disease

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THE recent development of surgical methods for the correction of certain congenital cardiac lesions has necessitated more specific anatomic diagnoses than were required in the days when such lesions were non-correctable curiosities. This necessity for precise preoperative differentiation of the various types of anomalies has given impetus to the development of accessory diagnostic measures to supplement older standard procedures. Among these newer methods are the techniques of angiocardiography and cardiac catheterization.

Methods

Angiocardiography¹ requires the rapid injection of radiopaque material into the venous system with the subsequent exposure of multiple x-ray films of the heart. By this method, the various cardiac chambers and great vessels are outlined at different times during the passage of the contrast medium through the heart. Not only the shape of the structure but also the times of opacification are of aid in disclosing various anatomic abnormalities. This technique requires special large bore syringes and cannulas to permit rapid introduction of the viscous contrast solution. The cannula is best inserted into a surgically exposed antecubital vein. The determination of circulation times aids in choosing the most suitable intervals for film exposures. These exposures are made by an x-ray changer capable of taking seven films as often as one per second.

Precautions are necessary to reduce the hazards of sensitivity to the contrast material.² These measures include (1) intradermal, ophthalmic, and intravenous sensitivity tests, (2) a carefully taken allergic history, and (3) the presence of a prepared syringe containing epinephrine.

Cardiac catheterization³ requires the passage of a special radiopaque catheter into the right side of the heart under visual fluoroscopic con-

trol. By this method data are obtained regarding the pressures and blood oxygen content of the various chambers and vessels. Normally these are the right-sided structures, but occasionally the catheter courses through an abnormal communication and reaches a left-sided chamber or vessel. Intracardiac electrocardiography and pressure readings supplement fluoroscopy in locating the catheter tip. Pressures are recorded by one of several devices (Hamilton, saline, or electrical capacitance manometers). Blood samples are drawn from each chamber and vessel and sent to the laboratory for analysis of oxygen content. X-ray films are taken of the catheter in the various positions where pressures and blood samples were obtained. Precautions are necessary to prevent air emboli, excessive irradiation, and cardiac arrhythmias.

It is to be emphasized that both techniques require the development of a team that is trained to understand the procedures and provide rapid performance of the various steps necessary to obtain controlled accurate observations with a maximum of safety for the patient.

General Principles in Applying These Techniques to Congenital Cardiac Problems

All patients are first thoroughly studied by standard methods, including a history, physical examination, electrocardiogram, chest x-ray, fluoroscopy with a barium swallow, and circulation times. Occasionally these routine methods are supplemented by other specialized techniques such as pulmonary function studies, electrokymography, and determination of arterial oxygen saturation. When the above methods fail to provide an unquestioned diagnosis, the patients are subjected to cardiac catheterization or angiocardiography. In such patients, both techniques may be required, but certain types of lesions are relatively better demonstrated by one method than the other. For purposes of discussion, congenital cardiac lesions can be divided

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From the Edward B. Robinette Foundation, Medical Clinic, Hospital of the University of Pennsylvania.

TABLE I
MAXIMAL DIFFERENCES IN BLOOD OXYGEN CONTENT
AT VARIOUS SITES AS FOUND IN CARDIAC
CATHETERIZATION OF NORMAL SUBJECTS

<i>Difference Between</i>	<i>Maximal Difference in Oxygen Content (Vol. %)</i>
Pulmonary artery and right ven- tricle	0.5
Right ventricle and right atrium ..	0.9
Right atrium and superior vena cava	1.9

- Comment:*
- Note that the greatest differences are found in specimens from the right atrium and venae cavae.
 - These differences are probably due to "streamlining":
 - Blood returning to the right atrium originates from various organs in streams containing variable amounts of oxygen; e.g., the oxygen content of coronary sinus blood is very low and that of the renal vein quite high.
 - Streams do not mix completely until blood reaches the right ventricular outflow tract or pulmonary artery.
 - Depending on the position of the catheter relative to these streams, the blood oxygen content of a given site may be greater or less than that of adjacent chambers or vessels.
 - Inherent errors in blood oxygen analysis may slightly increase or decrease these differences.

into three groups: (1) those with no mixing of the oxygenated and unoxygenated streams, (2) those with left to right shunts, and (3) those with cyanosis.

In general, angiocardiology is of little benefit in the group of patients with left to right shunts. Theoretically this technique should be helpful by demonstrating refilling of a right-sided structure with contrast medium coming back through the shunt from the left side. Actually one can never be entirely certain that such late density of the right side is due to opaque material returning through an abnormal communication. Too often some of the original injection of contrast material is held up in venous channels of the arm or shoulder and later enters normally into the right side of the heart after the major mass has passed through. Therefore, it is practically impossible to prove whether such late opacification of right-sided structures represents recirculation of contrast medium through a shunt or simply some of the original opaque material delayed in passage. Cardiac catheterization provides far greater help in these cases by demonstrating the increased oxygenation of right-sided blood produced by such shunts, or by permitting passage of the catheter through the defect into a left-sided structure. In the other groups, how-

ever, angiocardiology may provide the answer without the need for catheterization.

Results in Specific Malformations

This paper will not review all forms of congenital defects, but will include only those amenable to surgery, plus those which most often require differentiation from operable lesions. These defects will be discussed individually under the three groups outlined above.

GROUP I—Anomalies with No Shunting of Blood

Coarctation of the Aorta.—This lesion is usually easily diagnosed by ordinary clinical methods, but the surgeon is greatly helped in planning his procedure if the exact location and extent of the coarctation can be demonstrated. For this reason we have tried angiocardiology in these patients, although results are often inconclusive. The difficulties in obtaining good films are inherent in the defect: first, many of these patients have thick, well-developed chests with heavy musculature, and second, the marked collateral circulation off the aorta dissipates the opaque material so that there is poor contrast. In certain instances the lesion can be seen (see Fig. 1). The development of aortog-



Fig. 1. Angiocardiogram of a 21-year-old male patient with coarctation of the aorta. The arrow marks the constriction in the opacified aorta. The left ventricle (L.V.) is also opacified; note the increased thickness of its walls, as measured from the edge of the contrast media to the external border of the heart.

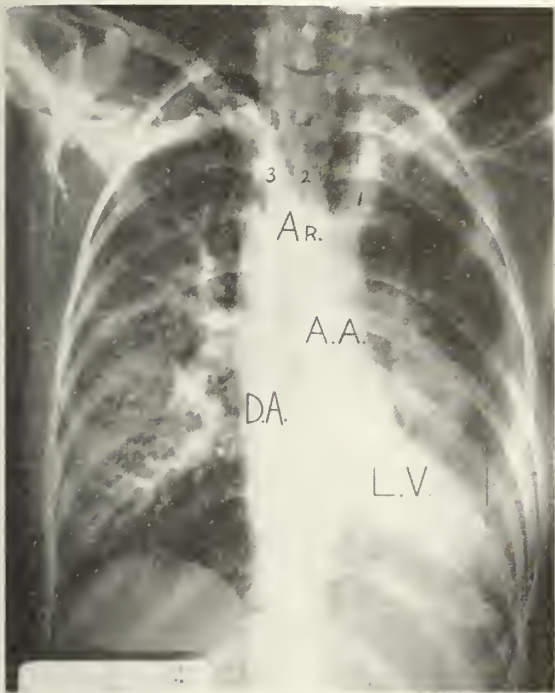


Fig. 2. Angiocardiogram of an 18-year-old female patient with patent ductus arteriosus and right aortic arch. The contrast material outlines the aorta, showing the ascending aorta (A.A.) on the left and the descending aorta (D.A.) on the right. Note that the vessels arise from the aortic arch (Ar.) in reverse of normal, with the innominate artery on the left (1), and with the right carotid (2) and right subclavian (3) arising as separate vessels. The left ventricle (L.V.) is also opacified. Note the rib defect of the previous left thoracotomy (see text).

raphy* may prove to be a better method of study in this malformation.

Right-sided Aortic Arch.—This lesion is not uncommon in association with other defects. Usually the side of the aortic arch is easily determined by ordinary fluoroscopy with barium swallow. Occasionally, however, when this is uncertain, angiocardiography is necessary to demonstrate the course of the aorta. Fig. 2

TABLE II	
CATHETERIZATION DATA FROM A PATIENT WITH PATENT DUCTUS ARTERIOSUS	
Site	Oxygen Content (Vol. %)
Right pulmonary artery	14.4
Right ventricle (apex)	12.8
Right atrium	13.1
Superior vena cava	13.3

Comment:

1. Pulmonary artery oxygen content higher.
2. Other oxygen contents in general agreement at a lower level.
3. This difference indicates a shunt of oxygenated blood into the pulmonary artery.

* Aortography is the introduction of contrast media into the aorta via retrograde arterial catheterization or injection. This technique must be considered an experimental procedure at the present time.

shows the angiocardiogram of a patient with patent ductus arteriosus and right-sided aorta. Surgeons at another institution had twice entered the left side of the chest but were unable to locate the patent ductus. Following angiocardiography and correct localization of the aorta, the ductus was found and ligated through a right-sided thoracotomy.

GROUP II—Abnormalities with Left to Right Shunts

Patent Ductus Arteriosus. — Usually this anomaly is easily diagnosed by clinical methods, but occasionally atypical cases require special studies. Cardiac catheterization is the procedure of choice and demonstrates the increased blood oxygen content of the pulmonary artery found in this condition.† Table II shows the catheterization data of a patient with patent ductus arteriosus. It is to be noted that the blood oxygen content of the pulmonary artery exceeds

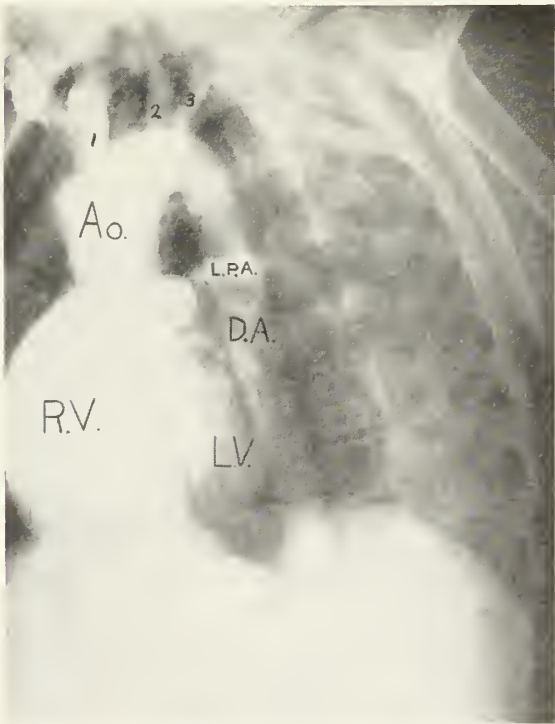


Fig. 3. Angiocardiogram of an 18-year-old female patient with the tetralogy of Fallot and right aortic arch. The aorta (Ao.) is opacified simultaneously with the enlarged right ventricle (R.V.), and before opacification of the left ventricle (L.V.). The small left branch of the pulmonary artery (L.P.A.) is seen crossing the descending aorta (D.A.). Note the absence of any significant pulmonary vasculature. As in Fig. 2, the vessels off the arch arise in reverse order as a left innominate artery (1), right carotid (2), and right subclavian (3).

† Dexter has estimated that the demonstration of increased blood oxygen content requires a defect of sufficient size to shunt at least 0.5 liter of blood per minute from left to right. Smaller shunts will probably not alter the oxygen content significantly unless the catheter tip lies exactly in the shunted stream. Catheterization data presented here for illustration are from typical patients with larger defects. Very small defects can be missed by this technique.

TABLE III
CATHETERIZATION DATA FROM A PATIENT WITH
VENTRICULAR SEPTAL DEFECT

Site	Oxygen Content (Vol. %)
Right pulmonary artery	19.8
Right ventricle (conus)	19.7
Right ventricle (apex)	19.9
Right atrium	16.8
Superior vena cava	15.8

Comment:

1. Oxygen content of pulmonary artery and two sites in the right ventricle are high and in agreement.
2. Oxygen content of right atrium and superior vena cava at a lower level.
3. This difference indicates a shunt of oxygenated blood into the right ventricle.

that of the right ventricle by 1.6 volumes per cent, a value greater than the maximal normal difference in oxygen content of blood samples from these two sites⁴ (see Table I). These data can be duplicated by such rare lesions as aortic septal defect or communication through the sinus of Valsalva, but for practical purposes they usually indicate a patent ductus arteriosus.

In this lesion, we have considered angiocardiology of less value than cardiac catheterization for the following reasons: (1) The direct proof by visualization of the communication itself has not been achieved in any of our patients. (2) Steinberg et al.⁵ have described a localized dilatation of the aorta in the angiocardigrams of patients with patent ductus arteriosus. We have observed this phenomenon in our angiocardigrams, but it is frequently ill-defined and we feel unable at present to depend on it as a pathognomonic finding. Often the aorta is poorly opacified, which seems understandable when one considers the great dilution and dispersion of the contrast medium during passage through the

TABLE IV
CATHETERIZATION DATA FROM A PATIENT WITH
ATRIAL SEPTAL DEFECT

Site	Oxygen Content (Vol. %)
Right pulmonary artery	15.5
Right ventricle (conus)	15.4
Right ventricle (apex)	15.3
Right atrium	15.2
Superior vena cava	12.4
Inferior vena cava	12.8

Comment:

1. Oxygen contents of pulmonary artery, right ventricle, and right atrium are in agreement at a higher level.
2. Oxygen contents of inferior and superior venae cavae are in agreement at a lower level.
3. This difference indicates a shunt of oxygenated blood into the right atrium.

dilated pulmonary vascular bed. (3) Enlargement of the pulmonary arteries is easily shown, but affords no differential information. (4) The presumptive evidence of the pulmonary artery refilling with contrast medium recirculated from the aorta generally fails to provide proof since delayed arrival of part of the original injection

TABLE V
PRESSURE DATA OBTAINED BY CARDIAC
CATHETERIZATION OF NORMAL SUBJECTS

Site	Pressure (Mm. Hg.)		
	Systolic	Diastolic	Mean
Pulmonary artery	18-30	6-8	.....
Right ventricle	18-30	0	.....
Right atrium .....	.....	...	-1 to +4
Venae cavae .....	.....	...	-1 to +4

cannot be ruled out (see discussion above). The development of aortography may prove a better method of contrast study in these patients.

Ventricular Septal Defect.—If this malformation is suspected as an isolated lesion, cardiac catheterization is the best diagnostic method when any special studies are needed. Data from such a patient are seen in Table III. It is to be noted that the blood oxygen content of the right ventricle exceeds that of the right atrium by 3.1 volumes per cent, a value greater than the maximal normal difference in oxygen content of blood samples from these two sites. This increase of blood oxygen content of the right ventricle over that of the right atrium signifies the shunting of oxygenated blood into the right ventricle. With certain rare exceptions, such a shunt is due to a defect of the interventricular septum.

TABLE VI
CATHETERIZATION DATA FROM A PATIENT WITH THE
TETRALOGY OF FALLOT

Site	Oxygen Content (Vol. %)	Systolic Pressure (Mm. Hg.)
Pulmonary artery	18.8	20
Right ventricle	18.4	92
Right atrium	17.1	..
Superior vena cava	17.2	..

(Arterial blood 71% saturated and hematocrit 82%)

Comment:

1. Pressure readings show:
 - a. Markedly elevated pressure in right ventricle.
 - b. Relatively lower pressure in pulmonary artery.
 - c. This difference indicates pulmonary stenosis.
2. Oxygen contents show:
 - a. Pulmonary artery and right ventricle in agreement at higher level.
 - b. Right atrium and superior vena cava in agreement at a lower level.
 - c. This difference indicates a ventricular septal defect.

TABLE VII
CATHETERIZATION DATA FROM A PATIENT WITH THE
EISENMENGER COMPLEX

Site	Oxygen Content (Vol. %)	Systolic Pressure (Mm. Hg.)
Pulmonary artery	14.1	102
Right ventricle	14.7	102
Right atrium	11.6	...
Superior vena cava	11.6	...

(Arterial blood 83% saturated and hematocrit 49%)

Comment:

1. Pressure readings show marked elevation to an equal degree in both pulmonary artery and right ventricle, indicating an absence of pulmonary stenosis.
2. Oxygen contents show:
 - a. Pulmonary artery and right ventricle in agreement at a higher level.
 - b. Right atrium and superior vena cava in agreement at a lower level.
 - c. This difference indicates a ventricular septal defect.

For reasons discussed above, angiocardio-graphy fails to provide definite evidence and is not used in instances of uncomplicated ventric-ular septal defect.

Atrial Septal Defect.—This malformation usually can be diagnosed clinically, but if further proof is required, cardiac catheterization again is the method of choice. Table IV shows the catheterization data from a patient with this lesion. It can be seen that the atrial blood oxygen content significantly exceeds that of the inferior and superior venae cavae, indicating that oxy-genated blood is reaching the right atrium. This finding usually signifies an atrioseptal de-fect, although rarely an aberrant pulmonary vein can return oxygenated blood to the right atrium. The path taken by the catheter, whether through an atrioseptal defect or into an aberrant pulmo-nary vein, is of diagnostic aid.

GROUP III—Cyanotic Patients

Tetralogy of Fallot.—Patients with this mal-formation often can be adequately studied by routine clinical measures. However, in certain patients in whom the diagnosis is not definite, considerable help can be provided by the tech-niques under discussion. We prefer to start with angiocardiology since it alone may make the diagnosis obvious, and further, may provide in-formation useful to the surgeon. The filling of the aorta, simultaneously with the right-sided structures and before the left ventricle opacifies, proves the presence of overriding aorta and ven-tricular septal defect. The size of the right ven-tricular cavity and thickness of its wall can often be seen. The presence of pulmonary stenosis

with reduced pulmonary artery blood flow is the crucial point. This lesion may sometimes be shown by visualization of the stenotic area itself, or by the presence of small pulmonary arteries and reduced pulmonary vasculature. Fig. 3 shows the film of a patient with the tetralogy of Fallot subsequently confirmed at operation; note the small pulmonary arteries and reduced pulmonary vascular opacification.

If angiocardiology fails to prove a definite pulmonary stenosis, then cardiac catheterization may provide the necessary evidence. Whereas oxygen values were of primary concern in car-diac catheterization data for the lesions previ-ously discussed, pressure readings are the key to diagnosis in the tetralogy of Fallot. In this mal-formation the right ventricle shows a high sys-tolic pressure, but if the catheter can be passed beyond the point of stenosis into the pulmonary artery, the systolic pressure falls sharply. (See Table VI and compare with normal pressure values as shown in Table V.) Where pulmonary stenosis is not present, the systolic pressure of the pulmonary artery does not fall in this man-ner.

Further evidence can be obtained, if needed, by the exercise test⁶ and the determination of

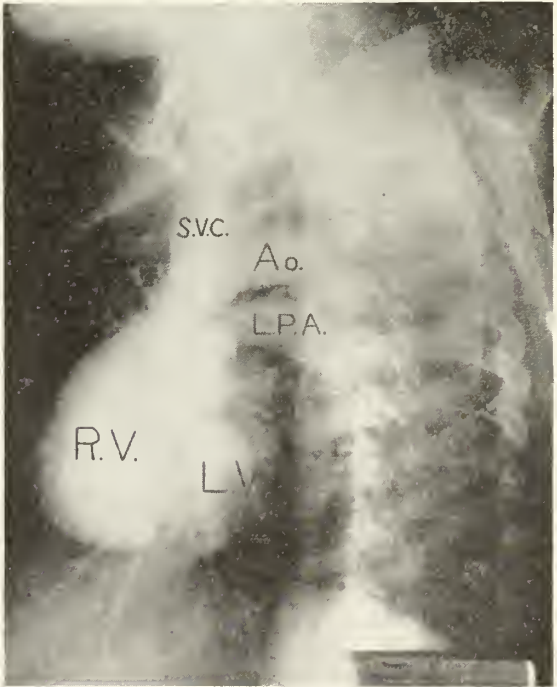


Fig. 4. Angiocardiogram of a 17-year-old male patient with the Eisenmenger complex. The aorta (Ao.) is opacified simul-taneously with the enlarged right ventricle (R.V.). The left ventricle (L.V.) is not opacified, although contrast material is seen in pulmonary vessels running through this region. The left branch of the pulmonary artery (L.P.A.) is large and ap-proaches the aorta in size. Note the pulmonary vasculature opacification, in contrast to Fig. 3. The superior vena cava (S.V.C.) is also opacified.

pulmonary blood flow. In many of these cases the pulmonary artery cannot be catheterized, and this difficulty prevents absolute diagnosis although it may be considered suggestive evidence of pulmonary stenosis. The oxygen values usually show evidence of a ventricular septal defect.

The Eisenmenger Complex.—This malformation is differentiated from the tetralogy of Fallot by the absence of pulmonary stenosis. On angiocardiology this lesion shows all the features described above, except that the right outflow tract is normal and the pulmonary arteries are normal or enlarged. Fig. 4 shows the angiocardigram of a patient with this malformation, demonstrating large pulmonary arteries and considerable opacification of the lung vessels. The contrast with Fig. 3 is readily appreciated.

Cardiac catheterization may aid in demonstrating the absence of pulmonary stenosis. In these patients the pulmonary artery is usually readily catheterized, and its systolic pressure does not fall below the ventricular reading as in the tetralogy of Fallot. Rather, the right ventricular and pulmonary arterial systolic pressures are elevated to a similar degree as shown in Table VII. The blood oxygen values provide no differential evidence, but usually show the presence of an interventricular septal defect as in the tetralogy of Fallot. The exercise test and determination of pulmonary artery blood flow may provide further help in differentiating these malformations.

Other Cyanotic Lesions.—Obviously, in this paper, all types of congenital cardiac lesions cannot be discussed in detail. There are a number of malformations which can simulate to various degrees the tetralogy of Fallot. Among the most common lesions requiring differentiation are: transposition of the great vessels, pure pulmonary stenosis, tricuspid valve atresia, truncus arteriosus, and the presence of a single atrium or ventricle.

The ease with which these various malformations can be diagnosed varies widely. In each instance the maximal amount of evidence must be assembled within the limits of safety and the probabilities of surgical correction. By correlating all the clinical, radiologic and laboratory

findings the correct diagnosis often can be surmised or suspected. There are certain instances in which the diagnosis may remain uncertain despite complete studies.

Summary and Conclusions

1. The techniques of angiocardiology and cardiac catheterization are reviewed briefly.
2. The application of these techniques to the diagnosis of certain congenital cardiac lesions is discussed.
3. It is emphasized that these techniques should not be used to replace standard clinical methods, but must be reserved for patients in whom ordinary studies prove inadequate.

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* * *

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CAN MONGOLISM BE ELIMINATED?

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FOR these past many years, Mongolism has been considered by the medical profession to be a congenital defect with a questionable etiology and a hopeless prognosis. Recently, Benda¹ has made some interesting observations from which we might gain some hope that Mongolism may eventually be eliminated. He has made an extensive study on the prenatal maternal factors in Mongolism, and he feels that they are primarily responsible for this condition.

Since Mongolism is present at birth and the characteristic anomalies date back to early stages of fetal development, the causative factors are either of a genetic nature or environmental factors operating in the pregnant mother. In 1939, Benda, Dayton and Pronty² produced evidence that Mongolism is not due to genetic factors, germ mutation, nor a primary inferiority of the ova. Consequently, we are led to believe that the environmental factors operating in the pregnant mother are responsible for this defect.

Mongolism is not a malformation or a monstrosity, but a deceleration of normal growth during the fetal period of six to fourteen weeks. At the time of most intensive fetal growth, some factors seem to slow down the growth rate with the result that certain developments, which usually take place in a matter of days, are not properly completed.

The diagnosis of Mongolism can often be made in a newborn infant by means of the characteristic physical signs:

The skin is smooth and delicate.

The hair is soft and abundant.

The skull is small, round, and has a short anteroposterior diameter.

The sphenoid and maxilla bones are underdeveloped.

The face is flattened, the nose squat, and the chin prognathous.

The eyelids are tilted outward and upward.

The ears are often misshapen.

The mouth is open, but the lips and tongue are smooth.

The hands are fat and fingers short.

The fifth fingers are often curved inward.

There is a cleft between the first and second toes.

The abdomen protrudes, and hernia is often present.

Gesell³ presents the behavioral characteristic of the infant Mongol with a distinctive picture of placidity, restlessness, grimacing, snorting, affectionate disposition, cheerfulness, imitativeness, and fondness for music and rhythm.

The Mongol develops fairly well during his first year of life, but soon after that the retardation becomes more apparent.

He sits alone at 1 year.

He walks alone at 2 years.

He uses simple words at 3 years.

He feeds himself at 4 years.

He is toilet-trained at 5 years.

He speaks in simple sentences at 6 years.

His developmental quotient will remain between 30 and 60.

After the first few years, the Mongol develops coarse skin and hair, thickened tongue and lips, tapered fingers, clumsy, awkward movements, and a guttural type of voice.

The Mongol's family is usually free of mental defects. The siblings develop normally and have no stigmata of the disease. Benda⁴ found only three cases of multiple Mongolism in the same family, one case of mongoloid children in two generations, and only three instances of twin pregnancy, in which one twin was a Mongol. Mongolism occurs about three times in every one thousand births.

Benda¹ studied a large series of mothers of Mongols and found the most significant symptoms to be: menopause, inability to become pregnant, impaired hormonal regulation, bleeding during pregnancy, menstrual irregularities, previous abortions, uterine and ovarian anomalies, and thyroid anomalies.

In the age group of 40 to 52 years, 54 per cent of the women were actually in their menopause.

Read before the Section on Medicine at the Ninety-ninth Annual Session of The Medical Society of the State of Pennsylvania in Pittsburgh, Sept. 27, 1949.

In the age group of 30 to 40 years, 81 per cent of the mothers had a slow fertilization time.

The maternal conditions which lead up to the development of Mongolism are due to:

1. Approach of the menopause in women over 40 years of age.
2. An insufficient response to fertilization in women over 30 years of age who have had no previous pregnancies.
3. An intercurrent illness which might render the mother temporarily unfit for pregnancy.

These different factors may be responsible for Mongolism in the various age groups. Any mother is potentially the mother of a mongoloid child if she is approaching menopause and carries her baby under certain adverse conditions.

The common denominator for all conditions under which Mongolism develops is a threshold condition of hormonal sterility. The maternal organism appears to be unable to produce the proper endocrine environment for the embryo. The necessary adjustments are either delayed or insufficient, so that the fetus is deprived of a number of nutritional factors which are essential for its proper development.

Until recently, the treatment of the mongoloid child consisted of one thing, and that was placement. This is highly desirable, so that the parents and siblings may have a normal home, and it is the kindest thing that can be done for the Mongol, the family, and society.

However, Zimmerman, Burgemeister, and Putnam⁵ recently reported encouraging results from the effects of glutamic acid upon the mental function of mongoloid children. Further research in this direction may yield another tool with which we may be able to treat this difficult problem.

Now, the main problem in Mongolism should be in its prevention. Since it is a decelerating growth deficiency in the prenatal period, therapy must be concentrated on factors which will increase the developmental rate of the newborn.

Although no definite cure is available today, effective treatment should be started very early in pregnancy. With increasing knowledge of these prenatal factors which operate during pregnancy and which result in these malformations, it is hoped that therapy will progress in this direction.

During the past few years, the pediatricians have received a great deal of help from their obstetric friends:

First, since vitamin K therapy has become a routine procedure in all newborns, the incidence of hemorrhagic disease of the newborn has been greatly reduced.

Second, a much better use of anesthetics has reduced the incidence of anoxia in the newborn and many of its problems.

Third, since endemic cretinism has been recognized as a deficiency disease, the use of iodine has greatly reduced the incidence of this condition.

Fourth, since Gregg⁶ has shown the importance of German measles in the production of malformations, and since Warkany⁷ has shown the importance of vitamin deficiencies in the production of congenital defects, we have had a much better understanding as to the causation of these congenital anomalies and as to how many of them may eventually be eliminated.

Perhaps it is not too much to expect that in the near future the obstetricians will solve more and more of these threshold hormonal sterility problems, and eventually lead to the elimination of this mongoloid problem.

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EDITORIALS

THE DOLLAR APPARENTLY HAS TWO VALUES

The *New England Journal of Medicine* for Oct. 6, 1949, commenting editorially on a review of the report of the Hoover Commission, touches on contrasting costs of hospital construction—voluntary and Federal—as follows:

"Government construction costs range from \$20,000 to \$51,000 per bed, with voluntary hospital construction estimated at about \$16,000 per bed. The dollar has apparently two values—fifty cents to the average citizen, and twenty-five cents when spent by the Government!" . . . Further on we read: "Research, preventive medicine, and public health—all of which are factors in the prevention of disease—should be given high priority. The best way of lowering the costs of medical care is to decrease the need for it."

Several examples are given, from which we quote briefly, of what may be accomplished by preventive measures.

"Industry.—Employers report that a first-class medical and safety department will reduce occupational disease 63 per cent, absenteeism 30 per cent, compensation cost 29 per cent, and labor turnover by 27 per cent.

"Malaria.—The estimated 2 million cases a year cost some 500 million dollars. Based on control programs around military areas during World War II, it is stated that with 53 millions spent over seven years malaria could be virtually eradicated so that only a quarter million a year would be needed thereafter to keep it under control.

"Maternal and Child Health.—If the entire country had the infant mortality and maternal mortality rates of our best states, nearly 22,000 infants and 2100 mothers would be saved annually.

"Life Expectation.—If the 15 major causes of death during the productive period from 20 to 65 were completely eliminated, life expectancy at 20 would be increased by 3.95 years; 1.95 could be achieved by full application of our present knowledge."

A WAY OF LIFE

The PENNSYLVANIA MEDICAL JOURNAL is indeed fortunate in this period of aroused public interest in the early discovery of diabetes to be permitted to bring to its readers a very enlightening series of papers and discussions on the subject of diabetes with emphasis on its treatment in children.

There is a pointed discussion on the importance of the recognition and management of the psychologic aspects of the disease in children. The emotional and personality problems which confront diabetic children, springing from the restrictions necessarily placed upon them, need to be brought to the attention of both physician and parents.

One participant in the symposium dramatized

this phase of management by stating that when the diabetic child congregates with other diabetic children, "they learn to accept diabetes and its needs as a way of life."

This issue also contains a very readable and stimulating article on "A Future for Preventive Medicine." It is of special importance since the essayist dares to develop his theme on the basis that "preventive medicine in day-to-day medical care is often barred from the clinic and forgotten, or is disregarded by physicians."

A BRIEF FOR THE HEARING-AID INDUSTRY AND FOR ITS CO-OPERATION WITH OUR PROFESSION

Recently, from the pen of a hard-of-hearing American author, Percival Wilde, there appeared in the *American Mercury* (a monthly tabloid) a severe indictment of the manufacturers and dealers in hearing aids. A regrettable consequence of this "blast" was its reprint in the *Silent World*, the British journal of the organized deaf. The title to the reprint was most uncomplimentary and unfair—"Racketeering in Hearing Aids in America, a spirited exposé of the worst side of the industry in America, where high pressure salesmanship goes hand in hand with a greedy dealer system."

In all fairness to us Americans and to our way of doing business, a rebuttal of the statements and arguments of the disgruntled author is in order.

The facts in the case are:

1. In the United States we have developed the finest hearing aids in the world, by reason of a highly competitive state of trade. Improvements in aids are going on at a steady pace from much expensive research work.

2. The cost of aids is a perennial complaint and is unfairly set out against the cost of material in production. The fact has long been known that there have been no fortunes made in the industry. On the other hand, there is a high mortality among the firms going into the business. This is true of manufacturers as well as of dealers. In one large city a popular aid is being retailed by a firm doing a gross business of \$50,000 with a net profit to the owners of \$8,000. And this is the case of a well-operated business selling a good aid.

3. Service costs to the dealer are high and unprofitable, and yet service maintenance of aids

is essential to success. Profits from the sale of batteries are negligible until a sizable renewal business is built up over a period of four to five years. Battery costs to the customer have been cut nearly in half in a period of five years.

4. When vacuum tube aids supplanted carbon sets, the increased cost to the public was not greater than 15 per cent, although production costs were greatly increased and finer workmanship was demanded.

5. The prices of vacuum sets now range from \$65 to \$200. Quality and performance are reflected in the price. The old carbon aids of better make sold for around \$100 and are now largely obsolete.

6. Advertising in the industry has been expensive but necessary, and of great public benefit. Of the seven million hard-of-hearing in the U. S. A., only 700,000 wear aids. Ignorance and prejudice have been broken down by nationwide advertising campaigns, and more and more persons are coming to know and to use aids.

7. The industry is organized in a national association with a code of ethics and rules for marketing which reduces unfair practices to a minimum. This group has for some years been cooperating with the Council on Physical Medicine and Rehabilitation of the American Medical Association. New hearing aids are submitted to the Council and are required to meet its standards for acceptance. Standards of ethical advertising are set by the Council and cooperation from manufacturers and dealers has on the whole been good.

Much itemized detail might be given to all the angles and to each of the complaints, yet, all in all, this industry and business is no different from other businesses. It has grown and improved under the competitive system, whereas already in Britain with a government-made hearing aid given away free, the free aid has met with unfavorable criticism *according to a confidential report prepared at the request of the Labor Government made by an outside survey corporation.* (This survey was undertaken when the Labor Government sensed that not enough people were applying for free hearing aids.)

Otologists, and the medical profession in general, should be thankful that here in the U. S. A. hearing aids have come to fill an enormous need to the hard-of-hearing public. Such a need existed by reason of the astounding amount of deafness and because of the indifference of the deafened public to otologic care. The deafened, like so many of us, want immediate and quick results, and so (even though an aid is but a splint, with no effect on the progression of deafness) the

hearing aid is here to stay. Our aids will continue to improve under our system, and better and better hearing will be obtained with them. "Racketeering" is not in the picture.

DOUGLAS MACFARLAN, M.D.

(EDITOR'S NOTE: Dr. Macfarlan has long been interested in the evolution of hearing aids, having been chairman of the committee making the first study of these instruments in 1926. He is a member of the committee of the A.M.A. Council concerned with hearing aids.)

OUR 101st ANNIVERSARY

A stenographic record of the transactions and the programs presented at our ninety-ninth annual convention celebrating the one hundred and first anniversary of The Medical Society of the State of Pennsylvania may be found on three score pages in this issue of the JOURNAL. For the story of the convention written in more picturesque language, with emphasis on its social and entertainment features, we are here indebted to the editors of the *Pittsburgh Medical Bulletin*, who in three successive weekly issues set forth their impressions of that which from many angles has been declared to be the best state medical society convention ever held in Pittsburgh. We quote:

The 1949 meeting of The Medical Society of the State of Pennsylvania opened most impressively on Sunday afternoon, Sept. 25, 1949. At two o'clock in the afternoon the visitors and members attending the meeting were welcomed in the Commons Room of the University of Pittsburgh by the ladies of the Woman's Auxiliary to the Allegheny County Medical Society, who acted as hostesses.

Students from the University of Pittsburgh guided the visitors on tours of the beautiful Nationality Rooms in the Cathedral of Learning, and a rare opportunity was afforded of viewing authentic and detailed representations of the cultural life of the various countries of the world, as portrayed in these beautiful classrooms surrounding the four-story Gothic-arched Commons Room of the Cathedral of Learning. Visitors were visibly impressed.

An overflow audience, with many turned away, thronged the Heinz Memorial Chapel on the campus of the University of Pittsburgh at 4 p.m. for the Religious Hour, which was preceded by an organ recital. The Chapel, famed for its beauty of architecture and stained-glass windows, was a fitting locale for the addresses delivered by Solomon B. Freehof, D.D., of the

Rodef Shalom Temple of Pittsburgh, and Howard C. Scharfe, D.D., of the Shadyside Presbyterian Church, also of Pittsburgh. Raymond E. Brittain, D.D., chaplain of the Heinz Memorial Chapel, presided over a well-rounded program, which included music by the vested Chapel Choir under the direction of Theodore M. Finney, Doctor of Music.

Rabbi Freehof pointed out how man's burdens and long sufferings through famine, war, and disease have eventually and always led to his advancement in overcoming the effects of these burdens. His sound explanation of many of the imaginary ills, anxieties, and neuroses that beset so many people today was that they are due to a lack of fundamental faith in God and in his universal laws. We cannot prevent our burdens from overcoming us without God's help.

Dr. Scharfe pointed out in his talk the many points of similarity in the medical and ministerial professions. Both are fundamentally interested in helping their fellow man. Both must have great hope, optimism, and long patience in their work. Both accomplish the seemingly impossible in many instances by practicing these attributes. His contention that many doctors feel the need of a Higher Power, and realize that in their work they can go only so far, would seem to have been borne out by the attendance of an overflow crowd of doctors and their families.

Following the religious services a social hour, including tea and a light repast, was enjoyed in the Faculty Club on the 17th floor of the Cathedral of Learning. The tremendous attendance of Pittsburghers and out-of-towners made this occasion truly worth while.

The scientific program opened at 1 p.m. on Monday, with a combined medical and surgical session in the Urban Room of the Hotel William Penn. The first portion of the program was devoted to the Symposium on the Present Status of the Silicosis Problem. Every seat of the Urban Room was filled as Dr. Burgess L. Gordon of Philadelphia opened with a discussion of the clinical aspects of anthracosilicosis and its complications.

The second phase of the afternoon session was on the newer aspects of cardiovascular disease. A capacity audience and standees along the walls and back of the hall greeted Dr. Andrew B. Fuller of Pittsburgh as he introduced the first speaker.

The scientific exhibits made an important contribution to the success of the meetings.

They were well prepared, and showed considerable work and thought on the part of the phy-

sicians who had made this effort to graphically portray these interesting subjects. The exhibits were well attended and each visitor felt that much of value had been gained by time spent in the exhibits.

Technical exhibits filled the Ballroom on the 17th floor of the Hotel William Penn and overflowed into the adjoining rooms and halls.

At the conclusion of the afternoon meeting and after the closing of exhibits there was a reception for delegates and exhibitors preceding the State Dinner in the Pittsburgh Room at 7 p.m. The banquet hall was completely filled with the 448 members and their wives and guests who attended.

At the conclusion of the excellent meal, Dr. Gilson Colby Engel introduced the guest speaker of the evening, the Honorable Clarence J. Brown, Congressman from Ohio. Mr. Brown is extremely sincere, and is one of the outstanding men of the group of legislators who are cognizant of the *socialistic* trend and are willing to put forth every effort to stop this apparently inexorable progress toward destruction. Congressman Brown made an excellent address, driving home the important facts which emphasized the disadvantages of the socialization of medicine, and pointed out that this would be the keystone in the arch of general socialization; that the present trend toward national socialization has been given considerable impetus by the excessive taxation and improper distribution of tax money. Practically 75 per cent of our taxes goes into federal distribution, with only 15 per cent going to state and 9 per cent to local use—a complete reversal of the distribution of tax money in the past twenty-five years.

In other words, the threat of national socialization is imminent and impending. Defense against the socialization of medicine will exert a powerful “braking” influence on the progress toward this unhappy end.

During the dinner, music played by Homer Ochsenhirt's Orchestra wove a fitting musical pattern into the tapestry of the evening's program. The Westinghouse Quartet in their inimitable style sang and dramatized a number of songs which were enthusiastically received.

A short playlet by Ketchum & Company, public relations consultants, was presented after the Congressman's address. It was a satisfying climax to his talk and portrayed excellently the part that the physician should play in his contact with patients, in educating them on the dangers of socialized medicine, and the accomplishments and virtues of free enterprise and American-style medicine. The Congressman's

position in this question was well presented, showing that doctors and their families represented less than 1 per cent of an average Congressman's constituents, and that he is compelled to be more interested in the opinions of the other 99 per cent. The third act of the play showed representatives of the Parent-Teachers Association, a union labor leader, a representative of the Chamber of Commerce, and a farmer calling upon the Congressman, all as a result of the efforts of the doctor in his contacts with these various individuals and groups, to inform him that they are opposed to the compulsory health insurance bill and want him to use his influence against such unnecessary, socialistic, and extravagant legislation. The Congressman enthusiastically replied that since he knew so many representative people in his district were opposed to this legislation, as well as the doctors, he would surely do all he could to see that the proposal never became a law.

The entire evening was a delightful affair and well repaid the large number who attended.

The SRO sign was out before the Urban Room as the Symposia on Diabetes Mellitus and Pediatric Endocrinology were presented. The Monongahela Room was well filled for the program on eye, ear, nose and throat diseases and the Symposium on the Advances in Surgery.

Tuesday afternoon meetings included the most recent developments in dermatology and the Clinicopathologic Conference. The Symposium on Surgery Trauma was a well-rounded program and the Obstetrics and Gynecology Conference was well attended.

The Wednesday morning program included an excellent presentation on the subject of body fluids and the Symposium on Modern Therapy. On the surgical side, the Symposium on Pediatric Surgery presented many new phases and the Section on Surgery provided an excellent program. The Wednesday afternoon program propounded the most pertinent problems to be met in nervous and mental diseases, and the outstanding problems of virus infection were discussed. On the surgical side, a Clinicopathologic Conference and excellent discussion of urologic pathology completed an afternoon replete with information.

The Thursday morning Symposium on Gross Gastro-intestinal Hemorrhage was appreciated by all who were able to obtain admission to the hall, and the program on Preventive Medicine and Public Health was equally well attended. A Symposium on Anesthesia and Surgery of Malignancy provided maximum appeal to the attentive audience. The meeting concluded with

a Symposium on Problems of the Newborn, with the pathologic and radiologic fields presenting material of considerable diagnostic value.

The Tuesday evening program at Carnegie Hall was well received, with its interesting musical program, the installation of officers, and an address by Dr. Ralph J. Gampell, who presented many interesting facets of the problems in socialized medicine as found in England. The audience carried away a new interpretation of the problems present in England and was duly appreciative of the dangers inherent and unfavorable potentialities of the socialization of medicine in this country (see address in full on page 1633).

The President's Ball on Wednesday evening was one of the most colorful attractions of the State Society meeting. The Pittsburgh Room was filled to capacity. The receiving line was headed by Dr. Wendell B. Gordon, chairman of the Committee on Arrangements, and Mrs. Gordon, who graciously introduced the guests to the incoming president of the State Society, Dr. E. Roger Samuel, and to Mrs. Samuel. Dr. Harold B. Gardner, the newly elected president-elect, and Mrs. Gardner, next greeted the guests before they were received by the incoming president of the Woman's Auxiliary, Mrs. Drury Hinton, and Dr. Hinton and President-elect Mrs. Howard H. Hamman and Dr. Hamman. After Dr. Hamman came Dr. Paul G. Bovard, president of the Allegheny County Medical Society, and Mrs. Bovard.

The music by Baron Elliot's orchestra afforded an excellent opportunity for dancing. Pleasant social relaxation and renewal of friendships continued throughout the room in the intervals between dances.

The Local Committee on Arrangements deserves great credit for much of the success of the socio-economic and entertainment features of last month's state medical society convention held in Pittsburgh. The remainder of the credit goes to hundreds of members of the Allegheny County Medical Society and its Woman's Auxiliary who individually served on numerous occasions in the capacity of host.

The University of Pittsburgh threw open the doors of its beautiful Heinz Memorial Chapel, and opened wide in its Cathedral of Learning the portals to its matchless Commons Room and Nationality Class Rooms. Ladies representing the office of the Dean of Women of the University graciously served fruit juices in the Commons Room on Sunday afternoon before the Religious Hour service in Heinz Chapel. Scores

were turned away from that service after standing room facilities were exhausted.

After the religious service the facilities of the Faculty Club in the campus Cathedral were employed to serve light refreshments to 300 men and women, many from distant points, who enjoyed, as well, the appointments of the club and the magnificent views from its seventeenth floor windows.

To the University of Pittsburgh, the Allegheny County Medical Society, the newspapers and the radio stations of Allegheny County, the Board of Trustees of The Medical Society of the State of Pennsylvania have recorded and extended expressions of appreciation and gratitude for their respective contributions to the success of "the best state medical society convention ever held in Pittsburgh."

Drs. J. W. Fredette, Harold B. Gardner, J. G. Linn, H. N. Mawhinney, J. W. Shirer, and W. B. Gordon, chairman, composed the Local Committee on Arrangements.—*Pittsburgh Medical Bulletin*.

INFANT FEEDING

With Schedule from Birth

Breast feeding of the infant under one year of age is still the method of choice for optimum growth and development. However, in spite of procedures now used to stimulate and increase the production of breast milk, most mothers are unable to nurse their babies for any length of time or in sufficient amounts. They are obliged either to give their babies a supplementary formula of milk along with breast feeding or to put them entirely on an artificial milk formula. Fortunately, most infants tolerate cow's milk well and if fed sufficient and properly prepared formulas they develop as well as babies that are breast-fed.

Newborn infants nowadays are sturdier and better developed than those of a generation ago, which is due no doubt to the excellent prenatal care of their mothers, and they are able to tolerate stronger milk formulas and greater quantities at a time. The crying, irritability, and restlessness of a very young infant are due to hunger in the majority of instances. A child that cries a great deal because of hunger will swallow air into the stomach and develop gastric distress. Therefore, so-called colic can frequently be relieved by a stronger milk formula, larger amounts, or more frequent feedings. There are

many young babies under three months who cannot take sufficient food at four-hour intervals to satisfy them and do better on three or even two-hour feedings. Self-demand feeding for the infant under three months of age is often the method of choice.

During the past year we have again changed the feeding schedules that are used in our Well Baby Clinic and have increased both the quantity and quality of the formulas for each monthly period. The type of formula given to a baby is not determined solely by the baby's height and weight, but according to the age of the infant and his appetite as well. If the child has a good metabolism and is gaining too rapidly, it is wiser to reduce the carbohydrate in the formula rather than the amount of milk which is necessary for the rapidly developing bony structure. Also, if a child has a poor appetite and is small in stature, it is again better to give a strong milk formula with added carbohydrate so that the baby gets enough calcium and sufficient calories for growth. Occasionally an obese child gets along well on partially skimmed milk and little or no added carbohydrate, especially after six months of age. The feeding schedule should be altered to suit the needs of the individual infant. In our Well Baby Clinic printed forms are made up for each month of life during the first year. They contain the formula with the amount and frequency of feedings, and the addition of other types of food and when they should be given.

We start at birth with a formula of 14 ounces of milk, 7 ounces of water and $1\frac{1}{2}$ tablespoonfuls of a carbohydrate such as Karo or sugar. The formula is gradually increased and at one month of age the baby is given 20 ounces of milk, 5 ounces of water, and 2 tablespoonfuls of the carbohydrate. The amount of milk is increased every two to four weeks, but the water remains the same. The carbohydrate is increased to 3 tablespoonfuls. At five or six months of age the baby is put on whole milk and the carbohydrate is gradually withdrawn. The number of feedings is reduced to four, and 8 ounces of milk is given at a feeding.

Most children are able to tolerate pasteurized or homogenized milk. Boiling of the milk is recommended up to six months of age as it makes a finer curd and is, therefore, more easily digested. There are some babies in whom it is advisable to use an evaporated milk formula. This is especially useful when mothers live in the country, do not have pasteurized milk, and do not wish to boil the raw milk, and also in families where there is no refrigeration. The

mother, if necessary, can make up individual bottles when needed. The formulas which we use for evaporated milk are computed from the whole milk formulas.

Cereal is usually added to the diet at two months of age, but in some instances it may be prescribed as early as one month. Vegetables are well tolerated at three months in most infants. The commercial puréed vegetables are the easiest to use, but home-puréed, fresh vegetables are of equal value. Babies as a rule like fruit and it may be added to the diet at three and a half or four months. Where constipation is present, it may be started earlier. We prescribe commercial prune juice for constipation, even in very young infants. A tablespoonful to two ounces is usually sufficient to give a normally formed bowel movement. Cathartics of any kind are of no value for infants with constipation and are harmful if used often.

At five months egg is added to the diet. Since many children show an allergic reaction to the protein in egg, a small amount should be given at a time. We recommend that the egg be hard-cooked and about a tablespoonful of the hard yolk to be pushed through a tea strainer. This should be mixed with the cereal or vegetable and not given plain, as the dryness may cause choking.

Puréed meat is added to the diet at about six months. This should also be mixed with the cereal or vegetable, as babies take it better. If an infant is anemic, the puréed meat may be added to the milk formula as early as six weeks of age. It mixes well with the milk and the preparation will pass through an ordinary nipple.

There has been an increasing tendency during the past few years to give babies multiple vitamins in the form of drops and not prescribe any form of cod liver oil or orange juice.

We have been seeing evidence of early rickets in infants under one year of age. These children invariably have been given multiple vitamin drops and no cod liver oil. Scurvy is frequently seen in babies as early as six months of age where ascorbic acid has been prescribed in place of orange juice. This is no doubt due to the absence of the P vitamin found in orange juice. If an idiosyncrasy to orange juice is present, small amounts, even as low as a tablespoonful daily, along with 50 mg. of ascorbic acid will prevent this disease. We have found that most children after the third or fourth month can tolerate orange juice, grapefruit juice, or tomato juice without any untoward reaction.

In summarizing, children nowadays need stronger formulas, can be put on whole milk at

an early age, and can well tolerate the addition of solid food during the first six months of life. Cod liver oil in some form is necessary daily as well as prescribed amounts of the citrus fruits. Children that are well fed are happy babies, cry-

ing is reduced to a minimum, and their physical and mental development is highly satisfactory.

EDITH E. NICHOLS, M.D., *Director of Pediatrics,*
Geisinger Hospital Clinic, Danville, Pa.

ONE-MINUTE CASE REPORTS

Prepared by the Commission on Diabetes of The Medical Society of the State of Pennsylvania

CASE III

Insulin Shock

(Reading time 50 seconds)

C. P., a pale, cold, perspiring 8-year-old white girl, was admitted to the hospital in a semi-stuporous state. Her mother stated that she had had diabetes mellitus since she was five years old. At 10 a.m. the child became listless and inattentive at school, slumped in her chair, and could not be aroused. She began to vomit, perspire, and throw her arms and legs about without control. Before breakfast she had been given 10 units of protamine zinc insulin and 17 units of regular insulin, one unit less than her usual daily dosage.

With the administration of 50 per cent glucose solution intravenously consciousness returned, and at 4 p.m., two hours after admission, the child was completely rational.

The findings and history in this child on admission, with confusion, perspiration, pallor, rapid pulse, and a history of convulsion, were typical of the hypoglycemic syndrome. The laboratory findings showing absence of glycosuria and a low blood sugar confirmed this.

CASE IV

Circulatory Collapse

(Reading time 60 seconds)

The patient, M. B., was first seen July 2, 1948, the day glycosuria was discovered in a routine health examination. She apparently had been diabetic for six months.

General physical examination was entirely negative. The blood sugar was 176 mg. per cent and the urine contained 2 per cent sugar. She and her husband refused to consider taking insulin.

She was not seen again until Sept. 17, 1948, when she was admitted to the hospital unconscious and in circulatory collapse. The blood sugar was 460 mg. per cent; the CO₂ combining power 7 volumes per cent; hemoglobin 82 per cent; white blood cells 16,300, and there was acetone on the breath, also Kussmaul breathing and marked evidence of dehydration. The blood pressure was 80/50, the temperature 98 (R), and the pulse 120.

With insulin, saline, M/6 lactate, and plasma she made a satisfactory recovery and left the hospital eight days later on a diet of protein 90 grams, fat 90 grams, carbohydrate 150 grams, and 25 units of protamine zinc insulin and 30 units of regular insulin before breakfast and 10 units of regular insulin before supper.

Infection is the usual precipitating cause of diabetic coma, but the changing of the character of the disease must also be kept in mind. *The initial blood sugar is not always an indication of the severity of the disease, nor is it much of a clue as to the final insulin requirements.*

ACCEPTED PRODUCTS

The following is a list of currently accepted products of the A.M.A. Council on Pharmacy and Chemistry:

SOLUTION DEMEROL HYDROCHLORIDE, 50 mg. per cc., 2 cc. ampuls and 30 cc. vials and TABLETS DEMEROL HYDROCHLORIDE, 50 mg. (George A. Breon & Co.)

AQUEOUS SUSPENSION ESTRONOL, 20,000 I.U. (2 mg.) per cc., 10 cc. vials and 50,000 I.U. (5 mg.) per cc., 5 cc. vials (Central Pharmacal Co.)

CHOLINE DIHYDROGEN CITRATE, 113.4 Gm. bulk package; IODOCHLOROXYQUINOLINE, 28.3 Gm. bulk packages (Chemo Puro Manufacturing Corp.)

SOLUTION CALCIUM LEVULINATE 10%, 10 cc. ampuls; SOLUTION ESTRADIOL IN SESAME OIL, 0.14 mg. per cc., 1 cc. ampuls and 30 cc. vials, and SUSPENSION ESTRADIOL WITH BENZYL ALCOHOL 4%, 0.14 mg. per cc., 30 cc. vials and 0.28 mg. per cc., 30 cc. vials; SOLUTION ESTRADIOL IN SESAME OIL, 0.28 mg. per cc., 1 cc. ampuls and 30 cc. vials (Chicago Pharmacal Co.)

TABLETS ANTISTINE HYDROCHLORIDE, 100 mg., OPHTHALMIC SOLUTION ANTISTINE HYDROCHLORIDE 0.5%, 15 cc. dropper bottles (Ciba Pharmaceutical Products, Inc.)

CALCIUM LEVULINATE (BULK) (Cliffwood Chemical Corp.)

SOLUTION (INJECTION) AMINOPHYLLINE, 0.5 Gm. in 2 cc. ampuls and 0.25 Gm. in 10 cc. ampuls (Carlo Erba, Inc.)

PULVULES DICUMAROL, 25 mg., 50 mg. and 100 mg.; SOLUTION METUBINE IODINE, 0.5 mg. per cc., 10 cc. ampuls (Eli Lilly & Co.)

CRYSTALLINE PROCAINE PENICILLIN G IN PEANUT OIL WITH 2% ALUMINUM MON-OSTEARATE, 300,000 units per cc. Bulk and 10 cc. vials (Merck & Co., Inc.)

SUSPENSION ESTROGENIC SUBSTANCES (WATER-INSOLUBLE), Therapules 2 mg. representing 20,000 I.U. of Estrone (Novocol Chemical Mfg. Co., Inc.)

TETANUS TOXOID (ALUM PRECIPITATED) 1 cc. vials and 5 cc. vials (Parke, Davis & Co.)

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Minutes of the Ninety-ninth Annual Session

Pittsburgh, September 26-29, 1949

MINUTES OF THE HOUSE OF DELEGATES

Monday Morning, Sept. 26, 1949

The first session of the House of Delegates of The Medical Society of the State of Pennsylvania at the ninety-ninth annual session convened at ten o'clock in the Monongahela Room, Hotel William Penn, Pittsburgh, Pa., with the speaker, Dr. Lewis T. Buckman, presiding.

SPEAKER BUCKMAN: The House will please be in order.

The Chair will recognize Chairman Wilson, of the Committee on Credentials.

DR. FRED B. WILSON (Beaver): There is a quorum present.

SPEAKER BUCKMAN: We are, therefore, ready to proceed with the ninety-ninth annual session of the House of Delegates of The Medical Society of the State of Pennsylvania.

An order of business is printed on the first page of your Transactions, and if there be no objection from the floor, that will be the accepted order of procedure for the House.

If there be no objection from the floor, we will dispense with the roll call.

The next order of business is the matter of the minutes of the 1948 session, which were printed in the December, 1948, *PENNSYLVANIA MEDICAL JOURNAL*. If there are no additions or corrections to be made to those minutes as printed, we will accept them. So ordered.

This brings us to the annual report of our retiring president. I don't suppose—and this is said with all due respect to the men who have immediately preceded him—that there has been any president so truly representative of The Medical Society of the State of Pennsylvania and who has taken such an active and definitive part in not only the affairs of this state but in the affairs of the nation as our retiring president, Dr. Gilson Colby Engel, whom I now present to you for his annual report. Dr. Engel!

PRESIDENT ENGEL: May I say that I had prepared about a thirty-minute talk, but I find by the By-laws that I am restricted to ten minutes. I have deleted whole pages, so if I should fumble through making connections, I hope you will understand. Mimeographed copies of the entire talk were distributed to you this morning.

Address of President Engel (Appendix A, page 1712)

SPEAKER BUCKMAN: President Engel's address will be referred to the Reference Committee on Reports of Officers and Standing Committees.

The next order of business is the In Memoriam.

The House stood as Secretary Donaldson read the following report:

In Memoriam

Members of the House of Delegates of The Medical Society of the State of Pennsylvania who have passed away since the 1948 session of the House (the years following each name indicate the years they served in the House):

ALLEGHENY COUNTY: John W. Ildza, 1945.

ARMSTRONG COUNTY: John S. McCafferty, 1935.

BUTLER COUNTY: Willis A. McCall, 1929.

DAUPHIN COUNTY: Hewitt C. Myers, 1938, 1940-48 (10 years).

ERIE COUNTY: Arthur G. Davis, 1930.

INDIANA COUNTY: Joseph C. Lee, 1947.

LACKAWANNA COUNTY: James D. Lewis, 1925 through 1940 (16 years).

LANCASTER COUNTY: Willis H. Lefever, 1935.

LEHIGH COUNTY: Mark A. Baush, 1946, 1947.

PHILADELPHIA COUNTY: Wm. Burrill Odenatt, 1937, 1940, 1941.

SCHUYLKILL COUNTY: Cyril A. Whalen, 1946, 1947.

WARREN COUNTY: Gail K. Ridelsperger, 1944, 1945, 1946.

SPEAKER BUCKMAN: The Chair this year will appoint tellers at the opening meeting of the House to serve not alone in counting the ballots on Wednesday morning during the election of officers, but to serve at any time during our meetings when there may be a rising vote or a vote by a showing of hands, or on such occasions as they may be called upon. I appoint Drs. Roy W. Mohler, Philadelphia; George Leibold, Allegheny; and H. Malcolm Read, York.

The usual reception for the members of the House of Delegates and exhibitors will be held Monday—today—at five o'clock in this room.

The state dinner follows the reception.

The Chair will ask the members of the House who wish to address the House or who rise at any time for any purpose to announce first their name and the name of their county.

In announcing the 1949 reference committees, the Chair takes the opportunity to call attention to the fact that with the new constitution and by-laws, the work of reference committees has been greatly diversified. It was the thought of those who framed the Constitution and By-laws, and your own thought when you accepted them last year, that this would lead to a more exact study, shall we say, of the several reports which are received from officers, committees and commissions, together with the resolutions that may be introduced, and that this in turn would lead to a more careful or more profound reference by the committee to the House. All of that is of no use unless there is discussion of controversial points.

In the past few years it has seemed to the Chair that there has been less discussion from the floor than we

used to experience a decade ago. It may or may not be a good thing, but it is the wish of the Chair and your officers that there be frank discussion from the floor.

The Committee on Credentials is:

Fred B. Wilson, Beaver, *Chairman*
Dorothy C. Blechschmidt, Philadelphia
T. Lamar Williams, Mt. Carmel

Reference Committee on Reports of Officers

Charles L. Brown, Philadelphia, *Chairman*
Charles L. Shafer, Kingston
Daniel H. Bee, Indiana
John C. Bryson, Pottsville
Norman C. Ochsenhirt, Pittsburgh

To this committee have been referred the reports of the secretary-treasurer, the executive secretary, and the chairman of the Board of Trustees. (The resolution from Columbia County Medical Society has been referred to the Reference Committee on Hospital Relations.) In addition, there have been referred to the Reference Committee on Reports of Officers the reports of the twelve trustees and councilors and the report of the delegates to the American Medical Association, as well as President Engel's address this morning.

Reference Committee on Reports of Standing Committees

Theodore R. Fetter, Philadelphia, *Chairman*
William J. Corcoran, Scranton
Herman A. Fischer, Jr., Wilkes-Barre
Mark K. Gass, Sunbury
Frederick O. Zillesen, Easton

To this committee have been referred the reports of the Committees on Archives, Educational Fund, Medical Benevolence, Military Affairs, Necrology, Public Relations, Telephone Directory, Advisory Committee to the Woman's Auxiliary, and the Committee on Workmen's Compensation Laws, except the concluding two paragraphs of that committee's report which are now referred to the Reference Committee on New Business. Other reports referred to the Reference Committee on Reports of Standing Committees are those of the State Healing Arts Committee and of the Conference of Professional Licensees.

Reference Committee on Reports of Commissions

Wendell B. Gordon, Pittsburgh, *Chairman*
John T. Farrell, Jr., Philadelphia
Hiram T. Dale, State College
Michael Margolies, Coatesville
James A. Welty, Oil City

To this committee are referred the reports of the Commissions on Acute Appendicitis Mortality, Cancer, Child Health, Conservation of Vision, Deafness Prevention and Amelioration, Diabetes, Industrial Health and Hygiene, Maternal Welfare, Nutrition, Tuberculosis, also the reports of the Advisory Committee to the Pennsylvania Board of Vocational Rehabilitation, the Commission on Mental Hygiene, and the Commission on Public Health and Preventive Medicine.

Reference Committee on Scientific Business

Henry F. Hunt, Danville, *Chairman*
Stanley D. Conklin, Sayre
Joseph Van S. Donaldson, Butler
Carl E. Ervin, Harrisburg
William T. Leach, Shenandoah

To this committee are referred the reports of the Committees on Scientific Work, Scientific Exhibit, Graduate Education, to Study Control of Rheumatic Fever, and on the Control of Syphilis and Venereal Diseases.

Reference Committee on New Business

Dudley P. Walker, Bethlehem, *Chairman*
L. Dale Johnson, Connellsville
Russell B. Roth, Erie
Daniel Ritter, Johnstown
Roy Deck, Lancaster

To this committee are referred the reports of the Committee on Medical Economics, the Commission on Emergency Disaster Medical Service, and the Committee on Public Health Legislation, except that portion of the report relating to mental health which is here referred to the Reference Committee on Reports of Commissions. Finally, to the Reference Committee on New Business is referred the report of the Commission on Defense of Medical Research.

Reference Committee on Hospital Relations

Thomas W. McCreary, Rochester, *Chairman*
John W. Fredette, Pittsburgh
William J. Goetz, Reading
Guy H. McKinstry, Washington
Willard C. Masonheimer, Allentown
Roy W. Mohler, Philadelphia
Henry Walter, Jr., Lancaster

To this committee are referred the reports of the Committees on Hospital Relations, Psychiatric Services to the Criminal Courts, Rural Medical Service, Laboratories, and Physical Medicine.

Reference Committee on Amendments to the Constitution and By-laws

Louise C. Gloeckner, Conshohocken, *Chairman*
Jesse G. Fear, Berwick
Harold B. Gardner, Pittsburgh
Augustus S. Kech, Altoona
John W. Shirer, Pittsburgh
Ex officio: E. Roger Samuel, Lewis T. Buckman, Walter F. Donaldson

To this committee shall be referred all proposals for additions, revisions, and modifications concerning the Constitution and By-laws.

[Announcement of reference committee meetings.]

SPEAKER BUCKMAN: The Chair is now ready to receive additional or supplemental reports from the several officers, committee and commission chairmen, and recognizes Secretary Donaldson.

Supplemental Report of Secretary-Treasurer

To the President and House of Delegates:

This supplemental report is devoted entirely to the history of the \$25 A.M.A. membership assessment.

When the responsibility for receiving and forwarding to the American Medical Association the \$25 membership assessment levied upon its Pennsylvania members was given the office of the secretary-treasurer, we prepared and distributed to each active member of The Medical Society of the State of Pennsylvania a combined explanatory statement and notice of indebtedness. In April, 1949, a second notice to those who had not paid was mailed out.

In July the assistance of county society officers was

solicited to encourage payment of the A.M.A. assessment. Success through the office of county society representatives has been phenomenal in some counties, mediocre in others, and nil in a score or more.

The current effort being made is not only to encourage prompt payment but to place on the record of delinquents such reasons for non-payment as "will pay eventually" (before Jan. 1, 1950), "unable to pay," or "refuse to pay."

We do not know the percentage rating in assessments paid in other state societies, such as New York, Ohio, Illinois, and California, but have been informed that we stand in sixteenth place among the 53 constituent A.M.A. societies. This is not a very proud position for the second largest society, but it is largely due to the fact that 35 of our county societies rate in our Pennsylvania percentage column with less than 85 per cent of their members paid. The average for the entire state is 76 per cent paid, but 19 of the 35 county societies above referred to fall below the state level of 76 per cent paid, and most unfortunately a few fall into the 50 to 60 per cent paid category.

The American Medical Association has made it clear that payment of the assessment shall not "work a hardship," but has stated that this is the time, also one of the objective methods by which to expect all loyal members to "stand up and be counted."

As the delegates review the table showing the current standing of their respective county societies, which will be distributed later, they should be inspired to add their efforts to those of their county society officers to bring about, before December 1, at least a 95 per cent response—a response that will definitely indicate that the membership of every county society in Pennsylvania stands back of its officers—county, state, and national—in all endeavors to support the two-year National Educational Campaign of the public, as directed by the American Medical Association.

Not more than 100 of our more than 10,000 active members are recorded as refusing to pay, and perhaps 200 have pleaded "hardship." For the former we have no answer, while those in the latter group have received, or will receive, a sympathetic and understanding reply. Most of the remaining delinquents are procrastinating and need to be told by their fellow members about the 7621 A.M.A. members in Pennsylvania who have paid the assessment. (SECRETARY'S NOTE: List on pages 1729-30, this issue, shows 8205 paid.)

Respectfully submitted,

WALTER F. DONALDSON,
Secretary-Treasurer.

SPEAKER BUCKMAN: This is referred to the Reference Committee on Reports of Officers and Standing Committees.

Does the chairman of the Board of Trustees have a report? Any trustee and councilor?

DR. MORGAN D. PERSON (Lehigh): I have a supplemental report on Rural Medical Service.

Supplemental Report of Committee on Rural Medical Service (Appendix B, page 1716)

SPEAKER BUCKMAN: This supplemental report will be referred to the Committee on Hospital Relations with the previous report from this committee.

DR. JOSEPH W. POST (Philadelphia): Chairman Palmer has asked me to read the supplemental report for the Committee on Public Health Legislation.

Supplemental Report of Committee on Public Health Legislation (Appendix C, page 1717)

SPEAKER BUCKMAN: This report has been mimeographed and is in your hands. The chairman of the committee should have prepared a short analysis which would have consumed not more than three minutes. The privilege of making supplemental reports has been abused for years.

This is referred to the Reference Committee on New Business.

Are there any further supplemental reports?

DR. JAMES L. WHITEHILL (Trustee): I have a supplemental report of the Committee on Educational Fund, dated Sept. 26, 1949:

Supplemental Report of Committee on Educational Fund

To the President and House of Delegates:

The Educational Fund Committee met this morning and completed the application forms which are to be used by the applicants. These forms will be printed and will be kept in the office of the Secretary-Treasurer, to whom the secretary of the county medical society must make application for the blanks.

Applications will be received beginning Jan. 1, 1950, and must be in the hands of the committee not later than April 1, 1950, for the beginning of the fall semester of 1950.

We sincerely hope that the secretaries of the component county societies will realize their part in the functioning of the Educational Fund Committee.

Respectfully submitted,

LOUISE C. GLOECKNER
ELMER HESS
WALTER F. DONALDSON
JAMES L. WHITEHILL, *Chairman*

SPEAKER BUCKMAN: This is referred to the Reference Committee on Reports of Standing Committees.

Are there any further supplemental reports? None!

We have today two visitors from New York State. I will introduce, first, an old friend who has been with us before and who always carries an interesting message—Dr. J. Stanley Kenney, councilor of the Medical Society of the State of New York and chairman of its Planning Committee for Medical Policies. Dr. Kenney!

DR. J. STANLEY KENNEY: This is my third consecutive appearance before this House, and I bring to you the most cordial greetings of Dr. John Master-son, the president of our state medical society, Dr. Walter Anderton, our secretary, and from the Council. Dr. Anderton regrets his inability to attend this year.

It seems that the keynote of your meeting was sounded by your President Engel in his annual report made a few minutes ago. I too feel that the time has come when the doctors should enter the field of politics, in their local areas particularly. When we realize the situation that this country finds itself in today and what is threatening, I don't think we can anymore take the placid and complacent attitude that we have in the past.

In New York we have a law that will go into effect next July called the disability sickness benefits law, which will provide cash benefits to the unemployed. That is a very complex subject. The law in New York has been incorporated as Article IX of our Workmen's Compensation Law and will be administered by the

Workmen's Compensation Board. We are giving a great deal of study to the physician relationship to that problem at the present time.

I want to thank you again for this opportunity of extending greetings from New York.

SPEAKER BUCKMAN: We are honored also to have Dr. Reuling from New York State, treasurer of the Medical Society of the State of New York and vice-speaker of the House of Delegates of the American Medical Association. Dr. Reuling!

DR. JAMES R. REULING: First, I want to express my deep appreciation for the invitation to address this House.

I was quite interested in your secretary-treasurer's report, being treasurer of the New York State Society. I noted that you paid \$7,500 for government bonds in 1939, which you have now cashed for \$10,000. But your astute secretary-treasurer points out that the \$10,000 of today is worth only \$6,650 of the dollars invested in 1939. That depreciation in dollar value usually precedes a depreciation in human values, and finally a depreciation of human rights until we get down to the socialist state.

At the present time we are at a crossroad in medicine. Just before I left New York to go to Chicago last week some information came to me which I beg leave to present to you if you will give me a little additional time. It is in the form of a letter from the Department of Justice, Washington, D. C., to the Medical Society of the State of New York and was dated Aug. 25, 1949. Similar letters were addressed to the Nassau County Medical Society, the Queens County Medical Society, the New York County Medical Society, and the Bronx County Medical Society. The letter follows:

"DEAR SIR:

"In connection with an investigation by this Department of alleged violations of the Federal Anti-Trust Laws in the medical field, it is requested that you make available for examination by the bearer, an agent of the Federal Bureau of Investigation, such of your files as he may request. Your cooperation in this investigation will be very much appreciated.

"Sincerely yours,

"HERBERT A. BERGSON,
Assistant Attorney General."

"Address reply to The Attorney General and refer to initials and number JEM 60-21-44."

"Information desired by the Anti-Trust Division, U. S. Department of Justice:

"A. Organizational setup of the medical society, including—

1. Constitution and by-laws.
2. Names of officers.
3. List of committees, boards, bureaus or other bodies within the organization.

"B. Review of all files, including correspondence, minutes of meetings, memoranda, and so forth, from Jan. 1, 1945, to date pertaining to—

1. Medical economics, prepaid medical plans, contract practice of medicine.
2. Group hospitalization policies or contracts, as well as reference to practice of medicine by hospitals.
3. Correspondence between your society and the American Medical Association, or any other national or local medical society.

4. Conditions or rules of eligibility necessary—
 - a. To become a member of your medical society.
 - b. To take specialty board examinations.
 - c. To use the facilities of hospitals approved or used by your society.
5. Code of ethics of your society—
 - a. Disciplinary action as to members.
 - b. Suspension or expulsion of doctors from your society.
 - c. Rejection of applicants to your society.
6. Occupation or efforts to occupy office space by doctors in the various medical buildings.
7. Publications and literature published by your organization.
8. Formation of doctor-sponsored prepaid medical care with details of any such plans.
 - a. Legislation or proposed legislation on prepaid medical care.
9. Malpractice insurance.
10. Doctor employment agencies."

It is not you as members of the House of Delegates who have to be alerted to this thing; it is your confreres, your patients, the people in your own localities; let them know what is going on. This is Gestapo technique in my opinion, and I am entitled to my opinion.

SPEAKER BUCKMAN: The Medical Service Association of Pennsylvania has asked permission to make a report through its president. If there be no objection from the floor, the Chair recognizes Dr. Daugherty.

Report of the Medical Service Association of Pennsylvania (Appendix D, page 1720)

(In reading his report Dr. Daugherty made the following interpolations:

Of the 195 members of this House of Delegates, only 16 are not participating physicians.

In a survey of subscribers made several months ago, this question was asked: Did your doctor accept Blue Shield service in full for his service? 54.9 per cent said yes; 43.5 per cent, no. In other words, 43 per cent of the subscribers are paying additional fees to the doctors.)

SPEAKER BUCKMAN: The surgeon of the Second Army Area has asked the privilege of the floor for a few moments. We present to you Col. Harold W. Glatly, of Fort Meade, Md.

War Department and Civilian Doctors

COLONEL GLATLY: I am the surgeon of the Second Army Area, which covers seven states, of which Pennsylvania is one, an area with about 80,000 troops in it. We have in your state about eight hospitals and fifteen dispensaries.

I am indebted to you for your courtesy in granting me a few moments.

As representatives of the medical profession in the State of Pennsylvania, I feel that you do have a very real interest in the armed forces as well as your own civilian communities with respect to maintaining high standards of medical attendance.

The validity of your interest and what you have done for us was wonderfully well illustrated this past summer. Had it not been for the action of certain of the members of your society, some of whom are delegates to this particular session, there would have occurred ere now a serious breakdown in medical service to the troops in this army area. So we feel that you do have a very real interest in the medical service to your own army, navy, and air force.

One of the most important, certainly one of the healthiest changes that has come about in the service during my career has been the close liaison that has been established between military and civilian medicine since the war. I doubt if many of you here realize just how important has been your voice in formulating broad general policies that affect the medical services to the armed forces. You may not know that there has been a continuous stream of the leaders in the several fields of American medicine in and out of Washington acting as advisors to the Surgeon General, even to some of the major staff sections. The Director of Personnel Administration, that is the War Department G-1, has been utilizing civilian doctors in his office to advise him with respect to medical procurement.

I am sure you know something about the committees that have been operating in Washington on the level of the Secretary of Defense, committees of civilian doctors advising the Secretary of Defense with respect to the needs or requirements of the armed forces. Of course, I know that you are familiar with the fact that we now have a Director of the Medical Services to the Armed Forces in the office of the Secretary of Defense, a position now held by Dr. Allen, president of Washington University, who is turning over his office to Dr. Miling in October.

Not only has this close relationship between military and civilian medicine been existent on the policy and planning level but it reaches right down to the operational field. Every single army hospital in the United States today has assigned to it civilian doctors who are mature, board-certified men, who are supervising their own particular specialties in these hospitals, and heading this entire consultant program is one of your own members, Dr. Garfield G. Duncan, of Philadelphia.

As senior consultant to the Second Army Area we have another of your delegates, Dr. Ravdin.

I am taking time to make these few remarks about the relationship of military and civilian medicine because I consider it extremely important that you recognize that this close liaison does now exist and that you through your representatives are now, in collaboration with us, actually determining military medical policies, and, of course, as a corollary to that the responsibility for these policies must now be shared between us.

I personally feel that had this close relationship been operative between World Wars I and II, certain of the misguided policies that were in existence in World War II could have been avoided.

In line with this trend of thought, may I say that I feel it to be one of the functions of my office as surgeon in the Second Army Area to appear before medical groups such as are assembled here in Pittsburgh today to report not only upon our local problems but to brief you with respect to the more important and vital changes in policies that are affecting the medical services to the entire armed forces, and there have been, gentlemen, some rather revolutionary changes in policy effected since the war, based upon our experiences in the last one. However, I do not have the time even to so much as outline these matters to you, but I do hope that next year an opportunity will be granted for a representative of the Medical Corps to present at a general session some of these military medical matters that would be of particular interest to the members of your society.

Today I only want to make mention of one particular topic, but it is one that I believe is uppermost in the minds of most of you. How have we been able to meet

the present emergency with respect to the critical shortage of doctors in the services?

You are probably familiar with the fact that from July of this year to July of next the Medical Corps of the Army and Air Force is losing 2700 doctors. These represent the last of that pool of young doctors who were trained during the war under the army specialist training program. Obviously, no procurement policy or method could possibly cope with any such mass separation as this.

I am not going to detail to you the various procurement efforts that have been made, but I will report to you that, in addition to our normal procurement methods, our residency training program which is conducted in both general hospitals and your civilian hospitals and our intern training program which is likewise conducted in both military and civilian hospitals have both been very successful, and it now appears that by July, 1952, the Corps will be back to normal. I personally think that we will be operating in a practically normal fashion by July of 1951, less than two years away.

Now with respect to our own Second Army Area. The first priority for the Surgeon General was obviously to staff his overseas stations, and of almost equal priority was the necessity to support our residency training program—a program which is going to be the means of getting us out of this emergency. To support that program in our general hospitals, the bulk of this shortage of doctors must of necessity fall upon the zone of interior small station hospitals, and so forth; in other words, upon the several army areas, of which there are six.

Last April we predicted that the number of medical officers in this area would drop from 170 to 40 by the first of September. I think we almost hit the nail on the head. Today we have 40 doctors in uniform in the Second Army Area. We have tried to keep one man in each station in uniform. We tried a number of expedients to keep some semblance of medical service going for our troops this summer. Our initial appeal was to the reserve officers, and they responded very generously; on short tours of duty they contributed between 4000 and 5000 professional days in our hospitals this summer. Some of them would have closed had it not been for the action of these reserve officers in volunteering their services.

We used third-year medical students this summer, and they worked out splendidly. These, however, were rather mature type of students who had served during World War II and held reserve commissions in the line. Some of them were majors in the Field Artillery. They were familiar with army procedure and worked out very well; in addition, they are going back as enthusiastic missionaries to their various universities. We had a number from Pittsburgh at Fort Meade this summer.

We likewise initiated a program to hire civilian doctors under civil service contracts to practice in our hospitals. We are very much indebted to our consultants especially, who pushed this program and combed the hospitals throughout this area to find young men who needed to fill in a short gap in their professional career; possibly they just finished a course in professional training and had a desire to recoup a bit financially before setting up for themselves. Anyway, we have done fairly well with that.

However, this has been a hand-to-mouth sort of arrangement. The doctor is here today and gone tomorrow. We needed some sort of program that would

provide some continuity in terms of staffing our hospitals, and such a program was devised by Dr. Raydin in Philadelphia last July. This program does provide the continuity we need. It is especially of value in helping us staff two of our largest hospitals in this Army Area—that at Camp Campbell, Kentucky, where we have an air-borne division, a 300-bed hospital, and at Fort Knox, where we have an armored division, and it is a 400-bed hospital.

I feel that I should read to you sections of a letter, dated September 15, written by Dr. Garfield G. Duncan to the chairman of each Army Area Committee with respect to this:

"DEAR DOCTOR:

"It is probable that in the near future the Surgeon of your Army Area will discuss with you the possibility of solving the zone of interior shortage of doctors in the Army along the lines already in operation in the Second Army. In short, this plan originated with Dr. Raydin and was put into effect by the Surgeon of the Second Army, with the cooperation of the staffs of several hospitals in Philadelphia, and involves the rotation of residents of the respective civilian hospitals through army hospitals, with the period of service as civil servants being two months. Several Philadelphia hospitals have taken on the responsibility of providing adequate professional service in this manner to Camp Campbell, Kentucky."

(And, incidentally, it has now also been implemented at Fort Knox.)

"This plan has the approval of the Pennsylvania State Board of Medical Education and Licensure and the fact that visiting consultants of the Camp Campbell station hospital are board men in their special specialties and the home hospital assumes the responsibility that this two months' tour is part of the residency training prevents possible difficulties in qualifying to take the board examination."

In closing, he says, "I am sure I speak for the National Committee, Drs. Woodhall, Schull, Hanson and Griswold, in hoping that the Army Area Committees will help in every way possible to achieve for the respective armies the full advantage that the foregoing plan offers in the solution of the doctor shortage."

I now want to pay tribute to the Pennsylvania State Board of Medical Education and Licensure. When Dr. Raydin wrote to them with respect to this plan to meet the problem that existed here in the Second Army, they replied that they considered it a patriotic duty that an exception be made to the ruling that a resident must not change his location from one hospital to another.

Gentlemen, I think that I have said enough to indicate the truth of my original assertion that you have indeed made our problems your problems. The action that has taken place this summer in this area, especially in Pennsylvania, is likewise a splendid answer to those who would indict the American medical profession with failure to assume their obligations.

In closing, may I give you the greetings of our Second Army commander, Lieutenant General Leonard T. Giereau, and his staff and their appreciation of the efforts you have made to help us this summer.

SPEAKER BUCKMAN: Are there any resolutions or motions to be offered?

DR. WALTER S. CORNELL (Philadelphia): The Philadelphia County delegation has asked me to represent the delegation in offering this statement and resolution:

Resolution

WHEREAS: 1. Two branches of the drugless therapy group, namely, masseurs and chiropractors, at the last session of the Legislature asked for more specific recognition by the passage of laws establishing separate boards of examiners for their licensure.

2. Both houses of the Legislature passed, and the Governor approved, House Bill 312 creating a State Board of Chiropractic Examiners. A companion bill, House Bill 313, failed to pass the Senate by reason of a tie vote. Doubtless a bill similar to House Bill 313, providing for regulation of the practice of chiropractic will be introduced at the next session of the Legislature, and in the event of its passage a State Board of Chiropractic Examiners will exist and operate.

3. As shown clearly in every annual State Board number of the *Journal of the American Medical Association*, a basic science law which provides for a separate examining board in the basic sciences of anatomy, physiology, bacteriology, chemistry, pathology and hygiene, successfully screens out most of the unfit, and so prevents even their appearance before the licensing board. It may be remarked that the existence of a Basic Science Board does not hamper a licensure board in any way, the licensure board being free to conduct its own examinations in the same subjects and to reject those who fail to pass.

4. The last State Board number of the *Journal of the American Medical Association*, issue of May 21, 1949, page 321, reports that in the nineteen states and territories which have basic science laws 65 per cent of the chiropractors appearing failed to pass.

5. The medical profession will have a stronger case before the public and before the members of the Legislature if it works for the passage of laws evidently designed to protect the public from unqualified members of the healing art, regardless of whether they be physicians, osteopaths, chiropractors, or others; therefore, be it

Resolved, That without abatement of effort to defeat any bill similar to House Bill 313 of last Legislature, the chief effort of this Society to protect the public against cults, the members of which possess inferior education, shall be directed toward the passage of a basic science law in Pennsylvania.

SPEAKER BUCKMAN: This is referred to the Reference Committee on New Business.

DR. WILLIAM A. COGGINS (Lackawanna): Lackawanna County Society offers the following resolution:

Resolution

Resolved, That the delegates of Lackawanna County Medical Society be instructed to introduce at the proper meeting of the House of Delegates a resolution calling upon the Legislative Committee to have introduced before the next meeting of the Pennsylvania legislative bodies, and at an early date during the legislative session, a bill

1. Liberalizing the length of time an employer will be liable for the medical and surgical expenses of employees.

2. Providing increases in moneys, or removal of limitations.

3. Providing medical and surgical care as long as the nature of the injury or illness may require.

SPEAKER BUCKMAN: This is referred to the Reference Committee on New Business.

Are there other resolutions or motions to be presented? Any supplemental reports? If not, a motion is in order to adjourn, with a specified time for our next meeting.

DR. WALTER S. CORNELL (Philadelphia): I move that we adjourn until three o'clock this afternoon.

[The motion was seconded by Dr. Ward O. Wilson, of Clearfield, put to a vote, and carried.]

[The House adjourned at twelve-five o'clock.]

GILSON COLBY ENGEL, *President*

LEWIS T. BUCKMAN, *Speaker*

WALTER F. DONALDSON, *Secretary-Treasurer*

Monday Afternoon, Sept. 26, 1949

The second session of the House of Delegates of The Medical Society of the State of Pennsylvania convened at three-fifteen o'clock, Speaker Buckman presiding.

SPEAKER BUCKMAN: The House will be in order.

DR. FRED B. WILSON (Beaver): There is a quorum present.

SPEAKER BUCKMAN: Unless there be objections from the floor, we will dispense with the roll call as well as with the reading of the minutes of this morning's meeting.

At this morning's meeting, a resolution was presented from the Lackawanna County Medical Society relative to legislation in regard to workmen's compensation. It was referred by the Chair to the Reference Committee on New Business. It has been pointed out to the Chair since then that it would be more appropriate to refer it to the Reference Committee on Standing Committees, inasmuch as they have to consider other reports from the Committee on Workmen's Compensation Laws. In order to do this, it will be necessary for the House to discharge the Reference Committee on New Business from consideration of this resolution and to refer it to the Reference Committee on Reports of Standing Committees. Will someone please offer such a motion?

DR. GEORGE L. LAVERTY (Dauphin): I so move.

[The motion was seconded by Dr. Ward O. Wilson, of Clearfield, put to a vote, and carried.]

SPEAKER BUCKMAN: We therefore refer this resolution to the Reference Committee on Standing Committees.

The Chair recognizes Dr. Hopkins.

DR. WALLACE E. HOPKINS (York): This resolution is offered by the York County Medical Society:

Resolution

WHEREAS, The House of Delegates at the 1948 Session of The Medical Society of the State of Pennsylvania adopted the revision of its Constitution and By-laws; therefore, be it

Resolved: 1. That a committee be constituted to evolve a model constitution and by-laws for component county medical societies.

2. That it conform with the Constitution and By-laws of The Medical Society of the State of Pennsylvania.

3. That copies be made available to component county medical societies for their consideration.

SPEAKER BUCKMAN: This is referred to the Reference Committee on New Business.

The Chair recognizes Dr. Hadley.

DR. JAMES E. HADLEY (Venango): At the last meeting of the Venango County Society, Sept. 16, 1949, it was voted to instruct our delegates to introduce the following resolution concerning the manner of appointing physicians for the further treatment of school children following their physical examinations:

Resolution

WHEREAS, One certain individual physician in each community has been arbitrarily appointed to care for further treatment of school children following examination; and

WHEREAS, In each community where these physicians are appointed there exist several well-qualified practitioners in the specialty; and

WHEREAS, One physician has been so appointed in Oil City and Meadville and none at all in Titusville, and the weather in this district is inclement during the winter, working a hardship on the patients; and

WHEREAS, The method of appointment of single practitioners of these specialties in individual cities is detrimental to the free choice of physician by the patient; therefore be it

Resolved, That the appointment of individual specialists only in certain cities be stopped and that those children needing further medical care be treated by any qualified physician specializing in that field in their home communities.

SPEAKER BUCKMAN: This is referred to the Reference Committee on New Business.

Are there any other resolutions? Any correspondence?

There being none, we come to new business.

One reference committee is prepared to present a partial report. The Chair recognizes Dr. Walker, chairman of the Reference Committee on New Business.

Report of Reference Committee on New Business (Continued on page 1708)

DR. DUDLEY P. WALKER (Bethlehem): *Committee on Medical Economics.*

This report is divided into five portions:

1. The Committee on Medical Economics reports

that an agreement and fee schedule was negotiated with the Veterans Administration and finally became effective on Jan. 1, 1949, and was renewed for one year from June 30, 1949, and was published in the June, 1949 issue of the PENNSYLVANIA MEDICAL JOURNAL.

2. The committee reports that V. A. Technical Bulletin 5-51 prohibits the establishment of an office for engaging in private practice by full-time members of the V.A. Department of Medicine and Surgery, and further prohibits such full-time members from engaging in private practice, except certain emergency consultation services and emergency medical services.

3. The committee studied the request of the National Foundation for Infantile Paralysis for a state-wide fee schedule and recommended to the Board of Trustees that physicians should be reimbursed at local prevailing rates, and that no state-wide fee schedule be formulated at this time.

4. The committee studied the proposed increase in telephone rates and found no evidence of discrimination against doctors of medicine.

5. The Medical Economics Committee reports a meeting, together with members of the Board of Trustees, the Commission on Industrial Health and Hygiene, and presidents and secretaries of some of the directly affected county medical societies with area directors of the United Mine Workers Health and Welfare Fund.

As a result of this meeting, the committee finds that the program outlined by the area directors seems to be entirely within the recommendations made in March, 1947, by the Commission on Industrial Health and Hygiene and the Committee on Medical Economics and expresses approval of the program as outlined. Further, the committee recommends (a) that fees paid physicians by the Fund be the same as those paid for like services in the community; (b) that county societies so desiring may negotiate county-wide fee schedules with the Fund; (c) that, before adoption, such county fee schedules be submitted for review to the Committee on Medical Economics of The Medical Society of the State of Pennsylvania.

Your reference committee feels that the Committee on Medical Economics has faithfully fulfilled its purpose to study and make recommendations on those matters referred to it by the House of Delegates and the Board of Trustees and recommends acceptance of its report as submitted.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Wilbur E. Flannery, Lawrence County, put to a vote, and carried.]

DR. WALKER: *Committee on Public Health Legislation.*

This report discusses only the important bills of the total of 161 that had health or medical care provisions in them which were introduced in the 1949 regular session of the Pennsylvania Legislature. The report discusses in detail eight controversial bills and their fate and then mentions briefly 26 more that were enacted.

The eight controversial bills are as follows:

Licensing of Nurses.—H. 18 providing for licensing and registration of practical nurses was indefinitely postponed in the House Committee. An amended bill S. 497, providing for the continuation and exemption of present and future practical nurses practicing in rural areas, passed the Senate and again lodged in the House Committee, where it remained.

Masseurs' and Chiropractors' Bills.—H. 221 providing for a State Board of Massage and H. 312 and 313

creating a State Board of Chiropractic Examiners and regulating their practice were referred to the House Committee on Professional Licensure. Our committee was denied a hearing on these bills. H. 221 reached the postponed calendar and was defeated on final passage. H. 312 and 313 were released from committee; our committee was informed that they would be re-committed and was asked not to have county societies contact their representatives. This procedure had been followed in 1945 and 1947 and the promise kept. However, this time the bills were presented for final passage and were passed by a vote of 174 to 21. The bills were then referred to the Senate Committee on Education. Our committee was granted a hearing. In spite of strong evidence presented by the State Board of Medical Education and Licensure, the Department of Public Instruction, and the Department of Health, the bills were reported out of committee 7 to 5. H. 312 creating a Board of Chiropractic Examiners passed the Senate 26 to 24 and was signed by the Governor on May 23. Its companion, H. 313, regulating their practice, failed to pass because of a tie vote and the Lieutenant Governor refused to cast the deciding vote. The chiropractors displayed amazing power and won a partial victory. It was learned that the C.I.O. had favored their licensure.

Osteopaths in M.S.A.P.—Our committee and the Board of Trustees succeeded in having amendments inserted into H. 450 and 451, which include osteopaths in the Medical Service Corporation Act but require them to keep within the practice limitations of their own law.

Income Limitations in M.S.A.P.—H. 1291 and 1292 give M.S.A.P., with our approval, the privilege of changing income limitations of subscribers, depending upon general economic conditions.

Dentists in M.S.A.P.—S. 834 and 835 amend the act providing for regulation of nonprofit medical service corporations by including in the plan certain limited dental services.

Coroners' Laboratory.—The State Medical Society-sponsored bill H. 502 providing a laboratory in the Department of Health for the use of coroners passed the House and Senate, but was vetoed by the Governor.

Animal Experimentation.—S. 278, to establish regulatory measures and licensure for stated institutions and to make available unclaimed and unredeemed dogs and cats, was released from committee and passed two readings and was finally committed to the Senate Committee on Public Health and Welfare. This is considerable progress over previous sessions, especially when the antivivisectionists' own bill, S. 345, received no consideration.

Osteopaths Sign Commitment Papers.—H. 529, making osteopaths qualified physicians under the Mental Health Act and annulling the decision of the Supreme Court, was reported from committee and passed the House by three votes and was referred to the Senate Committee on Public Health and Welfare, where it remained.

The committee report then describes the Joint State Government Commission created by legislative action to study controversial subjects between sessions. Our committee has offered to assist the commission in the study of the mental health code and the study of existing and previously proposed legislation pertaining to the regulation and licensure of those desiring to diagnose and treat human ailments.

The committee sent to its mailing list (500) copies of four legislative bulletins on federal legislation and eight papers prepared by the committee for use in discussions before lay organizations.

The committee requested and received petitions from the woman's auxiliaries and county societies and used these on a number of occasions.

The committee held three well-attended meetings on December 18, February 16, and April 19.

The report lists the amounts of Federal funds granted in the State Department of Health for the various activities under the Social Security Act for the fiscal year 1950—grand total \$2,328,397.

Finally, the report lists certain conclusions and recommendations:

1. That members of the State Society wishing to present legislation utilize the facilities of the committee, which in turn will give all credit to such members.

2. That there is definite animosity toward the profession and that limited licensees are regarded as underdogs and are being discriminated against.

3. That there is considerable complaint concerning lack of service and of overcharging by physicians.

4. That members of the Society must remember that practitioners of limited scope may now be licensed under the Medical Practice Act.

5. That political leaders report that doctors and their families are reluctant to register and vote, and this must be corrected.

6. That each member of the committee be more active in assisting county society officers in contacting legislative candidates before and after election.

7. That county society members and public health legislation committees keep in closer touch with state and federal legislators during the interim between sessions and elections.

The chairman expresses his appreciation of the excellent cooperation of other committees, of many county societies and their auxiliaries, and also of the services of Mr. James H. Thompson, attorney for the committee.

The chairman thanks especially Senator Leroy E. Chapman, a physician from Warren County, and Representative George J. Sarraf, a physician from Allegheny County, and recommends some recognition from the House of Delegates or Board of Trustees.

Your reference committee believes that the Committee on Public Health Legislation has performed a tremendous piece of work against strong opposition and difficulties which seem to be increasing each year. We recommend acceptance of the report, careful consideration of the conclusions, and a resolution of thanks by the House to Senator Chapman and Representative Sarraf.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Edgar S. Buyers, Montgomery County, put to a vote, and carried.]

SPEAKER BUCKMAN: The report of the Committee on Public Health Legislation is accepted, carrying with it the resolution of thanks from the House to these two gentlemen in the Legislature.

DR. WALKER: *Commission on Defense of Medical Research.*

The commission, with the assistance of the Public Health Legislation Committee and the Pennsylvania Society for Advancing Medical Research, and with suggestions from the National Society for Medical Research, prepared a bill "to establish regulatory measures and licensure for stated institutions and to make available to such institutions for scientific investigation,

experiment, or instruction, unclaimed and unredeemed dogs and cats impounded in public pounds in any city, county, borough, or township within the Commonwealth." This bill, S. 278, was reported out of the Senate Committee on Public Health and Welfare, passed two readings, was recommended, and remained there. The antivivisection bill S. 345 prohibiting "operations or experiments upon any living dog or cat for any purpose other than healing or curing such dog or cat" was opposed and died without any advance in the Senate Committee on Public Health and Welfare.

Prior to the beginning of the legislative session in January, 1949, the commission stimulated interest and informed professional and lay groups, including women's societies, clubs, and auxiliaries, on the importance of and need for the use of animals in the furtherance of scientific medicine. These efforts obviously have borne fruit, for this year our profession has ceased to be on the defensive and has definitely advanced to an offensive position.

Your reference committee believes that the Commission on Defense of Medical Research has performed its task well and recommends acceptance of the report as submitted.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Wilbur E. Flannery, Lawrence County, put to a vote, and carried.]

DR. WALKER: *Committee on Workmen's Compensation Laws* (paragraphs 5 and 6 only).

This portion of the committee's report notes a significant trend in the field of physical and vocational rehabilitation by labor union welfare funds. Your reference committee questions the use of the word "reluctants"; according to Webster, it means widows. Further, your reference committee believes that the Committee on Medical Economics and the Commission on Industrial Health and Hygiene, already in existence, are capable of representing the Society in any negotiations with representatives of labor on these matters. We, therefore, recommend the acceptance of this portion of the report.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield County.]

SPEAKER BUCKMAN: The question is on the adoption of the concluding paragraphs of the report of the Committee on Workmen's Compensation Laws.

DR. JAMES E. HADLEY (Venango): Does this put these two committees in a position to negotiate with this welfare fund that may be set up?

DR. WALKER: Dr. Laverty's committee report suggests that some standing committee of the Society be designated to deal with these matters.

Your reference committee merely suggests that the two committees mentioned, Medical Economics and the Commission on Industrial Health and Hygiene, might serve as the appointed committees.

SPEAKER BUCKMAN: Any further question? Are you ready for the question?

[The motion was put to a vote and carried.]

DR. WALKER: *Committee on Emergency Disaster Medical Service*.

The committee reports that one of its members attended the semi-annual meeting of the Council on National Emergency Medical Service of the A.M.A. on March 21, 1949. At this meeting, Dr. Norman C. Kiefer, Medical Services Advisor, Civil Defense Planning,

Office of the Secretary of Defense, suggested that the governor of each state appoint the state health officer as the head of the state civil defense setup; that this officer (1) alert the various state health groups; (2) develop a comprehensive civil defense plan; (3) survey available equipment and supplies, and (4) participate in a nation-wide program for training in medical aspects of new weapons of warfare.

The report further mentions "medical activities of the National Security Resources Board" whose functions are (1) to assess the Nation's needs in a future war, (2) to assess the Nation's means in a future war, and (3) to coordinate the Nation's needs and means. This board reports that our capacity for manufacturing drugs is excellent, but that for manufacturing surgical instruments and equipment is not so good.

Finally, the report discusses the activities of the Armed Forces Medical Advisory Committee, charged with the reorganization and conservation of available medical facilities for the joint armed forces, which report deals with the problems of procurement of medical and dental officers.

Your reference committee feels that our society through the committee of the House of Delegates should continue to study the problem, particularly with reference to the communities in the Commonwealth and their industries; should survey the available equipment and supplies; should follow any leads of the American Medical Association; and should cooperate in every way with the advisory groups mentioned in the report. We, therefore, recommend acceptance of the report as submitted. I move the adoption of this portion of the report.

[The motion was seconded by Dr. James E. Hadley, Venango County, put to a vote, and carried.]

DR. WALKER: I move the adoption of this portion of the report of the Reference Committee on New Business as a whole.

[The motion was seconded by Dr. Wilbur E. Flannery, Lawrence County, put to a vote, and carried.]

SPEAKER BUCKMAN: The Chair recognizes Dr. Klump, of the Board of Trustees and Councilors.

DR. GEORGE S. KLUMP: Your Board of Trustees at its meeting this afternoon considered two rather urgent matters.

The Board submits the following resolution to the House for its consideration and early action:

Resolution—A.M.A. Dues

WHEREAS, The House of Delegates of the American Medical Association at its last annual session at Atlantic City requested the Board of Trustees to consider the establishment of annual dues for its members; and

WHEREAS, In the opinion of The Medical Society of the State of Pennsylvania the Educational Campaign of the American Medical Association is in the best interest of the American people; be it

Resolved, That this House of Delegates commend the educational program of the American Medical Association and instruct our delegates to the American Medical Association House of Delegates to support the establishment of dues for members of the American Medical Association.

SPEAKER BUCKMAN: This is referred to the Reference Committee on Reports of Officers and Standing Committees.

DR. KLUMP: The second recommendation deals with the public health survey which was requested at a previous session of this House of Delegates, following which the Secretary of Health and the Governor complied with said request.

The Board of Trustees believes that proper understanding of the survey completed in 1948 by the Amer-

ican Public Health Association and released late in April of this year will of necessity require continued study and consideration by the officers and members of this society. The several chapters of the survey and the recommendations will require the advice of not only the Commission on Preventive Medicine and Public Health but of the various interested standing committees and several disease control committees.

The Board realizes that there has been insufficient time to develop a program to implement the several desirable recommendations of the survey. However, it believes that the 1949 House of Delegates recognizes its responsibility to the citizens of the Commonwealth and will want to take some positive action in this regard. It respectfully recommends to the House of Delegates that the following two major recommendations of the survey be endorsed. Both have been affirmed in principle by this House at previous sessions, and the second is represented in the A.M.A. twelve-point program.

1. A system applied to *all* public health personnel which will include the best modern practices in recruitment, methods of selection, permanence of employment, equality and adequacy of pay, impartial treatment, and provisions for economic security upon retirement.

2. The establishment of local health units in counties, cities, or other municipalities or in combinations thereof.

SPEAKER BUCKMAN: This is referred to the Reference Committee on the Reports of Standing Committees.

The Chair recognizes Dr. Lucchesi.

DR. PASCAL F. LUCCHESI (Philadelphia): I have a resolution.

Resolution

WHEREAS, The State of Pennsylvania is without adequate facilities for the care and rehabilitation of the severely handicapped, especially adults; and

WHEREAS, The State of Pennsylvania has a limited program for the care and rehabilitation of the severely handicapped, which is offered by the Pennsylvania State Bureau of Rehabilitation; therefore, be it

Resolved, (1) that the Commission on Physical Medicine and Rehabilitation of The Medical Society of the State of Pennsylvania make a complete survey of existing facilities for the care and rehabilitation of the handicapped in Pennsylvania, and (2) that the Commission on Physical Medicine and Rehabilitation of The Medical Society of the State of Pennsylvania conduct an exhaustive study of the existing public agencies such as are represented by the Pennsylvania State Bureau of Rehabilitation, the Society for Crippled Children and Adults and the National Foundation for Infantile Paralysis, etc., and (3) that upon completion of the survey, definite recommendations for the complete over-all program for the care and rehabilitation of the citizens of Pennsylvania be submitted to the Board of Trustees and Councilors of The Medical Society of the State of Pennsylvania for appropriate action.

SPEAKER BUCKMAN: This resolution has reference largely to the activity of the Commission on Physical Medicine and Rehabilitation. Their annual report had previously been referred to the Reference Committee on Hospital Relations. It may seem unusual to the House to refer this resolution to the Reference Committee on Hospital Relations, but that will be the ruling of the Chair.

Dr. Brown, the chairman of the Reference Committee on Reports of Officers, has a partial report which we will be pleased to receive at this time.

Report of Reference Committee on Reports of Officers (Continued on page 1706)

DR. CHARLES L. BROWN (Philadelphia): This report will be read in two parts. The first part represents the review and study of the several reports of the officers as printed in the August issue of the PENNSYLVANIA MEDICAL JOURNAL. The second part deals with supple-

mental reports, items of business referred to this committee during the current session of the House of Delegates, and the address of the President.

It is only the first part that I have ready at this time:

Chairman of the Board of Trustees and Councilors

The committee shares in the welcome of Dr. James Z. Appel as the new trustee and councilor for the Fifth District, and the return (October, 1948) of Drs. Charles V. Hogan and Joseph S. Brown, trustees and councilors for the Fourth and Sixth Councilor Districts, and wishes to express satisfaction and confidence in the leadership and influence that these men will bring to the Board. Also, at this time the committee wishes to join in the recognition and appreciation of the long and devoted service rendered by the retired chairman and trustee and councilor from the Fifth District, Dr. Park A. Deckard.

The committee wishes to compliment the Board on the appointments to the several committees and the reelection of Dr. Walter F. Donaldson, Mr. Lester H. Perry, and Mr. A. H. Stewart to their respective positions and wishes to express satisfaction and confidence in the dignified and effective work of these committees and officers.

It is gratifying to learn of the progress in the remodeling of the headquarters at 230 State Street, Harrisburg, and in these days of changing costs it is not surprising that the construction may cost more than was anticipated. There can be no doubt about the necessity of increased space to accommodate the expansion of the Society's administrative activities.

This report indicates the awareness and profound interest by the Board in matters of public relations, as exemplified in authorization of a survey of the public relations program, the continued support of Blue Shield, the cooperative distribution of the Survey Report of the Pennsylvania Department of Health entitled "Keystones of Public Health in Pennsylvania," the contribution to and support of principles of the World Medical Association, and the authorization of a State Health Council to deal particularly with problems in rural practice. All of these activities bespeak of breadth of vision and an understanding of the responsibilities of the profession in rapidly changing relationships in life not only at the individual level but at community, state, and national levels.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Pascal F. Lucchesi, Philadelphia, put to a vote, and carried.]

DR. BROWN: Reports of the Twelve Trustees and Councilors.

A review of the reports from these several councilor districts shows an amazing similarity in the problems, the reactions and responses to these problems, and the accomplishments by twelve different areas in spite of the variations in population and natural resources of these several areas. This amounts to a display of the influence and effectiveness of organized medicine, because it reflects the understanding and guidance of twelve men who gather to discuss these professional problems and contribute to their solution on their return to their home districts. Several items in these reports are outstanding and most significant.

(1) *A.M.A. membership assessment.* A few councilors are proud of the high percentage of members having already paid the assessment, but several councilors still are embarrassed by the low percentage of members having paid the assessment in their districts. As of July 1, the average for all counties was 70 per

cent paid. Dr. Donaldson provided the committee with a later figure which is encouraging but not completely comforting. As of September 20, "the state-wide percentage of assessments paid was 75 per cent, but 19 county societies, several of them among our largest, range as low as 53 per cent paid."

The committee concurs in the plea implied in so many of these councilor reports that every member make the supreme effort to pay this assessment at the earliest possible date. Likely the tardiness is due either to oversight or procrastination. Surely the minority who seriously object to the paying of this assessment is almost nil. If the objection is purely on the basis of "principle involved," let us look at that for a moment. It is now apparent that this money is being used in a proper, dignified, and effective way and not in a fashion to justify an earlier accusation that it served as a "slush fund." How better could the public be educated to know of the skill and facilities of the medical profession to care for the sick with methods reflecting the highest of learning and standards, and all implemented in the American way? This is good service for the public and it permits and maintains medical progress at a high level of accuracy and efficiency. This would be distinctly worth while to the profession, even if it were not labeled an assessment. The Commonwealth, through its medical schools and hospitals, contributes a large share of the undergraduate and postgraduate education in this country, and approximately one-fifteenth of all of the physicians in the United States are in this Commonwealth. Therefore, we have no small share and responsibility in things medical in this nation. It behooves us to come forward with a unity of purpose and effort. Here is an opportunity for the individual physician to contribute his part with little cost of time and money.

(2) *Attendance at councilor district meetings.* Two councilors raise the question, because of poor attendance, as to whether the councilor district meetings should be continued. However, other councilors mention highly successful meetings. Your committee does not see adequate reason for discontinuing these meetings, but instead suggests that the factors found to be important in the districts where meetings are successful be incorporated in setting up meetings wherever they have been disappointing.

It is suggested that the programs for the councilor district meetings be prepared approximately two months in advance, and that special effort be given to publicity. Furthermore, it is suggested that the Woman's Auxiliary is surely interested in these meetings and their aid could be solicited, particularly in those districts that have not done so. The spirit of cooperation would be enhanced if the councilor would more frequently visit his component societies and bring to the county level those things arising in State Society activities.

(3) Many councilors report an increased interest and enrollment in the Graduate Education Institute.

(4) Practically every councilor calls attention to increased activities of the Woman's Auxiliary and particularly refers to the splendid part the Auxiliary is playing in public relations work.

(5) The larger societies have organized committees for implementing the National Education Campaign of the A.M.A. and many have mentioned the creation of a speakers' bureau and training facilities to instruct speakers so that they may disseminate authorized information about socialized medicine.

(6) In the review of these reports, one feels the

recognition of the inadequacy of contacts with the lay public and the lack of using lay public help in many districts in establishing better public relations.

(7) It is apparent that the radio and press are being used much more than before to increase the scope of public relations.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield County.]

SPEAKER BUCKMAN: The question is on adoption of this portion of the report. The Speaker would remind you that, in the adoption of this, action is taken on the matter of the A.M.A. assessment, the question of how to pep up (if we may use the term) councilor district meetings, even whether they should be continued. It opens the way for frank discussion from the floor. Perhaps some county medical society officer would like to talk about how he has been successful in collecting the assessment or how he has not. Perhaps some of the councilors or trustees would like to amplify their reports in regard to the meeting.

DR. JAMES E. HADLEY (Venango): Mr. Speaker, my county society is among those with a low rating. We have had a tremendous amount of discussion throughout the county on the collection of the A.M.A. assessment. The main argument against it seems to be that it is a campaign of patting the backs of Whitaker and Baxter. There is no expression of what they are doing to interest the lay people. They are using the doctors as the doctors themselves have been doing previously and the society members who are objecting to this collection feel that it is a subsidization of this firm rather than any direct contribution to lay education.

Those are the arguments against this collection.

DR. WILBUR E. FLANNERY (Lawrence): In our county, where we have had 100 per cent participation in this fund, I would like to make these remarks: First of all, when our attention was called to this assessment that was being made, it was felt by our county society that if one member paid it, every member should pay it. As you know, we were notified in regard to this assessment soon enough so that it was possible to incorporate it in the collection of dues. In our society we do not issue a receipt to anybody for his dues unless he includes the \$25 assessment; therefore, we got 100 per cent participation. It seems to me that if one person pays it, everybody should.

I believe that the Society should be encouraged on that basis and even now try hard to get resolutions passed to force the issue.

SPEAKER BUCKMAN: Dr. Petry, do you have any ideas, inasmuch as it is largely under your committee? Any further discussion?

DR. DANIEL RITTER (Cambria): It may be appropriate to mention here the campaign in the 26th Congressional District of a few weeks ago. In discussing the matter with Dr. Joseph C. Anderson, of Ebensburg, chairman of our Medical Arts Committee, he expressed the opinion that organized medicine might have been of help to us in the 26th district if, perhaps, our councilor districts were organized along the lines of congressional districts. While listening to the discussion of the failure of some of our councilor district meetings, I thought that perhaps the distances involved could be largely overcome, greater interest in the meetings might be obtained, and each trustee and councilor would be

in much closer contact with the members of the component societies if the councilor districts in Pennsylvania were reorganized on the basis of congressional districts.

SPEAKER BUCKMAN: I know it lies close to the hearts of many of the councilors. This would be an appropriate time to have a frank discussion of it before the House.

DR. THOMAS R. GAGION (Councilor, Twelfth District): Thank you, Mr. Speaker. You called on me. It was not unexpected. I don't agree with the report of Dr. Brown. With profound respect to him, I don't think his analysis was keen enough. I have made a more exhaustive analysis, I think.

The average attendance at councilor district meetings is slightly less than 10 per cent. The councilors who reported a large attendance were those from Allegheny and Philadelphia counties, and if you couldn't get a good crowd in those districts, you couldn't get it anywhere.

Dr. Whitehill reported about 210 physicians present. There are about 2100 members, I believe, in the Tenth District.

Year after year, members of the House of Delegates approve of councilor district meetings, but they never attend. The combined meeting of the Third, Fourth, and Fifth Districts was held May 13 in Bethlehem. The distances were not great—not more than 70 miles on good roads. The day was delightful, the program splendid, and, except for those who had to be there, by actual count there were 37 physicians out of 1250. If you call that a successful meeting, I don't.

Dr. Brown came to my own councilor district some years ago with several other speakers for a June meeting. The Woman's Auxiliary was contacted. I was embarrassed to have Dr. Brown and other busy doctors come to Wilkes-Barre to address less than fifty out of a total district membership of 1250. Now, those are statistics.

In eight years of councilor district meetings it has been my experience that few attend, especially now with the competition of specialty societies plus the graduate education courses. To my mind, these meetings are a waste of your money and the councilors' time.

I brought this matter before our Board of Trustees and lost by one vote. That is the way the Board stands.

If you will carefully look over your councilor district reports except for the largest districts where they should have a large attendance, most of the men throughout the State feel, I believe, the way the councilor of the Twelfth District does; the meetings are not worth your money and our time.

SPEAKER BUCKMAN: The question is on the adoption of the reference committee's report relative to the report of the several trustees and councilors. Are you ready for the question?

SECRETARY DONALDSON: I can't let this opportunity go by without saying a few words on the subject. I and others have indicated that there is a weakness due to the combining of two or three councilor districts in a single meeting.

Even a 10 per cent attendance in two or three districts this year meant that more than a hundred were present, while 20 per cent at the Sixth District meeting meant that 60 doctors were present. If between 10 and 20 per cent of the members of county medical societies will come out to a meeting and listen as representative teachers, officers, and committee chairmen of the State

Medical Society bring to them current and timely problems, I think you can well believe that they may return to their county societies and become a nucleus which will expand and contact other members who do not take the time and trouble to attend.

Our constitution and by-laws provide for such meetings. They are to be largely social in character. It may be that the programs are not adequately arranged. I ask you to accept this report and give the councilors an opportunity to learn from less fortunate experiences how to correct them.

SPEAKER BUCKMAN: The question is on the adoption of the reference committee's report relative to the reports of the twelve trustees and councilors. Are you ready for the question?

[The motion was put to a vote and carried.]

DR. BROWN: *Report of the Secretary-Treasurer.*

There has been a total net gain of 113 members throughout the State during the year; 161 members died, 112 resigned, and 66 have moved from Pennsylvania. This would indicate that we have 452 new members enrolled. Where are these new members located; have they gone to the rural or other areas needing them most? Ten counties have gained 5 or more new members, accounting for 100 new members: Philadelphia, 20; Montgomery, 19; Delaware, 15; Erie, 9; Lebanon, 9; Lehigh, 9; Mercer, 9; Butler, 8; Westmoreland, 6; and Berks, 5. Five counties have lost 5 or more members: Allegheny, 20; Luzerne, 10; Cambria, 9; Warren, 7; Armstrong, 5. In general, these shifts in membership are in the most populous areas, and there is no indication that the rural areas are particularly benefiting from the membership changes.

A careful study of the financial statement illustrates the many interests, responsibilities, and activities of the Society and makes one cognizant of the fact that the Society is a big business concern for the service of the profession and the public as well. In these times of changing costs, also desirable and necessary enlargement and expansion, it is satisfying and comforting to realize the sound financial status of the Society, which reflects the wisdom and ability of its officers.

It speaks well for the membership, especially in these troublesome and changing times, that, among more than 10,000 physicians and all of the practice they represent, there were only six applications for assistance from the Medical Defense Fund and only \$79.12 was expended from this fund in twelve months.

Thirteen of the outstanding 57 non-interest-bearing loans to veteran members have been repaid in full, which is an excellent showing.

We concur in the disappointment that 14 county societies did not send representatives to the 1949 Secretaries-Editors Conference. Since travel and living expenses are paid to attend this meeting, oversight or lack of interest must be factors. The societies which were not represented should be informed emphatically of the instructive and stimulating character of these meetings and urged to send representatives this year; it is important in presenting a united front, as these representatives become the cohesive element for activation of all State Society interests and responsibilities.

Comment is made elsewhere regarding collection of the A.M.A. membership assessment.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. James E. Hadley, Venango County, put to a vote, and carried.]

DR. BROWN: *Report of the Editor.*

The affairs of the PENNSYLVANIA MEDICAL JOURNAL

have been conducted on a high and dignified level, maintaining a progressive and informative service to the membership and to others, as exemplified in a circulation of about 12,000. The versatility, originality, and breadth of vision of our untiring and most able editor are amazingly apparent when it is known that he prepared 25 of the 48 editorials published during the year. This committee concurs in the regret that editorial contributions have been so few from the membership.

We concur in the Editor's comments concerning contemplated changes in the technical printing features of the PENNSYLVANIA MEDICAL JOURNAL.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. James E. Hadley, Venango County, put to a vote, and carried.]

DR. BROWN: *Report of Delegates to American Medical Association.*

The full attendance of all of our delegates at the third Interim Session of the House of Delegates at St. Louis, Nov. 30 to Dec. 3, 1948, and at the annual session in Atlantic City, June 6-10, 1949, is commendable and only more strongly establishes the confidence expressed in their election by this body. It is noteworthy that more than half of our delegates occupied positions on important committees, and we are especially proud to acknowledge the high esteem in which one of our delegates is held, namely, Dr. Francis F. Borzell, who is the Speaker of the A.M.A. House of Delegates. The holding of these important positions by our delegates reflects the influence and leadership of the State Society in medical matters at the national level.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Pascal F. Lucchesi, Philadelphia, put to a vote, and carried.]

DR. BROWN: That completes the portion of our report that is now ready.

SPEAKER BUCKMAN: Will someone move the adoption of this portion of the report of the Reference Committee on Reports of Officers as a whole?

DR. ELWOOD T. QUINN (Montgomery): I so move.

[The motion was seconded by Dr. James E. Hadley, Venango County, put to a vote, and carried.]

SPEAKER BUCKMAN: There is an interesting question to lay before the House. President-elect Samuel in his inaugural speech, to be given tomorrow night, has a recommendation. It is really not the privilege of the Chair to tell you what it is. As a matter of fact, it cannot be handled in the ordinary way as he would desire, which is that it be referred to a reference committee, because only matters that are brought to the House can be referred to a reference committee of the House; yet this matter should be referred to an appropriate reference committee for study, if it is going to be studied that way, so that it may be brought back to the House, say, Wednesday morning for action. It would be entirely appropriate, I suppose, for some member of the House to move that such portion of Dr. Samuel's inaugural address as he would like to refer to the Reference Committee on Reports of Officers be so referred following his public presentation.

DR. THOMAS H. A. STITES (Northampton): Mr. Speaker, I so move.

[The motion was seconded by Dr. Pascal F. Lucchesi, Philadelphia.]

SPEAKER BUCKMAN: I cannot read it because I am not giving the speech. The question, then, is on ex-

tending the privilege, let us say, to Dr. Samuel of referring to our Reference Committee on Reports of Officers such portions of his speech as he thinks should have action by the House this year. Are you ready for the question?

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: The Chair recognizes Dr. Borzell.

DR. FRANCIS F. BORZELL (Philadelphia): I shall try to be as brief as possible, particularly in view of the remarks that the Speaker just made.

Dr. Reuling, of New York, spoke to you this morning of the approach of the Federal Bureau of Investigation (F.B.I.), at the request of the Department of Justice, to the New York State Medical Society and three or four of its component societies. Apparently the investigation is for the purpose of trying to find out if they are guilty of criminal actions in conspiracy. They apparently are seeking some evidence that they do not have.

Dr. Reuling did not tell you the entire story. The Oklahoma State Medical Society, the Chicago Medical Society, and the American Medical Association have also been approached in exactly the same manner.

The initiation of the A.M.A. National Education Campaign required a departure from the time-honored custom of the American Medical Association of not charging its membership direct dues. With changing times and circumstances facing the medical profession, the Association found it necessary to inaugurate the National Education Campaign and the A.M.A. assessment of \$25 was levied.

The House of Delegates of the American Medical Association, however, at Atlantic City in June of this year passed without opposition a resolution asking the Board of Trustees of the American Medical Association to explore ways and means and to come back to the House at its Interim Session in December with recommendations providing for the annual collection of dues from all members of the American Medical Association.

The A.M.A. Board of Trustees carefully explored the matter and found that the machinery for the collection of dues from all members is already in the Constitution and By-Laws of the American Medical Association. It requires that the Board of Trustees recommend the levying of such annual dues as it finds advisable to the House of Delegates. Then the House of Delegates will approve or disapprove the recommendation of the Board of Trustees.

Our National Education Campaign has distributed literally millions of copies of literature throughout this country. It was distributed not only by the medical profession but largely by organizations outside the scope of our own organization. These organizations have requested this literature and have adapted their own facilities to its distribution. It is becoming more and more effective in bringing to our support outside groups that realize we are fighting a battle which is fundamentally a battle to maintain American democracy.

My plea to this House of Delegates now is that it support the resolution of the Board of Trustees of our own State Society and instruct our own delegation to support this program.

SPEAKER BUCKMAN: Are there any other resolutions or matters of new business to be referred to committees? If not, we will entertain a motion to adjourn.

DR. WILBUR E. FLANNERY (Lawrence): I move that we adjourn until ten o'clock tomorrow morning.

[The motion was seconded by Dr. Pascal F. Lucchesi, of Philadelphia, put to a vote, and carried.]

[The House adjourned at four thirty-five o'clock.]

GILSON COLBY ENGEL, *President*

LEWIS T. BUCKMAN, *Speaker*

WALTER F. DONALDSON, *Secretary-Treasurer*

PARK BERKHEIMER, *Assistant Secretary-Treasurer*

Tuesday Morning, Sept. 27, 1949

The third session of the House of Delegates convened at ten-fifteen o'clock, Speaker Buckman presiding.

SPEAKER BUCKMAN: The House will be in order, Dr. Wilson, of the Committee on Credentials, having reported a quorum present. If there be no objections from the floor, we will dispense with the roll call and also with the reading of the minutes of yesterday's meeting.

We will proceed immediately to consideration of the report of the Reference Committee on Reports of Commissions. The Chair recognizes Dr. Gordon, of Pittsburgh.

Report of Reference Committee on Reports of Commissions

DR. WENDELL B. GORDON (Pittsburgh): The Reference Committee on Reports of Commissions submits the following:

Commission on Acute Appendicitis Mortality

We feel that this commission should be commended for continuing the educational campaign to inform the public of the danger of delay and the administration of laxatives, and especially commended because of its warning against the overenthusiasm for the local use of sulfonamides and antibiotics in a peritoneal cavity and in the wounds of patients who have been operated upon for perforated appendices. We feel that the statement in the report that no drug or compound has been discovered which, when placed in the peritoneal cavity, will kill microbes on the one hand and not produce cell irritation on the other should be re-emphasized to the entire profession.

Continuation of the Commission on Acute Appendicitis Mortality is recommended.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield County, put to a vote, and carried.]

DR. GORDON: Commission on Cancer.

We wish to thank the Commission on Cancer for its excellent and extensive work over the past year, and we wish to express appreciation for the cancer bulletin which is published and distributed through its efforts. In the work of the commission in educating the laity regarding early examination and diagnosis of cancer, we suggest that due regard be given to the danger of producing undue anxiety and cancerphobia in the minds of many people which in some cases is as much to be dreaded as the disease itself.

We would call attention to the statement that the Medical Society should retain control of all phases of the cancer problem. Cancer is essentially a medical problem and its direction should remain under medical supervision rather than come under the supervision of lay groups.

We urge continuation of the Commission on Cancer.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Wilbur E. Flannery, Lawrence County, put to a vote, and carried.]

DR. GORDON: Commission on Child Health.

We commend the Commission on Child Health for its suggestion to the Pennsylvania Department of Health that a card be sent to parents along with each birth certificate with the admonition to see their doctor about (1) regular examinations, (2) supervision of diet, weight, growth and development, and (3) immunization against preventable diseases—the method used to be subject to the practice of the family doctor.

We also approve of the practice of routine periodic tuberculous testing as suggested by the commission.

We recommend continuation of the Commission on Child Health.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Dudley P. Walker, of Bethlehem, put to a vote, and carried.]

DR. GORDON: Commission on Conservation of Vision.

We appreciate the excellent work of this commission, particularly in regard to school children.

The commission has been active in the past year, particularly in regard to the education of the profession on the early recognition of glaucoma.

Your reference committee recommends the further study by this commission of the problem of the high cost of glasses. We feel that there is no justification for the exorbitant prices which the public must frequently pay for glasses following refraction. This reflects unjustly on the entire profession, especially in view of the present agitation regarding high medical costs.

Regardless of the cause of this condition, we suggest that this commission undertake its study and correction.

We recommend continuation of the Commission on Conservation of Vision.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Ward O. Wilson, of Clearfield, put to a vote, and carried.]

DR. GORDON: Commission on Deafness Prevention and Amelioration.

We commend the Commission on Deafness Prevention and Amelioration for its efforts to establish deafness clinics throughout the State and urge their extension.

We recommend continuation of this commission.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Thomas W. McCreary, Beaver County, put to a vote, and carried.]

DR. GORDON: Commission on Diabetes.

Your reference committee congratulates the Commission on Diabetes for its excellent work throughout the past year, especially its educational program and the campaign for the detection of unknown diabetics.

We recommend continuation of this commission.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Wilbur E. Flannery, Lawrence County, put to a vote, and carried.]

DR. GORDON: Commission on Industrial Health and Hygiene.

Your reference committee commends the Commission on Industrial Health and Hygiene for its work of the past year. The members have cooperated extensively with labor unions and industry in the improvement of industrial health.

We particularly commend their work regarding the study of alcoholism in industry and urge its extension.

We recommend continuation of this commission.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. John T. Farrell, Jr., of Philadelphia, put to a vote, and carried.]

DR. GORDON: Commission on Maternal Welfare.

The Commission on Maternal Welfare has made a detailed study of maternal mortality with the view of reducing deaths from those causes. We commend its work in this field and particularly the recommendation that staffs of all hospitals throughout the State rigidly enforce the requirement of early competent consultation in all obstetric difficulties and the continued emphasis on adequate antepartum care.

We recommend continuation of this commission.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Ward O. Wilson, of Clearfield, put to a vote, and carried.]

DR. GORDON: Commission on Tuberculosis.

The report of the Commission on Tuberculosis states that in spite of its inactivity there is a real need for a dynamic educational program, particularly in connection with the physician's responsibility in the follow-up of conditions found in the various chest x-ray surveys. The chairman of the commission also states that the leadership of this commission should be in the hands of someone who can devote sufficient time to organizing and correlating its activities.

With these statements we concur, and suggest continuation of a reorganized commission.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. George L. Laverty, Dauphin County, put to a vote, and carried.]

DR. GORDON: Commission on Mental Hygiene.

The Commission on Mental Hygiene submits an extensive detailed 14-point report covering its work for the past year. We particularly urge the adoption of its suggestion that the State Board of Medical Education and Licensure be impressed with the importance of psychiatric training during internship.

We recommend continuation of this commission.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Ward O. Wilson, of Clearfield.]

SPEAKER BUCKMAN: The question, then, is on the adoption of this portion of the report, with a recommendation to the State Board of Medical Education and Licensure.

[The motion was put to a vote and carried.]

DR. GORDON: Advisory Committee to Pennsylvania Board for Vocational Rehabilitation.

This committee reports that the State Bureau of Rehabilitation has received a \$300,000 deficiency appropriation and a \$1,800,000 appropriation for the next biennium.

The work of this advisory committee lies in the future, and we therefore urge its continuation.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Wilbur E. Flannery, Lawrence County, put to a vote, and carried.]

DR. GORDON: Commission on Public Health and Preventive Medicine.

Your reference committee commends this commission for its efforts over the past year. We particularly approve of its recommendation to the Committee on Public Health Legislation that a bill be introduced providing subsidies to general hospitals for tuberculous patients.

The commission has also recommended legislation for approval of a sanitary code for cities of the first and second class.

We recommend continuation of this committee.

Committee on Public Health Legislation

The portion of the report of the Committee on Public Health Legislation referring to the transfer of the Bureau of Mental Health from the Department of Welfare to the Department of Health was referred to this reference committee. We note that because of a difference in opinion regarding the transfer of local administrative boards in the state mental institutions and state-owned hospitals, the matter was dropped.

Then we have a communication here from the Pennsylvania Nutrition Council. I will read the final paragraph:

"Inasmuch as the commission is presently without a chairman, consequently not functioning in its former capacity, I earnestly solicit you to consider recommending to the House of Delegates the continuation of the Commission on Nutrition."

I move the adoption of these portions of the report and recommend continuation of these three commissions.

[The motion was seconded by Dr. Ward O. Wilson, of Clearfield.]

SPEAKER BUCKMAN: The question, then, is on the adoption of this portion of the report which covers the report of the Commission on Public Health and Preventive Medicine, that portion of the Committee on Public Health Legislation report which covered the discussion of the Bureau of Mental Health, and that portion of the reference committee's report which recommends continuation of the Commission on Nutrition.

Are you ready for the question?

[The motion was put to a vote and carried.]

DR. GORDON: I move the adoption of the entire report of the Reference Committee on Reports of Commissions.

[The motion was seconded by Dr. Thomas W. McCreary, Beaver County, put to a vote, and carried.]

SPEAKER BUCKMAN: We will proceed to a consideration of the report of the Reference Committee on Scientific Business. The Chair recognizes Dr. Hunt, chairman.

Report of Reference Committee on Scientific Business

DR. HENRY F. HUNT (Montour): The Reference Committee on Scientific Business reports at this time on the printed reports assigned to it:

Commission to Study Control of Rheumatic Fever

The commission reports that three stated meetings were held during the year and that a fourth meeting will be called for Wednesday of this week. It appears that this commission is unusually active and should be commended for the steps that it has taken to stimulate interest in this widespread disease. The survey conducted by the commission has accumulated much valuable data.

A rheumatic fever committee has been appointed in every one of the sixty county medical societies and the chairmen of these county medical society committees have been requested to urge the registration of cases and to arrange for yearly symposia on rheumatic fever or rheumatic heart disease.

The reference committee also wishes to commend the commission on its scientific exhibit covering the prophylaxis and treatment of rheumatic fever. Continuation of the commission is recommended.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Thomas W. McCreary, Beaver County, put to a vote, and carried.]

DR. HUNT: *Commission on the Control of Syphilis and Venereal Diseases.*

During the year this commission has completed and mailed to the membership of The Medical Society of the State of Pennsylvania an up-to-date article on "The Control of Syphilis by Means of Penicillin." The commission plans, as further advances are made in the treatment of syphilis, that supplementary articles will be published which may be added as extra pages to the booklet.

The commission plans as a future project a survey of the number of cases of syphilis in Pennsylvania; however, the details of the survey are not included in the annual report of the commission.

During the year the commission proposes to study the recently completed Public Health Survey dealing with the Venereal Division control program in the State of Pennsylvania and report to the Board of Trustees in the interim between sessions.

Continuation of this commission is recommended.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Ward O. Wilson, of Clearfield, put to a vote, and carried.]

DR. HUNT: *Commission on Graduate Education.*

The commission reports that the second annual program of the Graduate Education Institute has been completed. These meetings were held in ten centers throughout the State during the period September 21 to May 5.

A total of ten lecture days of eight hours each were assigned for each center, and 1085 physicians registered for the 1948-1949 program. The subject material for the 1949-1950 sessions was chosen from suggestions made by the registrants during the fall of 1949. At the request of the Berks County Medical Society, an eleventh center will be added in Reading for the 1949-1950 program. The commission has also made arrangements to alternate the Wilkes-Barre center with one to be established in Scranton.

The commission has prepared a special course in electrocardiography to be given one day each week for seven weeks during the months of November and December. This special program is to be tried out in Harrisburg, and if successful, will be rotated in other centers throughout the State.

The commission recommended that an evening be set aside during the 1950 session of the Society to appropriately recognize, by awarding certificates, those registrants who have attended 70 per cent of the lectures comprising the first three programs.

Your reference committee agrees that the registrants certainly deserve this recognition, but suggests that the decision in this matter be left to the Board of Trustees for consideration when the program for the 1950 meeting is being arranged.

The Commission on Graduate Education deserves to be specifically commended. The members of the commission, as well as the faculty members, merit the thanks of this Society—not only collectively but from many of us individually.

Continuation of this commission is recommended.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Thomas W. McCreary, Beaver County, put to a vote, and carried.]

DR. HUNT: This constitutes the final item of business that was submitted to our committee. Our re-

port is signed by Drs. Stanley D. Conklin, Joseph Van S. Donaldson, Carl E. Ervin, William T. Leach, and Henry F. Hunt, chairman.

Mr. Speaker, I now move the adoption of the report of the Reference Committee on Scientific Business as a whole.

[The motion was seconded by Dr. Ward O. Wilson, of Clearfield, put to a vote, and carried.]

SPEAKER BUCKMAN: The report is adopted as a whole.

We will proceed to a consideration of the report of the Reference Committee on Hospital Relations. The Chair recognizes Dr. McCreary, of Rochester.

Report of Reference Committee on Hospital Relations (Continued on page 1711)

DR. THOMAS W. MCCREARY (Beaver): The Reference Committee on Hospital Relations submits the following report on committee and commission reports referred to it:

Committee on Hospital Relations

Your reference committee believes that the establishment of a Committee on Hospital Relations was a desirable step. That committee recommends that the Board of Trustees of the State Medical Society set in motion the machinery necessary to establish within each component county medical society a standing committee on hospital relations. They have recommended the membership and the method of procedure in any case involving a controversy concerning business relationships between physicians and lay organizations, such as hospitals and clinics. We find that these recommendations are in accord with those made by the House of Delegates of the A.M.A. and recommend that they be favorably accepted by this House of Delegates.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Wilbur E. Flannery, Lawrence County, put to a vote, and carried.]

DR. MCCREARY: *Committee on Laboratories.*

Your reference committee looks with pride upon the honesty of the report of the Commission on Laboratories. The members have conducted state-wide tests of unknown chemical and bacteriologic specimens to determine the efficiency of participating laboratories. They express dissatisfaction with the over-all efficiency as judged by submitted results. Many reasons have been given for the deficiencies noted, and further study is anticipated for their correction. Your reference committee recommends that this commission and its studies be continued.

I recommend acceptance of this portion of the report.

[The motion was seconded by Dr. George F. Kowallis, Allegheny County, put to a vote, and carried.]

DR. MCCREARY: *Commission on Physical Medicine and Rehabilitation.*

Your reference committee notes that this commission has been active this year and has outlined a program to bring physical medicine to its rightful place in the practice of medicine. We feel that this work should be encouraged and that the commission should be continued.

A resolution was submitted yesterday which will be included in the report:

Resolution

WHEREAS, The State of Pennsylvania is without adequate facilities for the care and rehabilitation of the severely handicapped, especially adults; and

WHEREAS, The State of Pennsylvania has a limited program for the care and rehabilitation of the severely handicapped, which is offered by the Pennsylvania State Bureau of Rehabilitation; therefore, be it

Resolved, (1) That the Commission on Physical Medicine and Rehabilitation of The Medical Society of the State of Pennsylvania make a complete survey of existing facilities for the care and rehabilitation of the handicapped in Pennsylvania; (2) that the Commission on Physical Medicine and Rehabilitation of The Medical Society of the State of Pennsylvania conduct an exhaustive study of the existing public agencies such as are represented by the Pennsylvania State Bureau of Rehabilitation, the Society for Crippled Children and Adults, and the National Foundation for Infantile Paralysis, etc.; and (3) that upon completion of the survey definite recommendations for the complete over-all program for the care and rehabilitation of the citizens of Pennsylvania be submitted to the Board of Trustees and Councilors of The Medical Society of the State of Pennsylvania for appropriate action.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. James E. Hadley, Venango County.]

SPEAKER BUCKMAN: The question is on the adoption of this portion of the report, including the adoption of the resolution offered yesterday.

[The motion was put to a vote and carried.]

DR. MCCREARY: *Committee on Psychiatric Services to Criminal Courts.*

Your reference committee views with favor this committee's attempt to prepare legislative proposals dealing with criminal offenders. More especially do we commend the committee's attempt to help in the preparation of legislation to assist the courts in dealing with sexual offenders. All are aware of the increased incidence of sex offenses in the present day, and we urgently recommend that this committee be continued and that it continue its untiring efforts to assist in preparing satisfactory legislation, with the view of controlling such offenses.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Charles J. H. Kraft, Wyoming County, put to a vote, and carried.]

DR. MCCREARY: *Committee on Rural Medical Service.*

This report will include the supplemental report submitted at the first day's meeting.

Your reference committee notes that our state committee is endeavoring to organize a general health council in accordance with the request of the A.M.A. Committee on Rural Health. Since its original report, the committee has presented a supplemental report which was read to the House of Delegates at its first session. In this report it indicates that a general health council has been organized in Pennsylvania, which includes various schools, service organizations, professional clubs, church organizations, and other similar groups.

The principles of the organization have been enumerated, which will aid in preserving the high standards of medical practice in Pennsylvania.

We commend the committee for its work and recommend that this committee be continued.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. John W. Barr, Cambria County, put to a vote, and carried.]

DR. MCCREARY: Report on that portion of the *Report of the Chairman of the Board of Trustees* which was referred to our committee:

Your reference committee has received from the Board of Trustees its official recommendation relating to the resolution of the Columbia County Medical Society which was referred to the Board by the 1948 House of Delegates for study and report to the 1949 House of Delegates. Your committee feels that to re-

fresh the memories of the members of the House of Delegates the original resolution of the Columbia Medical Society should be read. It follows:

Resolution

WHEREAS, The American Medical Association has condemned by formal resolution the practice of medicine by closed staff institutions which employ physicians on a salary basis, exploiting their services, and which thereby do practice medicine as institutions, the Columbia County Medical Society of the State of Pennsylvania hereby urges the adoption by The Medical Society of the State of Pennsylvania of a similar resolution so that such institutions as exist in this state might be informed that their practices are opposed to the efforts and policies of organized medicine and not contributory to the public weal; therefore, be it

Resolved, That whereas the American Medical Association has condemned by formal resolution the practice of medicine by closed staff institutions which employ physicians on a salary basis, exploiting their services, and which thereby do practice medicine as institutions, The Medical Society of the State of Pennsylvania reaffirms its endorsement of the policies of the American Medical Association in condemnation of institutions engaging in such practices. The Board of Trustees and Councilors after due consideration have presented the following resolution on the previous resolution.

(SECRETARY'S NOTE: Our Board of Trustees and Councilors submitted the following resolution as expressing its reaction to the problem as stated to the 1948 House of Delegates by the Columbia County Medical Society and by it referred to the Board of Trustees and Councilors.)

Resolution

WHEREAS, Medical hospital services may be defined as those services other than administrative, rendered by a registered physician directly or indirectly to or in behalf of an individual patient for the obtaining and interpretation of data, including consultation and advice, for the diagnosis, treatment, and prevention of disease; and

WHEREAS, Such services will embrace the general and special practice of medicine, surgery, and obstetrics, and the practice of the related specialties including anesthesiology, physical medicine, radiology, pathology and clinical pathology, including bacteriology, clinical chemistry, and other clinical laboratory specialties; and

WHEREAS, It is accepted as a basic principle of good medical practice that a professional interpretation should accompany the report on radiologic examinations and on materials and tissues examined by the pathologist; and

WHEREAS, There have been recorded many complaints from radiologists, pathologists, and anesthesiologists that hospitals have been applying the profits from these specialized services to help recoup deficits in other departments; therefore, be it

Resolved:

1. That the medical costs of hospital care be separated from the non-medical costs, as can be done by existing and accepted methods of cost accounting, and that they appear thus separated on the statement submitted to the patient.

2. That bills for all medical services be rendered in the name of the physician or physicians performing the services.

3. That a basic principle in the establishment of charges should be that each department be self-supporting. This principle should be so applied that neither the hospital nor the physician rendering the service will exploit the patient or each other.

4. That the basis of financial arrangement between hospital and physician may be salary, commission, fees, or such other method as will best meet the local situation, with due regard to the needs of the patient, the community, the hospital, and the physician.

5. That fees for medical services which are collected by the hospital be established by joint action of a representative committee of the staff and the governing body of the hospital and including also the head of the department and the administrator.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. James E. Hadley, Venango County.]

SPEAKER BUCKMAN: The Chair recognizes Dr. Eves, of Columbia County.

The Chair will state the question before the discussion. The question is on the adoption of the reference committee's report, which includes a recommendation that we adopt the resolutions referred to us by the Board of Trustees in reply to the resolution submitted last year by the Columbia County Medical Society.

DR. OTIS M. EVES (Columbia): As will be noted, the main issue of this resolution is the condemnation of closed staff institutions which employ physicians on a

salary basis and practice medicine as institutions. This position has already been taken by the American Medical Association in formal resolution when in 1915 such practices were termed illegal and unethical by the House of Delegates, and again in 1947 when opposition was voiced to the encroachment by hospitals and other organizations on the private practice of medicine.

The resolution as submitted by the Board of Trustees has recommended in a very excellent manner the measures that should be taken by a hospital in presenting bills including doctors' fees and that the basic principle in the establishment of charges should be that each hospital department be self-supporting. Although these recommendations, if followed, should go a long way in correcting relationships between private physicians and certain institutions, it is highly doubtful that they would entirely solve the problem or conform with the previously mentioned resolution made by the American Medical Association.

It is obvious that as long as closed staff institutions employing physicians on a salary basis continue to practice medicine in the State of Pennsylvania, and even though endowed by the State, excluding local practitioners from staff privileges, these institutions do encroach upon the rights of private physicians and these practices should be condemned by The Medical Society of the State of Pennsylvania.

SPEAKER BUCKMAN: The question is on adoption of the report of the reference committee, which recommends the adoption of the resolution submitted by the Board of Trustees.

DR. WILBUR E. FLANNERY (Lawrence): To make these recommendations effective, consideration should be given to the June, 1949 action on the report of the A.M.A. Committee on Hospitals and the Practice of Medicine, as follows: "Insurance programs whose service plans shall provide payment for hospital services only; medical service plans should supply payment for all the medical services, including pathology, x-ray, etc." (**SECRETARY'S NOTE:** At the December 6-8 meetings of the 1949 A.M.A. House of Delegates, the Committee on Hospitals and the Practice of Medicine was reactivated with advice to rewrite portions of its June, 1949 report, to be presented at San Francisco in June, 1950.)

It would seem to me that somehow or other, in order to make this recommendation effective, our own Blue Shield Plan should begin some kind of operation to see that these fees now paid by hospital plans are switched over into the Blue Shield Plan.

DR. ELMER HESS (Erie): Those words "shall" and "should" were put into that paragraph with a definite meaning. We do not wish to interfere with those contracts which already exist. We were hopeful that as the older contracts cease to exist or come to their conclusion the people who renewed the contracts would so change them that Blue Shield would cover all medical service and Blue Cross cover only hospital care.

We don't think that we should disturb any machinery that is already set up and working satisfactorily in the voluntary insurance field. These things have to be done gradually, not suddenly, otherwise we will ruin the voluntary health insurance programs, which are the only thing we have to offer the public in place of compulsory sickness insurance.

In your deliberations on questions like this, I hope that you will use good and cautious judgment.

DR. ELWOOD T. QUINN (Montgomery): Mr. Speaker, Dr. Hess did not bring up the issue. We are discussing why the Board of Trustees has not adopted the A.M.A. resolution. I think it would be wise for the present Board of Trustees to so state on that subject.

SPEAKER BUCKMAN: The question is on the adoption of the reference committee's report, which carries with it the adoption of the resolution submitted to us by our Board of Trustees. Any further discussion?

DR. WILBUR E. FLANNERY (Lawrence): Mr. Speaker, it still seems to me, even if it is a long-time point of view, that some official statement would have to be made to our Blue Shield operating group to begin considering the situation at least. As it is at the moment, I presume they can think about it or not, as they see fit. It would seem to me, to make it effective, that somehow or other some machinery should be set into motion whereby they will give serious thought as to how they should do it, if not this year, next year, or whenever it could be done.

SPEAKER BUCKMAN: Any further discussion? Are you ready for the question? The question is on the adoption of the reference committee's report, which carries with it the adoption of these resolutions submitted by the Board of Trustees.

As many as favor, signify by saying "aye"; contrary-minded, "no."

As many as favor will please rise? You may be seated.

As many as are opposed will please rise.

There being 62 in favor and 32 opposed, the "ayes" have it. The reference committee's report is adopted, carrying with it the resolutions recommended by the Board of Trustees.

DR. MCCREARY: I move the adoption of the report of the Reference Committee on Hospital Relations as a whole.

[The motion was seconded by Dr. S. Meigs Beyer, Jefferson County, put to a vote, and carried.]

SPEAKER BUCKMAN: We will proceed to a consideration of the report of the Reference Committee on Reports of Standing Committees. The Chair recognizes Dr. Fetter, chairman.

Report of Reference Committee on Reports of Standing Committees

DR. THEODORE R. FETTER (Philadelphia): The Reference Committee on Reports of Standing Committees and such resolutions and other reports as were referred by the Speaker of the House reports as follows:

Report of Committee on Public Relations

This committee has done a prodigious amount of work. Its report should and must receive the support of all practicing physicians if organized medicine desires to maintain a service of medical care untrammelled by political interference. We as physicians recognize that the health of the people is a matter of national concern. We disagree with that segment of thinkers and planners who would foist upon the nation a system of compulsory medical insurance. We believe that medical practice would undergo severe detrimental changes that would be harmful to the public.

If one must comment on the political events of the latter part of 1948, it may be noted that the medical profession was called severely and suddenly to task in regard to the spread of adequate medical care across

the nation. This fact more forcibly than any other single factor required prompt action on the part of organized medicine. We have had a Committee on Public Relations for a number of years and many physicians who participated in medical organizational work had some idea what was in the foreground, but it took a real political fact to awaken organized medicine into feverish activity. Thus the political upheaval may eventually prove to have been a real boon to the cause of freedom not only in medicine but in many other lines of endeavor.

It is a fact that physicians must develop an awareness of the constantly changing social order of the economy of the people. The impact of any serious economic upheaval is promptly manifested in the individual physician's income. This type of economics is readily understood, but the present philosophy of those groups who are thinking in terms of social security is an entirely new concept and is not as simple of solution. There is no doubt that we, as physicians, would prefer to practice medicine and let others deal with political and economic questions. Whether we like it or not, medicine today is so intricately associated with economics that we are finally compelled to study and analyze the underlying reasons for this apparent trend of the basic change of medical practice.

The tools and techniques employed by this committee are indeed well discussed. We trust that every member will read this report. This work should be widely publicized among our members. It is indeed unfortunate and certainly not healthy when a statement is made that not one doctor in twenty has an adequate understanding of the present threat to medicine. It is our impression, after reviewing the work of the committee, that the public and the medical profession were well served with information. It is sincerely hoped that the physicians themselves will become familiar with the present problem so that they can speak intelligently about it.

It is indeed obvious that a committee of this kind must have adequate personnel. If we have failed in any one item heretofore, it might be said truthfully that the doctor grudgingly gives financial support to organized medicine. This must be rectified. We must inform our membership that in order to do a good job, and in keeping with the times, adequate, paid personnel is a prime necessity. We are finally convinced that a physician is not trained as a public relations counsel. It is simply amazing that we have done so well with so little. The House should encourage the officers and the Board of Trustees to maintain the services of trained personnel to assist this committee.

In regard to the National Education Campaign, little need be said. You are all familiar with it. It is disappointing that only 22 county societies have organized their membership into component units for publicity purposes in order to combat compulsory health insurance. It might be useful to request the various counties to submit reports to the state committee in regard to the public's response to the Education Campaign. In general, we know that the public has become intensely interested, but it may be beneficial if we obtain more specific information on this subject. There is no doubt that the success of a local unit depends on the development of a speakers' bureau. The participants in this phase of publicity must be good talkers, be familiar with the subject, and not permit themselves to become riled by a "heckler" in the audience.

It is noteworthy that the committee, under a separate heading, calls our attention to emergency medical

care service. This is most important and must be considered seriously by every physician. It is one of the public's chief criticisms of the medical profession.

There is no doubt that in many localities throughout the State our relationship with the press has improved. It is essential that we continue to nurse this liaison and renewed friendship by cooperating with the press and radio wherever possible and whenever feasible.

There should no longer be any doubt that the Woman's Auxiliary to the State Medical Society is one of our most valuable aids in the promotion of public relations. It is simply amazing that it took the physicians so many years to really appreciate its potential worth. It is certainly essential that this happy relationship be expanded so as to make the Auxiliary a vital necessity to the efforts of the Committee on Public Relations. We trust that a wide-awake Auxiliary will insist upon its share of responsibility.

We heartily endorse the recommendations of the committee as outlined in its report. The varied activities as outlined in the summary of the report indicate that the entire field of public relations is well understood and appreciated.

We recommend the adoption of this portion of the report.

[The motion was seconded by Dr. Roy W. Mohler, of Philadelphia, put to a vote, and carried.]

DR. FETTER: *Committee on Workmen's Compensation Laws.*

Your reference committee was particularly concerned with the statement made by this committee that the State of Pennsylvania, insofar as medical and hospital care of its industrial injured is concerned, is one of the backward states in the nation. Obviously, this delinquency should be corrected. It is suggested that the causes for this state of affairs be studied by already existing machinery within our organization, namely, the Committee on Public Health Legislation, the Commission on Industrial Health and Hygiene, and the Committee on Public Relations in conjunction with the Committee on Workmen's Compensation Laws. In view of the industrial leadership of our state, we should make every effort to correct any lack of adequate medical care among the industrial injured workers. Here is another example where medicine, industry, and labor relations must improve.

I recommend the adoption of this portion of the report.

[The motion was seconded by Dr. Ward O. Wilson, of Clearfield, put to a vote, and carried.]

DR. FETTER: *Committee on Medical Benevolence.*

The function of this committee is designated by its title. Everyone should be familiar with its intent. There is no doubt of its necessity. It is apparent that the woman's auxiliaries have again manifested their continued interest by their annual contributions. Your reference committee would remind the members that individual donations are welcome. One cannot very well overlook the generosity of the Woman's Auxiliary in regard to this fund. The committee is to be congratulated on its very satisfactory report.

The reference committee recommends the adoption of this portion of the report.

[The motion was seconded by Dr. Dudley P. Walker, Northampton County, put to a vote, and carried.]

DR. FETTER: *Committee on Archives.*

Your reference committee wishes to commend this committee for its continued interest in the preservation

of records of the various functions of the Society and its component societies.

The members should be reminded at intervals to submit to the Society any records or material of historical significance, so that the files of the Committee on Archives may continue to be a source of authoritative reference of the history of medicine in Pennsylvania.

Conference of Professional Licensees

Your reference committee appreciates the need for continuation of this committee's function. It is apparent that it is more important than ever before that the Society recognize its responsibility to the public in regard to enforcement of the provisions of the various medical practice acts.

Committee on Necrology

Your reference committee commends the work of this committee in maintaining accurate factual records on the death of members of the Society.

Advisory Committee to the Woman's Auxiliary

Your reference committee notes with pride the tremendous contributions to the Society by the amazing activities of the Woman's Auxiliary during the past year. It is recommended that each county society appoint an advisory committee to the Woman's Auxiliary if it has not already done so. The influence of the Woman's Auxiliary in its particular sphere of community enterprise cannot be overlooked any longer. The reference committee wishes particularly to commend this committee and President Engel for his foresight in recognizing the worth of our Auxiliary.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Charles L. Brown, of Philadelphia, put to a vote, and carried.]

DR. FETTER: Committee on Military Affairs.

This committee has had no function to perform during the year and its report consists of a statement of fact on the need for an assigned function. The reference committee recommends that the suggestions made by the Committee on Military Affairs be adopted by the House. It is apparent that there is a definite need for such a committee, particularly in the preparation and annual revision of a list of county medical society members from the standpoint of their probable availability or non-availability for service in case of war or major disaster. Since the preparation of the report by the reference committee, the House of Delegates was addressed by the surgeon in charge of the Second Army Corps Area, and it is apparent that military and civilian medicine must be closely allied in view of national defense policy of the armed services as developed at the top level. It is advisable that the Military Affairs Committee be in constant liaison with other committees or commissions dealing with the health of the people and in particular with the Committee on Emergency Disaster Medical Service.

Committee on Telephone Directory Classifications

Your reference committee feels that the major functions of this committee should be handled at a county level. If proper action is not obtained at the local level, the aid of the state committee should be utilized to give weight and prestige to the local group. Your reference committee suggests that telephone classification shall be designated as Physicians and Surgeons M.D.

I move the adoption of this portion of the reference committee's report.

[The motion was seconded by Dr. John F. McCullough, Allegheny County, put to a vote, and carried.]

DR. FETTER: Report of the Board of Trustees relative to the survey by the American Public Health Association completed in 1948:

Your reference committee recognizes that the 1949 House of Delegates has a distinct responsibility to the citizens of this Commonwealth in regard to the health survey completed in 1948 by the American Public Health Association. Therefore, the reference committee recommends adoption of the report of the Board of Trustees on the following two major recommendations which, incidentally, have been affirmed in principle by this House at previous sessions:

1. A system applied to *all* public health personnel which will include the best modern practices in recruitment, methods of selection, permanence of employment, equality and adequacy of pay, impartial treatment, and provisions for economic security upon retirement.

2. The establishment of local health units in counties, cities, or other municipalities or in combinations thereof.

Committee on Educational Fund

Your reference committee has studied the preliminary and supplemental reports of the Educational Fund Committee. It is obvious that in the initial efforts of any new endeavor the structural formation of the rules and regulations in regard to administration must of necessity yield to change and modification or clarification. The rules as submitted by the Educational Fund Committee are to serve as a working unit in order to carry out the purpose of the Educational Fund.

Your reference committee realizes the tremendous responsibilities of the committee members administering this fund and urges that the House give them its support.

State Healing Arts Advisory Committee

Your reference committee noted the very complete report of this committee. It is chiefly informative and factual in regard to the number of participating physicians and medical expenditures distributed among physicians, clinics, dentists, nurses, and pharmacists. The reference committee recommends continued liaison with the Department of Public Assistance.

I recommend adoption of this portion of the report.

[The motion was seconded by Dr. Charles L. Brown, of Philadelphia, put to a vote, and carried.]

DR. FETTER: On the resolution submitted to this House of Delegates by the Lackawanna County Medical Society and referred to this reference committee, which reads as follows:

Resolution

Resolved, That the delegates of the Lackawanna County Medical Society to the ninety-ninth annual session be instructed to introduce at the proper meeting of the House of Delegates a resolution calling upon the Legislative Committee to have introduced before the next meeting of the Pennsylvania legislative bodies, and at an early date during the legislative session, a bill

1. Liberalizing the length of time an employer will be liable for the medical and surgical expenses of employees.
2. Providing increases in moneys and removal of limitations for doctors of medicine.
3. Providing medical and surgical care as long as the nature of the injury or illness may require.

The reference committee recognizes the need for liberalization of compensation for services rendered to injured employees under the workmen's compensation laws in the state of Pennsylvania, and further notes that the Committee on Public Health Legislation has

introduced like legislation in each legislative session within the past years. It is recommended, therefore, that the Committee on Public Health Legislation in conjunction with the Committee on Workmen's Compensation Laws continue the efforts to obtain legislative support in the direction as outlined in the resolution.

The reference committee recommends adoption of this portion of the report.

[The motion was seconded by Dr. James E. Hadley, Venango County, put to a vote, and carried.]

DR. FETTER: The reference committee recommends that the report of the Reference Committee on Reports of Standing Committees be adopted as a whole.

[The motion was seconded by Dr. Wallace E. Hopkins, York County, put to a vote, and carried.]

SPEAKER BUCKMAN: There have been submitted for consideration this year amendments to the Constitution and By-laws. This would seem to be the appropriate time to consider the report of the Reference Committee on Amendments to the Constitution and By-laws. We recognize Dr. Gloeckner, of Conshohocken.

Report of Reference Committee on Amendments to the Constitution and By-laws

DR. LOUISE C. GLOECKNER (Montgomery): The Reference Committee on Amendments to the Constitution and By-laws has considered the following proposed amendments—first, on eligibility for active membership.

The following resolution embodies an amendment to Article IV, Section 1, of the Constitution of the M.S.S.P. and an amendment to Chapter VIII, Section 2, of the By-laws, as adopted by the Erie County Medical Society, May 3, 1949, and is submitted for consideration and action by 1949 House of Delegates:

(NOTE: These two proposed amendments involve only deletion of the words "citizens of the United States" and substitution of the words "Doctors of Medicine" in the requirement for eligibility for membership.)

Resolution

WHEREAS, The laws of the Commonwealth of Pennsylvania permit otherwise qualified Doctors of Medicine to be licensed to practice medicine and surgery on the strength of holding first papers for United States citizenship; and

WHEREAS, A number of Doctors of Medicine who are foreign-born but who hold such first papers are duly licensed in the Commonwealth of Pennsylvania and are practicing medicine therein; and

WHEREAS, The Constitution of The Medical Society of the State of Pennsylvania requires full United States citizenship as a prerequisite for membership, thereby denying component county societies the opportunity to accept those legally qualified fellow-practitioners into Society membership with its corollary rights and privileges and mutual advantages; therefore, be it

Resolved, That the Erie County Medical Society proposes that Article IV, Section 1, of the Constitution of The Medical Society of the State of Pennsylvania be amended to read as follows: "The active members of this Society shall be Doctors of Medicine licensed to practice medicine in the Commonwealth of Pennsylvania, members in good standing in the component county medical societies, and whose annual assessments in this Society have been paid"; and, be it further

Resolved, That Chapter VIII, Section 2, of the By-laws of The Medical Society of the State of Pennsylvania be amended by deletion of the phrase "citizens of the United States."

Your Reference Committee on Amendments to the Constitution and By-laws recommends the *rejection* of this resolution by Erie County Society as printed in the Transactions.

I move the adoption of this section of the committee's report.

SPEAKER BUCKMAN: The question is on the amendment of Article IV, Section 1, of the Constitution,

deleting the words "citizens of the United States" and substituting the words "Doctor of Medicine."

The question is on the adoption of the amendment, notwithstanding the recommendation of the reference committee. In other words, an affirmative vote would reject the recommendation of the committee; a negative vote would accept the recommendation of the committee.

Do we have a second?

[The motion was seconded by Dr. Ward O. Wilson, Clearfield County, and several other members.]

SPEAKER BUCKMAN: There is a second to the recommendation of the committee, which places the question on the floor.

DR. RUSSELL B. ROTH (Erie): The Erie County delegation appreciates the conservative attitude of the reference committee, but feels that a little more discussion on the matter is in order. We would like to stress that there is nothing about this proposed amendment which in any way lowers the standards for the practice of medicine in the State of Pennsylvania.

We are talking only about men who are already licensed and are practicing among us. The Pennsylvania Board of Medical Education and Licensure has a reputation for upholding rigid requirements. It might be pointed out that as far as foreign-born individuals are concerned, no graduate of a foreign medical school has been admissible since 1941 under the rules and regulations of the Medical Practice Act as interpreted by this Board. Canada has not been considered a foreign country under these terms. Graduates of Canadian medical schools have been admissible. As a matter of fact, it is in Erie County principally a matter of our Canadian colleagues who have interned in our hospitals and who are practicing among us. We feel very conclusively that these men who have chosen to live in the United States and who have started the process of becoming citizens need the helping hand and the guidance of the Medical Society. We should encourage them to be of us and not apart from us.

We believe that our greatest opportunity in getting them to practice medicine the way we think it should be practiced, ethically speaking, is to take them into our county societies, the State Society, and the American Medical Association. We feel that we are fighting their battles in the current National Education Campaign and it is only fair to give them a chance to fight with us and to make contributions to it the same as we make.

These men are practicing. There is nothing in this resolution that affects their status. It is simply to bring about a correction of the disparity between the requirements for licensure in this state and the requirements for membership in our Society.

It might be interesting for you to consider that tonight you are going to hear an English physician who has fled from a system which we don't want inflicted upon us here. We have him as a guest of honor to speak to us, to present his point of view, but we would not welcome him into our Society for five years if he happened to pick this state in which to practice.

We are putting ourselves in a position in which we are excluding persons at a time when we are presumably striving for solidarity within the profession.

It has been suggested that we add a stipulation to this resolution by saying that holders of first papers may be granted membership only for a period of five years, until such time as they complete their requirements for citizenship. That has its merits, but there is

a lot of opposition. It was once in our Constitution, but it was dropped because of the fact that it was legally untenable.

We of the Erie County delegation, in spite of the recommendation of the reference committee, would like your earnest consideration of this minor but fairly important point. We submit that if you turn this down, it can be interpreted as bad public relations, as bad internal professional relations. We would like to extend a helping hand to and benefit by the association of these already licensed physicians.

DR. WILBUR E. FLANNERY (Lawrence): I would like to concur in the expression made by the doctor from Erie. It seems ridiculous to me that we should have standards for membership higher than the standards of the Pennsylvania Board of Medical Education and Licensure which permits these doctors of medicine to practice. They can practice in our community legally; they certainly should be among us as members of the Society.

SPEAKER BUCKMAN: The question is on the acceptance of the reference committee's report. An affirmative vote on that would reject the resolution from Erie. An affirmative vote for the committee's recommendation would permit the Constitution to stand as it is. A negative vote for the committee's recommendation would amend the Constitution. Are you ready for the question?

As many as are in favor and would have the Constitution stand as it is written will please rise.

As many as are opposed and would amend the Constitution please rise.

The vote being 19 for and 66 against, the recommendation of the reference committee is rejected and the Constitution has been amended.

Now, the question is on the recommendation of the reference committee relative to Chapter VIII, Section 2, of the By-laws, again embodying the same action; that is to say, they advise against deletion of the words "citizens of the United States" and substitution of the words "Doctors of Medicine."

An affirmative vote would accept their recommendation. A negative vote would be opposed.

DR. JOHN W. BARR (Cambria): Please repeat that.

SPEAKER BUCKMAN: An affirmative vote would be that the committee's suggestion be rejected.

As many as are in favor of the reference committee's recommendation will please rise. [No one arose.]

As many as are opposed please rise.

Since the "noes" have carried it, the By-laws likewise have been amended in the same fashion.

DR. GLOECKNER: The following proposed amendments to the By-laws are submitted by the Board of Trustees:

CHAPTER II, SECTION 1.—The House of Delegates shall meet on the morning of the day *before that* fixed as the first day of the annual session . . . (amendment involves only omission of the italicized words).

The Reference Committee on Amendments to the Constitution and By-laws approves this amendment to the By-laws and moves that it be adopted.

SPEAKER BUCKMAN: The question is on amending Chapter II, Section 1, of the By-laws by deleting the words "before that."

[The motion was seconded by Dr. Charles L. Fackler, York County, put to a vote, and carried.]

DR. GLOECKNER: CHAPTER V, SECTION 2.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the morning of the *third* (second) day of the annual session.

The amendment involves only substitution of the word "third" for the word "second," as it reads at present the second day.

Your reference committee approves this amendment and moves that it be adopted.

[The motion was seconded by Dr. Ward O. Wilson, Clearfield County.]

SPEAKER BUCKMAN: The question, then, is on the amendment of Chapter V, Section 2, of the By-laws, involving the substitution of the word "third" for the word "second," which continues the custom of the election of officers on Wednesday, the first day of the session now having become the Monday of that week.

[The motion was put to a vote and carried.]

DR. GLOECKNER: The Board of Trustees submits this amendment to the By-laws: Chapter VII, Section 11, now reads: The Advisory Committee to the Woman's Auxiliary shall consist of three members. They shall act in an advisory capacity to the Woman's Auxiliary, and shall hold meetings whenever it is necessary to furnish advice to the Woman's Auxiliary on any debatable question regarding the change in their constitution or other functions.

Amend by changing the last sentence to read: "They shall act in an advisory capacity to the Woman's Auxiliary *whenever called upon by the Woman's Auxiliary regarding its functions or changes in its constitution and by-laws.*"

The reference committee recommends the acceptance of this change and moves that it be adopted.

[The motion was seconded by Dr. Thomas W. McCreary, Beaver County.]

SPEAKER BUCKMAN: It has been seconded. The question, then, is on amending Chapter VII, Section 11, by adding the words "whenever called upon by the Woman's Auxiliary regarding its functions or changes in its constitution and by-laws."

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: Are there any resolutions or motions to be offered before we adjourn so that they may be considered overnight by the appropriate reference committee?

DR. WILBUR E. FLANNERY (Lawrence): I move that the Reference Committee on Hospital Relations meet during the session and consider the propriety of putting in proper form for adoption the possibility of recommending to this House of Delegates that the general outline of the A.M.A. report of its Committee on Hospitals and the Practice of Medicine be accepted in principle, and that an attempt be made in our state to achieve gradually the objectives therein outlined.

The intent of this action, of course, is to bring into focus those portions of the A.M.A. recommendation which are in addition to those already accepted this morning by this House of Delegates.

SPEAKER BUCKMAN: This is referred to the Reference Committee on Hospital Relations.

DR. THEODORE R. FETTER (Philadelphia): I move that we adjourn until tomorrow morning at ten o'clock.

[The motion was seconded, put to a vote, and carried.]

[The meeting adjourned at eleven fifty-five o'clock.]

GILSON COLBY ENGEL, *President*,
LEWIS T. BUCKMAN, *Speaker*,
WALTER F. DONALDSON, *Secretary-Treasurer*.

Wednesday Morning, Sept. 28, 1949

The fourth and final session of the House of Delegates convened at ten-twenty o'clock, Speaker Buckman presiding.

SPEAKER BUCKMAN: The House will be in order. Chairman Wilson of the Credentials Committee announces a quorum.

If there be no objection, we will dispense with the reading of the minutes of yesterday's meeting.

The next order of business is the roll call.

[Secretary Donaldson called the roll.]

SPEAKER BUCKMAN: The house will be in order.

Westmoreland County Society has a membership of 208, which entitles it to three delegates in addition to the secretary. The Secretary's office has three delegates listed on the official roster of the House. The bulletin of the Westmoreland Medical Society for September, 1949, announces four delegates whom they have honestly, apparently, elected, each with two alternates. One of these alternates has been seated all through our meeting for a delegate to whom, apparently, they were entitled. This was done in good faith.

Don't misunderstand the Chair and don't misunderstand the delegate or the alternate nor the Committee on Credentials. Two of their delegates have not been here at all. The secretary has been here through the meetings until this morning, acting as delegate, and one delegate has been here through the meetings until this morning acting as delegate. Now, the alternate who has been seated for a fourth delegate to whom they are not entitled presents himself again and wonders why he is not on the roll call.

I ask consent of the House to seat Dan G. Bierer, an alternate for a delegate to which they were not entitled. I ask permission of the House to seat him as an alternate for one of the delegates who has not been here.

DR. CHARLES L. BROWN (Philadelphia): I so move.
[The motion was seconded by Dr. Archibald R. Judd, Berks County.]

SPEAKER BUCKMAN: If there be no objection from the floor, we will seat Dan G. Bierer as an alternate for John F. Maurer. If there is no objection, it isn't necessary to have a motion, gentlemen. I think I gather from the good humor of the response that there is no objection.

Now, the other man from Westmoreland County asks to be placed on the roll call. We cannot seat him because he wishes to represent, as an alternate, Willis H. Schimpf who has already been seated as a regular delegate.

Chairman Wilson, of the Committee on Credentials, informs me that there are 197 regularly elected delegates and we have seated 142, which is a higher proportion than we have experienced for a long time.

The next order of business is election of officers. Will the tellers, Drs. Mohler, Leibold, and Read, please take their seats in the front of the house?

Election of Officers

The first office to be filled is that of president-elect. The Chair is ready to receive nominations.

DR. JOHN F. McCULLOUGH (Allegheny): Mr. Speaker, Mr. President, and members of the House of Delegates: I am honored to represent the delegation from Allegheny County Medical Society in placing a name in nomination for the office of president-elect in The Medical Society of the State of Pennsylvania. This gentleman has practiced medicine in Pittsburgh for many years. This gentleman—and I mean this appellation to convey the fullest meaning of the word—is one whom most of you know. He is a member of this House. He is one who greets you with a smile that implies friendliness. He has a most pleasing and agreeable personality. He is healthy and robust and equal to the physical effort required by the strain in carrying out the duties of the high office of president. Professionally, he is an outstanding example of a practitioner of medicine and this, too, in the full meaning of the word.

He is past president of the Allegheny County Medical Society. He has been an active member in various key committees of our county society and has done creditable service in both executive and scientific activities for a number of years.

He is chairman of the Advisory Board of Health of the City of Pittsburgh. He is a member of the senior staff of the Medical Center in the University. He has had the professorship of therapeutics in the Medical School in Pittsburgh for many years.

Last year, as first vice-president of our State Society, he attended diligently the various meetings of the Board of Trustees. He has served faithfully on the Committees on Medical Economics and Public Health Legislation. He was one of the members of the House of Delegates in the A.M.A. representing Pennsylvania at its last session. As an active participant in the executive and scientific functions of the county society, he has the training for the highest office of this Society.

I nominate Dr. Harold B. Gardner, of Allegheny County, for president-elect.

[The nomination was seconded by many.]

DR. GEORGE L. LAVERTY (Dauphin): I move that the nominations be closed.

[The motion was seconded by Dr. T. Lamar Williams, Northumberland County.]

[The motion to close nominations was put to a vote and carried.]

SPEAKER BUCKMAN: This elects by acclamation Dr. Harold B. Gardner to be president-elect.

Your president thinks that the Chair should read for your information Chapter VI, Section 3, of the By-laws, which states:

"The vice-presidents shall assist the president and president-elect in the performance of their duties. In case of the death, resignation, or removal of the president, the vacancy shall be filled by the ranking vice-president."

The next order of business is the election of the first vice-president.

The Chair had forgotten to make an announcement, at the request of Dr. Kech, that there would be a caucus in the rear of this room of the members here from the Sixth Councilor District before we reach the election of trustees and councilors.

DR. CHARLES L. SHAFER (Luzerne): Luzerne County is happy to present the name of Louis W. Jones, a hard-working member of this House for many years, as a nominee for first vice-president.

[The nomination was seconded by several.]

DR. S. MEIGS BEYER (Jefferson): I move that the nominations close.

[The motion was seconded by Dr. Carl E. Ervin, of Harrisburg, put to a vote, and carried.]

SPEAKER BUCKMAN: This elects by acclamation Louis W. Jones to the office of first vice-president. This brings the office of second vice-president before us.

DR. ELWOOD T. QUINN (Montgomery): I wish to place in nomination Dr. Louise C. Gloeckner, of Conshohocken, for second vice-president.

[The nomination was seconded by Dr. Ward O. Wilson, of Clearfield.]

SPEAKER BUCKMAN: Any other nominations?

DR. THOMAS W. McCREARY (Beaver): I would like to present the name of Dr. L. Dale Johnson, of Fayette County.

[The nomination of Dr. Johnson was seconded by several.]

SPEAKER BUCKMAN: Any other nominations? If not, we will declare the nominations closed and ask the tellers to spread the ballot.

[The ballots were distributed, collected, and tallied. Dr. Gloeckner received 57 votes and Dr. Johnson, 56.]

SPEAKER BUCKMAN: Never underestimate the power of a woman!

The Chair declares Dr. Louise C. Gloeckner elected second vice-president.

[Vice-speaker Wilbur E. Flannery assumed the chair.]

VICE-SPEAKER FLANNERY: Nominations for the office of third vice-president are now in order.

DR. T. LAMAR WILLIAMS (Northumberland): Northumberland County takes pleasure in nominating its efficient secretary, Mark K. Gass.

DR. ROY W. MOHLER (Philadelphia): I move that the nominations be closed.

[The motion was seconded by Dr. Charles L. Fackler, York County, put to a vote, and carried.]

SPEAKER FLANNERY: This being the only nomination for third vice-president, Dr. Mark K. Gass is declared elected.

We are ready to receive nominations for fourth vice-president.

DR. GEORGE L. LAVERTY (Dauphin): I present in nomination Dr. L. Dale Johnson of Fayette County.

[The nomination was seconded by Dr. Elwood T. Quinn, Montgomery County.]

[Upon motion duly seconded and carried, the nominations were closed.]

SPEAKER FLANNERY: Dr. L. Dale Johnson is declared elected fourth vice-president.

We come to nominations for the office of secretary-treasurer.

DR. THOMAS H. STITES (Northampton): I take pleasure in renominating Dr. Walter F. Donaldson.

DR. DUDLEY P. WALKER (Northampton): I move that the nominations be closed.

[The motion was seconded by Dr. James E. Hadley, Venango County, put to a rising vote, and carried unanimously.]

SPEAKER FLANNERY: Dr. Walter F. Donaldson is declared elected to the office of secretary-treasurer.

We come now to nominations for the office of assistant secretary-treasurer.

DR. MILTON F. PERCIVAL (Philadelphia): I nominate the present incumbent, Dr. Park Berkheimer, Dauphin County.

ASSISTANT SECRETARY BERKHEIMER: I decline the nomination. I feel that I do not have the time to devote to it.

SPEAKER FLANNERY: Are there any other nominations?

DR. THEODORE R. FETTER (Philadelphia): Mr. Speaker, I nominate Dr. Malcolm W. Miller, of Philadelphia.

[The nomination was seconded.]

SPEAKER FLANNERY: Any other nominations?

DR. JOSEPH W. POST (Philadelphia): I move that the nominations be closed.

[The motion was seconded, put to a vote, and carried.]

SPEAKER FLANNERY: In view of the fact that Dr. Berkheimer, apparently in all sincerity, has asked to have his name withdrawn, I feel that it would be satisfactory, if it is agreeable with the delegates, that his name be withdrawn.

DR. ELWOOD T. QUINN (Montgomery): Mr. Speaker, I think it is most important to know whom we nominate and elect for this office. Will Dr. Malcolm Miller be willing to follow it through?

DR. FETTER: Yes, sir.

SPEAKER FLANNERY: If there are no other nominations, we will declare Dr. Malcolm W. Miller elected to the office of assistant secretary-treasurer.

Next, nomination for speaker of the House of Delegates.

DR. THEODORE R. FETTER (Philadelphia): I nominate Dr. Lewis T. Buckman, of Luzerne County.

[The nomination was seconded by several.]

DR. CHARLES L. FACKLER (York): Mr. Speaker, I move that the nominations be closed.

[The motion was seconded by Dr. James E. Hadley, of Venango County, put to a vote, and carried.]

SPEAKER FLANNERY: Dr. Lewis T. Buckman is declared elected.

[Speaker Buckman resumed the chair.]

SPEAKER BUCKMAN: The Chair will now entertain nominations for the office of vice-speaker.

DR. THOMAS W. McCREARY (Beaver): I nominate Dr. Wilbur E. Flannery.

[The nomination was seconded by Dauphin County.]

DR. THOMAS H. A. STITES (Northampton): I move that the nominations close.

[The motion was seconded by Dr. Dorothy C. Blechschmidt, of Philadelphia, put to a vote, and carried.]

SPEAKER BUCKMAN: That elects by acclamation Dr. Wilbur E. Flannery, of Lawrence County, as vice-speaker.

We now have to elect a trustee and councilor for the First Councilor District.

DR. JOSEPH W. POST (Philadelphia): Philadelphia County regrets the retirement of Dr. Hugh M. Miller

who has served faithfully and efficiently, and in his place I present the name of one whom you all know, who needs no introduction or presentation—Dr. Gilson Colby Engel.

SPEAKER BUCKMAN: Is there a second to this nomination?

DR. T. LAMAR WILLIAMS (Northumberland): I second that nomination.

SPEAKER BUCKMAN: Any other nominations?

DR. ELWOOD T. QUINN (Montgomery): I move that the nominations close.

[The motion was seconded by Dr. Dorothy C. Blechschmidt, of Philadelphia, put to a vote, and carried.]

SPEAKER BUCKMAN: This declares the election of Dr. Gilson Colby Engel to be trustee and councilor for the First District.

Is the caucus ready to report on a nomination for a trustee and councilor for the Sixth District?

DR. DONALD C. MALCOLM (Huntingdon): Dr. Joseph S. Brown, our trustee, does not wish re-election. I nominate Dr. Robert P. Banks, of Juniata County. He, his father, and great grandfather were physicians, all outstanding men, and his son will follow along in the same profession.

[The nomination was seconded by several.]

SPEAKER BUCKMAN: Any other nominations?

DR. ELWOOD T. QUINN (Montgomery): I move that the nominations close.

[The motion was seconded by Dr. Dudley P. Walker, Northampton County, put to a vote, and carried.]

SPEAKER BUCKMAN: This declares the election of Dr. Robert P. Banks, of Juniata County, to be trustee and councilor from the Sixth District.

At this point it is customary to have a report from the chairman of the Committee to Nominate Delegates and Alternates to the American Medical Association. The chairman, Dr. Ravdin, is now reading a paper in the scientific section. I ask permission of the House to postpone hearing this report. Will someone offer a motion that we postpone the election of delegates and alternates to the A.M.A. until eleven-thirty?

DR. EDGAR S. BUYERS (Montgomery): I so move.

[The motion was seconded by Dr. Ward O. Wilson, of Clearfield, put to a vote, and carried.]

SPEAKER BUCKMAN: The Chair recognizes Secretary Donaldson.

Election of District Censors

SECRETARY DONALDSON: We have here the nominations as they have been presented by the various component societies.

DR. WILBUR E. FLANNERY (Lawrence): I move the election of the district censors as presented.

[The motion was seconded by Dr. George L. Laverty, Dauphin County, put to a vote, and carried.]

Election of District Censors

Adams, Eugene E. Elgin; *Allegheny*, David P. McCune; *Armstrong*, Ellis C. Winters; *Beaver*, Philip F. Martsoff; *Bedford*, John A. Topper; *Berks*, Philip D. Woodbridge; *Blair*, James W. Hershberger; *Bradford*, Willis A. Redding; *Bucks*, Allen H. Moore; *Butler*, Earle L. Mortimer; *Cambria*, Paul W. McCloskey; *Carbon*, Clinton J. Kistler; *Centre*, Leroy

Locke, Chester, William Linberger; *Clarion*, Charles V. Hepler; *Clearfield*, Ward O. Wilson; *Clinton*, Gerald F. McDonough; *Columbia*, William C. Hensyl; *Crawford*, John H. Bailey; *Cumberland*, Newton W. Hershner; *Dauphin*, Edwin A. Nicodemus; *Delaware*, John B. Klopp; *Elk*, Joseph E. Madara; *Eric*, Elmer G. Shelley; *Fayette*, Othello S. Kough; *Franklin*, William B. O'Rear; *Greene*, Donald R. Jacobs; *Huntingdon*, Frederic H. Steele; *Indiana*, Joseph W. Gatti; *Jefferson*, Hollister W. Lyon; *Juniata*, Robert P. Banks; *Laekawanna*, William A. Coggins; *Laneaster*, Mahlon H. Yoder; *Lawrence*, Charles F. Flannery; *Lebanon*, John D. Boger; *Lehigh*, John H. Henne-muth; *Luzerne*, Herbert B. Gibby; *Lyeoming*, Albert F. Hardt; *McKean*, Robert D. Donaldson; *Mercer*, Nelson J. Bailey; *Mifflin*, Raymond R. Decker; *Monroe*, William R. Levering; *Montgomery*, Elmer R. Place; *Montour*, Vincent J. Cassone; *Northampton*, Clinton F. Stofflet; *Northumberland*, Henry F. Ulrich; *Perry*, O. K. Stephenson; *Philadelphia*, Hugh Robertson; *Potter*, Robert H. Kazmierski; *Schuylkill*, Francis M. Dougherty; *Somerset*, Charles J. Hemminger; *Susquehanna*, James J. Grace; *Tioga*, Eleanor Larson; *Venango*, Charles C. Bridenbaugh; *Warren*, Arthur J. O'Connor; *Washington*, Paul P. Riggle; *Wayne-Pike*, Clifford H. Mack; *Westmoreland*, D. Ray Murdock; *Wyoming*, William J. Llewellyn; *York*, Charles L. Fackler.

SPEAKER BUCKMAN: They are declared elected district censors.

The Chair recognizes a member from Westmoreland County Society who has a resolution.

DR. WILLIAM E. MARSH (Westmoreland): We propose the following resolution for your consideration and request its adoption:

Resolution

WHEREAS, Outlying hospitals with more than average clinical material and modern equipment are unable to obtain interns and residents due to a scarcity created by recent graduates being engaged in military service and training for the specialties; and

WHEREAS, The exceedingly high scholastic standing of our medical schools prevents many otherwise suitable students from becoming physicians who in turn would be good general practitioners; and

WHEREAS, The great number of specialists and students training to become specialists does not in any way relieve the present deficiency in medical service; and

WHEREAS, The number of physicians in the nation has not kept up with the proportionate increase in population; and

WHEREAS, The Westmoreland County Medical Society has recognized the appended complaint from the staff of the Westmoreland Hospital to be bona fide and has recommended that corrective measures be instituted through the American Medical Association; therefore, be it

Resolved, That the delegates of The Medical Society of the State of Pennsylvania be instructed to bring these defects before the House of Delegates of the American Medical Association for consideration and correction.

SPEAKER BUCKMAN: At this hour it is inconvenient, if not impossible, to refer further resolutions and motions to reference committees, unless we expect to meet again after noon today. If this resolution receives a second from the floor, it will be possible for the House now to consider it informally, which virtually means unlimited debate from the floor, amendment, etc. Do you wish to receive this resolution through means of a second? This resolution is from the Westmoreland County Medical Society and points out that it is difficult to obtain interns and residents.

[The resolution was seconded by Dr. Wilbur E. Flannery, Lawrence County.]

SPEAKER BUCKMAN: They give the several reasons and offer the resolution that our delegates to the Ameri-

can Medical Association be instructed to bring this question to the floor of the House of Delegates of the American Medical Association.

DR. GEORGE L. LAVERTY (Dauphin): If it is in order, I move that this resolution be referred to the Board of Trustees for action.

[The motion was seconded by Dr. Roy W. Mohler, of Philadelphia.]

SPEAKER BUCKMAN: The question, then, is on referring this resolution to the Board of Trustees for action.

DR. FRANCIS F. BORZELL (Philadelphia): For your information and for that of the obviously well-intentioned authors of this resolution, the American Medical Association has had the problem of shortage of residents and interns before it time and time again. There are special committees that are seriously considering the problem at the present time.

In addition, this resolution contains a statement which is perhaps not quite accurate. I do not have the figures with me, but later statistics show that there has been a gradual increase in the number of physicians practicing medicine over and above the increase in population. As to the motion that the resolution be referred to the Board I would suggest that this need not be done; our delegates will be embarrassed if they are required to bring in resolutions on matters which are already being seriously considered by the American Medical Association.

SPEAKER BUCKMAN: The question is on referring this resolution to the Board. Are you ready for the question?

As many as favor will signify by saying "aye"; contrary-minded, "no."

As many as are in favor of referring this to the Board of Trustees, please rise. [Four arose.] Contrary-minded, please rise. The vote is overwhelmingly against referring this to the Board of Trustees.

DR. JOSEPH J. BELLAS (Mercer): I move that this resolution be tabled.

[The motion was seconded by Dr. Archibald R. Judd, Berks County, put to a vote, and carried.]

SPEAKER BUCKMAN: The Chair recognizes Dr. Brown, of Philadelphia, chairman of the Reference Committee on Reports of Officers.

Report of Reference Committee on Reports of Officers (continued)

DR. CHARLES L. BROWN (Philadelphia): This is a continuation of the report of the Reference Committee on Reports of Officers.

Supplemental Report of the Secretary-Treasurer

The supplemental report of the Secretary-Treasurer contained additional information and essentially concerned only the collecting of the A.M.A. membership assessment. The report of the reference committee dealt at some length with this subject yesterday and your reference committee acknowledges this additional information and recommends that it be received by the House along with previous similar subject material.

Mr. Speaker, I move the adoption of this portion of the report.

[The motion was seconded by Dr. Ward O. Wilson, of Clearfield, put to a vote, and carried.]

DR. BROWN: *Resolution by Board of Trustees.*

The resolution by the Board of Trustees, introduced

by Dr. George S. Klump, was to commend the educational program of the American Medical Association and to instruct our delegates to the American Medical Association House of Delegates to support the establishment of dues for members of the American Medical Association. The reference committee recommends the adoption of this resolution.

Mr. Speaker, I move the adoption of this portion of the report.

[The motion was seconded by Dr. Walter H. Brubaker, of Lebanon, put to a vote, and carried.]

DR. BROWN: *Address by the President, Dr. Gilson Colby Engel.*

The address of President Engel was forceful and timely. It epitomizes the many activities and accomplishments of progressive leadership during the past year and stimulates and motivates continuity of effort in the future toward those high ideals and responsibilities for which this society stands. The sanction and support provided by this society to President Engel in his endeavors to retard and change the trend of events leading to socialized medicine are recognized and President Engel is to be commended for the effective and dignified manner in which he has conducted himself under trying circumstances in carrying the cause to Washington. Your reference committee considers it fitting and would recommend that the House make formal recognition and express appreciation to President Engel for his splendid service to the medical profession, which has been far beyond the mere call of duty.

Many other suggestions in the address of President Engel have been touched on in the several printed reports of officers, and previously considered by this committee, again reflecting the coherent and effective guidance of President Engel during this very important year in our history, when destructive forces almost overtook us.

State Society Problems: The suggested changes in the structure of Society committees are noted with great interest and your reference committee has weighed very carefully the import of these proposed changes. There has been a rather extensive consultation with several members of the House who currently are concerned with the changes relating to the merging of certain committees. Your reference committee makes the following recommendations to the House:

1. That a special committee of the House of Delegates be appointed to study the over-all committee program with specific duties as outlined in President Engel's address, and at this time the reference committee wishes to record its recognition of the urgent significance of and advisability of creating the Disease Control Committee and the merging of certain committees, as outlined in sections 1 and 2, 4 and 5, in President Engel's address, and furthermore, would urge that this new special committee give the above matter early priority in its deliberations.

2. That a handbook be published, as outlined in section 3 of President Engel's address.

Public Health: President Engel commented on the survey of public health facilities in Pennsylvania, as made by the American Public Health Association, and stated that many pertinent recommendations were forthcoming in the report of this survey. Also, he referred to a report which would be presented to the House by Dr. Pascal F. Lucchesi, from the Commission on Public Health and Preventive Medicine, containing recommendations that can be effective without legislation and

urging favorable action by the House on these recommendations.

Other recommendations in this Public Health Survey report would require legislation to become effective; President Engel suggested that the House of Delegates refer the remaining portion of the report, that is, those recommendations requiring legislation, to the Board of Trustees and that this body be charged with designation of portions of the report to the several committees and commissions involved; these committees and commissions to hold meetings and bring in recommendations to the Board of Trustees at its first meeting following this annual session, after which the Board through existing Committees on Public Relations and Public Health Legislation should carry out the approved recommendations to insure changes in the Department of Health consistent with a strengthened Health Department.

Your reference committee concurs in this suggestion and recommends that such action be taken by the House.

Mental Health: We note the comments of President Engel concerning the mental health problem and the pathway of its management at present, and your reference committee concurs in the suggestion that the Society remain alert to all the factors involved and continue efforts to strengthen the relationship of mental health to the Department of Health.

Mr. Speaker, I move the adoption of this portion of the report.

[The motion was seconded by Dr. Dorothy C. Blechschmidt, of Philadelphia.]

SPEAKER BUCKMAN: The question is on the adoption of this portion of the report, which covers several questions; do you wish them divided to consider separately, or will you take action on the reference committee report as presented? This part covers Dr. Engel's address and has several recommendations in it.

[The motion was put to a vote and carried.]

DR. BROWN: *Excerpt from the address of President E. Roger Samuel concerning the matter of an interim session of the House of Delegates.*

The committee carefully considered this recommendation from every angle, and believes it to be a good one, but at the present time the absolute necessity of an interim meeting does not seem sufficiently pressing to justify the additional cost.

The reference committee does not recommend the activation of an interim session at this time.

Mr. Speaker, I move the adoption of this portion of the report.

[The motion was seconded by Dr. Charles L. Fackler, of York, put to a vote, and carried.]

DR. BROWN: I move the adoption of the report of the Reference Committee on Reports of Officers as a whole.

[The motion was seconded by Dr. Ward O. Wilson, of Clearfield, put to a vote, and carried.]

SPEAKER BUCKMAN: The report is adopted as a whole.

The Chair recognizes Dr. Ravdin, chairman of the Committee to Nominate Delegates and Alternates to the A.M.A.

Report of Committee to Nominate Delegates and Alternates to the A.M.A.

DR. I. S. RAVDIN (Philadelphia): The Committee to Nominate Delegates and Alternates to the American Medical Association submits the following nominees for

the six vacancies for delegates which will occur on Dec. 31, 1949 (to serve in 1950 and 1951):

Dr. William L. Estes, Jr., Bethlehem
Dr. James L. Whitehill, Rochester
Dr. George S. Klump, Williamsport
Dr. Elmer Hess, Erie
Dr. James Z. Appel, Lancaster
Dr. Gilson Colby Engel, Philadelphia

Your committee submits the following nominees for the six vacancies which will occur in the alternates to delegates on Dec. 31, 1949 (to serve in 1950 and 1951):

Dr. M. Louise Gloeckner, Conshohocken
Dr. Thomas W. McCreary, Rochester
Dr. Edward Lyon, Jr., Williamsport
Dr. Elmer G. Shelley, North East
Dr. Robert L. Schaeffer, Allentown
Dr. Constantine P. Faller, Harrisburg

Your committee submits the following nominees for the eleven vacancies which will occur in the alternates-at-large on Dec. 31, 1949:

Dr. Robert R. Impink, Reading
Dr. J. Arthur Daugherty, Harrisburg
Dr. J. Hart Toland, Philadelphia
Dr. Robert D. Donaldson, Kane
Dr. George W. Hawk, Sayre
Dr. Louis W. Jones, Wilkes-Barre
Dr. John K. Covey, Bellefonte
Dr. Wilbur E. Flannery, New Castle
Dr. L. Dale Johnson, Connellsville
Dr. Frederick O. Zillesen, Easton
Dr. William H. Erb, Ridley Park

DR. JAMES E. HADLEY (Venango): I move that the report of the Committee to Nominate Delegates and Alternates to the A.M.A. be adopted.

[The motion was seconded by Dr. Joseph J. Bellas, Mercer County.]

SPEAKER BUCKMAN: The question, then, is on the acceptance of the report of the Committee to Nominate Delegates and Alternates to the A.M.A., which acceptance would declare the election of those whose names were submitted.

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: I will ask Dr. McCullough, of Allegheny County, and Dr. Post, of Philadelphia, to bring forward Dr. Harold B. Gardner.

[The audience arose and applauded as Dr. Gardner was escorted to the platform.]

SPEAKER BUCKMAN: It gives me great pleasure to introduce to you your president-elect, Dr. Gardner, of Allegheny County.

PRESIDENT-ELECT HAROLD B. GARDNER: I now know what it is to walk the last mile and then be shot.

I am also mindful of the honor of having been unopposed for this nomination. However, I think of one of the oldest stories that I can remember. Two individuals, one esthetic and one practical, were standing at Niagara Falls watching the onrush of water, one admiring the grandeur and commenting upon the volume of water going over the precipice; the other, a practical-minded individual, said, "Well, there's nothing there to stop it."

I know that I stand here perhaps in the eyes of some of my friends as somewhat of a prevaricator, because I have been known in the past to say that I never

wished to be found in the spot in which I now am. That thought was honestly expressed for two reasons: first, because I felt very definitely that there were men in this organization with better minds, more capable, and with greater training than I, who should be called upon; second, I felt that I could not, because of family obligations, make the sacrifice for the next year, which this will mean. However, into my thinking came another idea, the birth of it, perhaps, occurring about the time my older son entered the School of Medicine. For many years I have stood before my students feeling a definite sense of responsibility to them not only for my part in their instruction but also for the practice of medicine into which they were going. At that time the clouds that have almost engulfed us in the last two or three years were just appearing upon the horizon, and I felt that since my own son was starting down that road, as well as the rest of my students, that I myself should do what I could to try to preserve the independent practice of medicine.

About that time I accepted the first assignment in the State Medical Society. You know the story: one committee after another, the House of Delegates, this year the national House of Delegates, and particularly this year the privilege and unique assignment of sitting in on all sessions of the Board of Trustees.

I realized that the State Society had invested time, expense, and money, if you please, in training me and I felt that I did not have the right to decline whatever service I could be to this Society. I realize very well that much of the business of this Society is conducted by the Secretary-Treasurer, and it has been a great pleasure to me to have worked with Dr. Donaldson here in Pittsburgh these many years and to have profited by his advice and his friendship, by that of the Board of Trustees, by associates in the House of Delegates, and by our executive staff.

I recognize also that the duties of president-elect are not particularly onerous, that the burden comes when one is president. It will be my very great pleasure to serve under Dr. Samuel to the best of my ability this year, as I have tried to fulfill the assignments given me by Dr. Engel during this past year. I shall look forward with pleasure, as well as with sacrifice, to the duties of this office.

I want you to know that I do not thank you for this favorable consideration, for the honor of office, but I do very sincerely and very humbly thank you for the honor of your confidence. Thank you!

SPEAKER BUCKMAN: The Chair recognizes Dr. Klump, trustee and councilor for the Seventh District.

DR. GEORGE S. KLUMP: Will Dr. Hugh McCauley Miller step forward? Dr. Miller, as you know, is retiring as trustee and councilor for the First District. He has brought to our Board sure judgment, sound and progressive thinking, the kind we need.

This plaque, Dr. Miller, which is signed by the president, the chairman of the Board of Trustees, and secretary-treasurer, states: "To Hugh McCauley Miller, M.D., in recognition of your two years of faithful service to The Medical Society of the State of Pennsylvania while a member of the Board of Trustees and Councilors and in appreciation of your private and official observance of the ethical principles of our profession, the Society, through the undersigned officers, proffers you expressions of gratitude and confidence that your valued cooperation will be continued."

Hugh, we are sorry to see you retire from the Board. Thank you for all your services.

DR. HUGH MCCAULEY MILLER: Thank you very much.

SPEAKER BUCKMAN: We will now hear additional reports, if any, from the various reference committees.

The Chair recognizes Dr. Walker, chairman of the Reference Committee on New Business.

Report of Reference Committee on New Business (continued)

DR. DUDLEY P. WALKER: This is the continued report of the Reference Committee on New Business.

Concerning the *Supplemental Report of the Committee on Public Health Legislation*—legislative program for 1949-1950—the committee fears that in 1951 some member of the Legislature may introduce a compulsory health insurance bill. In order to better inform all candidates of the medical profession's viewpoint, the committee submits the following plan:

Each member of the State Society Committee on Public Health Legislation to contact presidents, secretaries, and the chairmen of the Public Health Legislation Committees in each councilor district and request that two or three members of each county medical society and of its woman's auxiliary be selected for *each legislative district* to serve as a liaison committee between candidates and the county society. Their duties shall be (1) to contact doctors, urging them and their families to register and vote; (2) to obtain from doctors the names of ten voters who can be depended upon to write letters to state and Federal legislators on pending bills, and also to ascertain from these doctors whether the voters, if convinced of the propriety of our viewpoint, would be willing to vote for or against a candidate, depending on his attitude toward public health and medical service problems; (3) to attend meetings with the candidates to discuss public health legislation.

A meeting in Harrisburg to inform county society legislative committee chairmen regarding past and possible future health legislation is suggested.

Chiropractic in Pennsylvania

There is now a Chiropractic Board in Pennsylvania which, however, has no powers. The Joint State Government Commission can study the problem of licensure for limited licensees. The suggestion for such a study by the commission should come from the Department of Public Instruction, which is willing to make the request if the State Board of Medical Education and Licensure will recommend it; therefore, Drs. Samuel, Deckard, and Palmer met with the latter board to urge such action. Discussed at this meeting were (1) the possibility that the Joint State Government Commission might suggest opening the Medical Practice Act to admit displaced persons; (2) that the new act providing for injunctions against those practicing without a license should be of assistance to the board; (3) that chiropractors under their own board might establish schools in Philadelphia, Pittsburgh, and Harrisburg; (4) that a composite board, although distasteful to the present board members, might nullify the complaint that the present system is licensure without representation. After this meeting, the State Board, instead of suggesting the study by the Joint Commis-

sion as urged, proposed preparation of a bill outlining the powers of the newly appointed Board of Chiropractic Examiners.

Therefore, the Committee on Public Health Legislation suggests a resolution: That the Committee on Public Health Legislation be authorized to request the Joint State Government Commission to make a study of the question of limited licensees with the idea of suggesting some constructive solution to the problem, and that the Board of Medical Education and Licensure be respectfully requested to support such a request.

There are three "whereas" clauses, one of which is not clear and none of which seem necessary to clarify the resolution. The committee proposes to explore the legality of the appointment of two unlicensed chiropractors to the newly created Board of Chiropractic Examiners.

Federal Legislation

The committee will distribute its final bulletin as soon as the Washington Office of the A.M.A. supplies its final report.

The committee requests the privilege of making decisions after consultation with the Board of Trustees and others interested, in case legislation is introduced requiring such decisions.

The committee proposes to study (1) the Medical Practice Act in order to be in position—after consideration by the Board of Trustees, the State Board of Medical Education and Licensure, and the House of Delegates—to prepare bills for introduction in the next regular session of the Legislature, or if there be a special session, after consideration by the first two named bodies; (2) the mental health code, which it will also request the Joint State Government Commission to study.

The committee revises its opinion in its original report of the recent session of the Legislature and feels that the Medical Society fared better than any other group.

Your reference committee approves the plan submitted for organizing each legislative district. It also approves the resolutions submitted, minus the "whereas" clauses. It believes the Committee on Public Health Legislation should be empowered by the House to make decisions after consultation with the Board of Trustees and others interested, when necessary, and it approves the studies proposed.

Mr. Speaker, I move the adoption of this portion of the report.

[The motion was seconded by Dr. Ward O. Wilson, of Clearfield.]

SPEAKER BUCKMAN: The question is on the adoption of this portion of the reference committee's report.

DR. WALTER S. CORNELL (Philadelphia): Mr. Chairman, I rise for a point of information. In the supplemental report of the Committee on Public Health Legislation there appears the resolution to which Dr. Walker has referred. The text here says that the Committee on Public Health Legislation suggests the passage of this resolution. It is a very important resolution. You will notice that it follows some material in which it appears that the committee and the Medical Licensure Board are not altogether in harmony.

If we approve of this report, and I would say I approve it, I would like to know whether that carries with it the passage of this resolution which is found in the report which the committee approves.

SPEAKER BUCKMAN: Favorable action of this House would carry with it the passage of the resolution offered by the Committee on Public Health Legislation, except the "whereas" clauses to which the reference committee objects.

The reference committee rejected all three "whereas" paragraphs and accepted the resolution that the Committee on Public Health Legislation of The Medical Society of the State of Pennsylvania be authorized to request the Joint State Government Commission to make a study of the question of limited licensees as contained in House Resolution No. 74, which provided that the Joint State Government Commission study the Administrative Code and related statutes, which includes the Medical Practice Act and licensure of limited licensees, with the idea of suggesting some constructive solution to the problem; and also that the Board of Medical Education and Licensure be respectfully requested to support such a request.

The committee rejects, and the House would, therefore, reject, the three "whereas" paragraphs. Does that answer your question?

DR. JAMES E. HADLEY (Venango): The Committee on Public Health Legislation requests power to act on certain things without the approval of the State Society. What matters would this pertain to?

SPEAKER BUCKMAN: Dr. Palmer, if the House accepts the reference committee report which adopts your supplemental report, it is obligating itself to authorize your committee to take independent action under certain circumstances. The member from Venango County wants to know what these restrictions are, if any, on your independent action.

DR. C. L. PALMER (Allegheny): It is very difficult to tell you what the restrictions will be; nobody knows. We simply ask the privilege of acting in an emergency with the consent and advice of your Board of Trustees or any other committee or group that is interested; that is all. We do not want dictatorial power, but we do meet emergencies in legislation and we do need to have the backing of the committee, the Board of Trustees, and all others concerned; and that may even mean, if it is necessary, a special meeting of the House of Delegates.

SPEAKER BUCKMAN: Are you ready for the question which involves the adoption of the reference committee's report and the supplemental report of the Committee on Public Health Legislation minus the three "whereas" paragraphs?

[The motion was put to a vote and carried.]

DR. WALKER: For the comfort of the House of Delegates, the three "whereases" in the resolution are not important at all, but they are legally clear because they were written by the director of the Legislative Reference Bureau in Harrisburg who is an attorney.

On the resolution presented by the Venango County delegation: After considerable difficulty, your reference committee, through material furnished by Dr. Palmer's office, has found that the Medical Assistance Program for School Children was enacted on July 5, 1947, and is known as Act 522, and this program is placed in the hands of the Department of Public Assistance.

In the instructions issued by this department in December, 1947, "For County Boards of Assistance, School Districts, and Professional Practitioners" under General Plan, paragraph 7 (page 5) reads: "If found eligible, the parent is given authorization (DPA Form

B) upon which is entered (1) the name of the physician, clinic, dentist, etc., the parent has selected." Under Participation (page 7): "Participation in this program is open to: (1) Doctors of medicine or osteopathy who are duly licensed, (2) dentists who are duly licensed," etc.

Further in these instructions are enumerated fee schedules and methods of determining eligibility.

Therefore, your reference committee does not recommend to the House of Delegates adoption of this resolution.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Ward O. Wilson, of Clearfield.]

SPEAKER BUCKMAN: The question is on the adoption of this portion of the reference committee's report which rejects the resolution from Venango County.

[The motion was put to a vote and carried.]

DR. WALKER: On the resolution presented by the York County delegation, your reference committee finds that, although amendments to the Constitution and By-laws of The Medical Society of the State of Pennsylvania were adopted by the House in 1948, these required few changes by the component county societies to eliminate conflicting items. Further, Secretary Donaldson has notified all component county societies of the necessary changes. However, the Secretary informs your committee that his office will later prepare and issue a model "Constitution and By-laws for Component County Medical Societies." Therefore, your reference committee recommends adoption of the resolution with omission of paragraph 1, which would appoint a special committee.

I move the adoption of this portion of the report.

[The motion was seconded by Dr. Roy W. Mohler, of Philadelphia, put to a vote, and carried.]

DR. WALKER: This brings us to the statement in the resolution of the delegation from Philadelphia. At a meeting last evening, the Philadelphia delegation, with the approval of your reference committee, desired to withdraw its resolution as submitted on Monday and substitute a new one.

SPEAKER BUCKMAN: A resolution or motion, once it has been referred to a committee, cannot be altered in a committee. It, therefore, becomes necessary, if the parties that compromised in the dispute over this resolution wish to offer something else, for the House to discharge the reference committee from consideration of this particular resolution. A motion to that effect would be in order. It requires two-thirds to pass it.

DR. ROY W. MOHLER (Philadelphia): I move that the committee be discharged from consideration of the resolution.

[The motion was seconded by Drs. Thomas W. McCreary, Beaver County, and T. Lamar Williams, Northumberland County.]

SPEAKER BUCKMAN: The question is on discharging the committee from consideration of the Philadelphia resolution. Are you ready for the question?

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: The committee is discharged from consideration of the Philadelphia resolution.

Dr. Cornell, do you wish to withdraw the resolution?

DR. WALTER S. CORNELL (Philadelphia): Mr. Chairman, I would like to withdraw the original resolution. I make a motion to that effect.

SPEAKER BUCKMAN: Do you have the draft of the new resolution? The Chair recognizes Dr. Cornell.

DR. CORNELL: We presented for your consideration two days ago a resolution which was based on the success of the chiropractic group in the passage of a law establishing a Board of Chiropractic Examiners, the operation of which is temporarily held up because they failed by a tie vote in the Senate to pass a companion bill to regulate the practice of chiropractors and let them go to work. We are now living in a period between two sessions of the Legislature in which with literature at hand the president of the Medical Licensure Board will continue to license those chiropractors who are able to pass the limited examination given to them, but only until the next Legislature meets, and then we don't know what will happen.

The Philadelphia delegation, before we came to Pittsburgh, considered this matter. At that time the unanimous conclusion of those present—and that was a majority of us—was that the surest way to stop these inferior, irregular cults is by a basic science law, which is already in operation in eighteen states and one territory, and which no doubt is a very effective screen to stop this kind of thing right at the source—and you can get your own examining board, or medical examining board.

The resolution was introduced and read here. Subsequent to its offering and reference to the Reference Committee on New Business, the Philadelphia delegation met again to talk over various matters and then found a slight division in its ranks. One member felt that possibly a basic science board might introduce material which wouldn't quite fit the curriculum of the medical schools and perhaps—I am not sure of this—misrepresent the instruction, you might say, of a non-medical group on the practice of medicine. Another member, for whom I have the greatest respect, felt that the matter should be studied further from these various angles. As a result we realized that the only thing we could bring forward would be something in which we had a reasonably unanimous opinion, and those of us who felt so definitely about the basic science law and the basic science board would be wise in doing what we all have to do and that is to compromise to a point at which we are all agreed. For that reason, we have asked to have that original resolution withdrawn. However, for the sake of the record, I hope that with the new one—if it is endorsed and given consideration—the facts stated in the "whereases" of the original resolution will not be lost.

The present resolution, then, is as follows:

Resolution

The members of the Philadelphia delegation have given further consideration to its resolution regarding the licensure of chiropractors. They reaffirm the declaratory statements which precede the resolution. They desire to amend the resolution to read as follows—so that it will become an amended resolution, that is, a new resolution:

WHEREAS, Practitioners in all the healing arts should conform to minimal basic science requirements; and

WHEREAS, Identical examinations in the basic sciences should be given to all applicants for licensure in the healing arts; and

WHEREAS, A Joint State Government Commission exists, the province of which permits consideration of the entire subject of licensure; therefore, be it

Resolved, That the Board of Trustees of The Medical Society of the State of Pennsylvania is urged (unless events occur which in its judgment positively prohibit such action) to present to said State Government Commission, directly or through a committee designated by it, a statement of the principles here affirmed with requests for favorable consideration of the commission; and, be it further

Resolved, That the Board of Trustees report to the House of Delegates at the next annual meeting regarding action taken and results obtained.

SPEAKER BUCKMAN: The Chair will rule that no "whereas" paragraphs which appeared in the previous resolution can be considered with this resolution; they have been withdrawn. Any action by the House will be simply on the instrument as presented this morning, which you just heard. It is late in our session. It is practically impossible to refer this to a reference committee; by a vote of the House we can consider it informally. If there be no objection from the floor, the Chair will assume that the House is willing and ready to consider this informally, with unlimited debate and amendment.

Do I hear a second to this resolution?

DR. WILLIAM H. PERKINS (Philadelphia): I second it.

SPEAKER BUCKMAN: The question is on the adoption of this resolution. The essential thing is that the Board of Trustees of the State Medical Society is urged to take under consideration this matter of a basic science law.

Would you like to speak further on the question, Dr. Cornell?

DR. CORNELL: First, I want to say that, as far as I know, the members of the Reference Committee on New Business are unanimously in favor of the present amendment. We consulted Dr. Palmer, the chairman of the Public Health Legislation Committee, and he is in favor of it. Our own Philadelphia delegates are in favor of it. I only mention that because I can honestly say that we have done the best we could to meet the situation.

You will notice that Dr. Palmer's supplemental report has in it the possibility of a composite board; that is to say, a board of licensure which would take in possibly osteopaths, chiropractors, and so on, which in itself would produce identical questions probably in pathology and physiology for everybody—I hope so.

The Legislature will not meet for a year and three months. If it met next January, I would not recede one inch on this question of a basic science board; but we have another year to see what can be done along these other lines. During that year I hope that this State Government Commission can be persuaded to see things in the proper light. Thank you.

SPEAKER BUCKMAN: The question is on the adoption of this resolution. Are you ready for the question?

[The motion was put to a vote and carried.]

SPEAKER BUCKMAN: The Chair recognizes Dr. Walker.

DR. WALKER: This constitutes the final item of business that was submitted to our committee. Our report is signed by Drs. L. Dale Johnson, Russell B. Roth, Daniel Ritter, Roy Deck, and Dudley P. Walker, chairman.

Mr. Speaker, I now move the adoption of the report of the Reference Committee on New Business as a whole.

[The motion was seconded by Dr. Joseph W. Post, of Philadelphia, put to a vote, and carried.]

SPEAKER BUCKMAN: The Chair recognizes Dr. McCreary, chairman of the Committee on Hospital Relations.

Report of Reference Committee on Hospital Relations (continued)

DR. THOMAS W. MCCREARY (Beaver): The House will remember that yesterday, just previous to adjournment, a motion was introduced by Dr. Flannery, of Lawrence County. Your reference committee met immediately to prepare this recommendation:

Your Reference Committee on Hospital Relations recommends that this House of Delegates of The Medical Society of the State of Pennsylvania accept the principle of the report of the Committee on Hospitals and the Practice of Medicine of the American Medical Association and that an attempt should be made in our State to gradually achieve the objectives herein outlined.

I move the adoption of this report.

[The motion was seconded by Dr. Joseph W. Post, of Philadelphia, put to a vote and carried.]

SPEAKER BUCKMAN: Is there any other matter of new business to be brought before the House before we hear from the representative of the Board of Trustees?

The Chair recognizes Dr. James L. Whitehill, of the Board of Trustees.

DR. JAMES L. WHITEHILL: The Board of Trustees recommends to the House of Delegates that the dues of The Medical Society of the State of Pennsylvania for the year 1950 be \$23, of which \$1.00 will be allotted to the Medical Benevolence Fund and \$2.00 to the Educational Fund.

SPEAKER BUCKMAN: Do I hear a motion from the floor?

DR. ROY W. MOHLER (Philadelphia): I move that the report from the Board of Trustees be adopted.

[The motion was seconded by Dr. Constantine P. Faller, Dauphin County.]

DR. WILLIAM BATES (Philadelphia): I would like to offer an amendment to this recommendation of the Board of Trustees.

In this House, on the first day of the session, we were alerted to the possibility of A.M.A. membership dues. As a result, your delegates to the A.M.A. who will represent you at the Interim Session in Washington, in December, met at 7:30 a.m. the second day of the session. They desire the expression of this House on how they should vote on this question when the A.M.A. Board of Trustees recommends to the A.M.A. House of Delegates that membership dues (probably \$12) be levied for the first time in the history of the A.M.A.

This instruction has been obtained. Necessary implementation will be expedited by amending this present recommendation of your Board of Trustees by adding:

If and when the House of Delegates of the A.M.A. decide on membership dues, and establish the amount of such dues, that the secretary-treasurer of this organization be authorized to add the equivalent amount to the State Society dues now established on the membership bills for 1950 rendered by him to the secretary of each component county society.

[The amendment was seconded by Dr. Henry L. Gowens, Jr., of Philadelphia.]

SPEAKER BUCKMAN: The question is on the amendment to the resolution of the Board of Trustees which provides, if and when the A.M.A. dues are established, the billing will be on the county society level through

the Secretary-Treasurer's office in Pittsburgh. Are you ready for the question?

[The amendment was put to a vote and carried.]

SPEAKER BUCKMAN: The amendment is adopted.

The question is now on the resolution, as amended, providing State Society dues of \$23 annually, \$1.00 allocated to the Medical Benevolence Fund and \$2.00 to the Educational Fund.

Are you ready for the question?

DR. CHARLES L. FACKLER (York): May we have from the committee the reasons for increasing it when last year \$1.00 went to the Medical Benevolence Fund and \$2.00 to the Educational Fund? We have to report back to our component society why this increase went through when the same amount of money is going to the Medical Benevolence and Educational Funds.

DR. WHITEHILL: If you will study the financial statement on page 8, you will find that last year when we met in annual session we had a balance of approximately \$130,000. This year we have a balance of \$70,000. Therefore, we operated in the red this past year to the extent of \$66,000. If we operate in the red to the extent of \$66,000 again next year, our present balance of \$70,000 would be reduced in September, 1950, to about \$10,000, which is much too small.

Our allotments this year are the same as last year—\$1.00 to the Medical Benevolence Fund and \$2.00 to the Educational Fund. The \$8 increase is necessary on account of an expansion of our Public Relations Committee activities, for which we spent \$41,000 this past year. Their budget for the coming year is \$55,000. That is our biggest increase—public relations.

DR. FACKLER: Thank you very much. That answers the question.

DR. ELWOOD T. QUINN (Montgomery): We have to go back to our county societies and give some excuse for this increase in dues. As you will recall, we approved the Educational Fund with the provision that we *may* allot \$2.00 from each member's dues each year; we don't *have* to do it. We could save \$2.00 in that direction if we don't want to increase the 1950 dues.

Further, our investments are yielding about 2.9 per cent. There is no reason why we couldn't increase our income from investments. So there are two ways we might save money.

DR. WHITEHILL: You must remember that we are trustees of these invested funds. It is a question as to whether we should buy stocks and bonds in the open market rather than take the 2.9 per cent on government bonds. We who are responsible think that we should not take that risk in order to increase our income from investments, none of which would be available for administrative costs.

The Educational Fund amounts to \$21,000, and we do not know at the present time how much of that money we will need this coming year. With the \$2.00 allotment for our Educational Fund this coming year, we will have \$40,000 in that fund for the benefit of the children of deceased or disabled members.

SPEAKER BUCKMAN: The question is on the adoption of the amended recommendation of the Board of Trustees.

[The motion, as amended, was put to a vote and carried.]

SPEAKER BUCKMAN: The amended recommendation is adopted and dues are set at \$23 for the coming year.

Is there any other new business?

Gentlemen, at this point in our annual session it is always customary for somebody to offer a resolution expressing thanks to the local county medical society acting as host. The Chair will assume the responsibility of expressing the thanks of this House to the Allegheny County Medical Society and the Local Committee on Arrangements.

SECRETARY DONALDSON: I am authorized by the Allegheny County Medical Society to say that we enjoyed your company so much that we want you to come back in two years.

SPEAKER BUCKMAN: If there be no other business to bring before this House, we will declare this session adjourned sine die.

[The House of Delegates adjourned at twelve thirty-five o'clock.]

E. ROGER SAMUEL, *President*,
LEWIS T. BUCKMAN, *Speaker*,
WILBUR E. FLANNERY, *Vice-Speaker*,
WALTER F. DONALDSON, *Secretary-Treasurer*,
PARK BERKHEIMER, *Assistant Secretary-Treasurer*.

APPENDIX A

President Engel's Address

It was in this same hotel two years ago that you honored me by electing me as your president. I have served one of those years as president-elect and the second year as your president. I have tried during that time to serve you as an aggressive leader and at the same time with the dignity that high office commands. Now at the end of that period of service I report to you on the state of your society. I would be remiss if at the same time, from experience gained by three years' service on your Board of Trustees as president-elect, and as president, I did not make some specific recommendations to you. The recommendations that I will present for your consideration during this address are being made after exceedingly careful consideration and consultation, with the hope that The Medical Society of the State of Pennsylvania will become the leader in carrying the banner of American medicine. Our primary purpose, as it has always been, is better health for the American people.

I wish first to thank the officers, Board of Trustees, committees, this House of Delegates, and the members of this Society for their advice and support during my administration. I wish to thank, also, the Harrisburg and Pittsburgh office staffs for their excellent cooperation during the past year. At times I made sudden demands upon them which were always met with efficiency, dispatch, and a pleasant cooperation. I can assure you that your secretary-treasurer and your executive secretary and their staffs have been most cooperative.

Some of the committees of this Society have attained outstanding accomplishments during the past year. Six, in particular, should be mentioned: Public Relations, under Dr. Howard K. Petry; Graduate Education, headed by Dr. Charles Wm. Smith; the Cancer Commission, under the leadership of Dr. Martin S. Kleckner; the Committee on Medical Economics, under Dr. Louis W. Jones; the Committee on Preventive Medicine and Public Health, led by Dr. Pascal F. Lucchesi; and Dr. Palmer's Committee on Public Health Legislation, which worked exceedingly hard but because of the legislative trend ran into considerable difficulty

which with our present setup was beyond their control. Other committee programs were fair, but a number of committees did nothing.

I would like, in particular, to pay tribute to two of these outstanding committees. Your Committee on Public Relations has handed in an exceedingly creditable record of performance. They have at times been ahead of Whitaker and Baxter in their promotional activities. They have worked hard on the Educational Campaign, and no one, unless they have been in close contact with this committee, realizes the thought and effort behind their task. In these crucial times the Public Relations Committee is the very life of the medical profession in this Commonwealth. Dr. Petry and Mr. Brown have produced an enviable record and I ask this House for its whole-hearted support, both financially and morally, of our Public Relations Committee, with commendation for the excellent work done during the past year in making our program one of the outstanding ones in the United States.

The Graduate Education Committee likewise has made its program the envy of every state medical society. Dr. Charles Wm. Smith and Mr. Robert Richards should be especially commended for making this program the outstanding one in the United States. Needless to say, these two men alone could not accomplish this without the thought and help of not only the entire committee but with the excellent cooperation of the teachers as well. The meetings have been well attended and the few I have had opportunity to sit in on have been truly inspirational. The Medical Society of the State of Pennsylvania has become the leader in this field in America.

These two committees represent the peak of leadership and efficiency that may be obtained when a committee has inspired leadership aided by a staff assistant to carry out the details. This drives home to me the thought that any active key committee must have the benefit of a staff assistant for successful operation.

My sincere thanks goes also to the press, press associations, and radio of this Commonwealth and on the national level for the excellent manner of reporting our story to the American public. I would urge even greater cooperation between our Society and its members with the press and radio. They have done a magnificent job and will continue to do so with our full cooperation.

To the state and national legislators who have supported the policies of American medicine in the interest of the American public, I wish to express my sincere personal thanks for their support. American medicine should not forget their valuable aid when they are up for re-election regardless of party affiliation. American medicine must become politically conscious and politically active in the interest of the citizens and their welfare.

National Problem

Never before in the history of this country have the doctors of this nation had such a responsibility on their shoulders. We have had many epidemics in the past that threatened and took the lives of a great number of our citizens. Many more of our people have struggled through life handicapped in health because of the scourge of disease. Most of these diseases have now been eradicated by the doctors of America. Now, however, and it is hard to believe, the lives of the citizens are being threatened by a man-made epidemic. That epidemic which will jeopardize their very lives is Mr.

Truman's program for socialized medicine. We all fight off the enemy called Communism, and yet some of our own political leaders who profess to be Americans are trying to force through legislation which basically is the first step that nations have gone through on their way to the socialistic state. Examples are the Administration's Health Bill and the President's Reorganization Plan Number One. Both have been killed in this session.

This country is not only the healthiest major nation in the world but it is the only one that is still economically solvent. If we should collapse economically, the whole world would go Communistic. Most of the advice given to President Truman and other Administration leaders comes from theorists who have never accomplished anything in a practical way. This country cannot stay strong and progress on dreamed-up theories but only on sound, factual thinking. The health program of the Administration has been proved wrong and inefficient in many nations. Our leaders, if sincere and wise, should learn from the mistakes of others. It is time that the people of America arise and denounce the health policy of this Administration.

During the past session of the Congress the Administration program was buried in committee because of the bills introduced by Senator Lister Hill (D. Ala.) and Senator Robert A. Taft (R. Ohio). We must remember that Congress again meets in 1950 and we should be working now on legislation of a constructive nature to present at the opening of that session. American medicine and the American public are indebted to Senators Hill and Taft and the co-sponsors of their bills. We have many sound thinkers in the Senate and in the House and these legislators should have our whole-hearted support.

American medicine during the past year has come through the toughest struggle of its long career victoriously—a struggle to protect the lives and health of the American citizens and to protect the freedom of every American institution and enterprise against the vicious socialistic controls of statism. The lines of battle in this campaign are well defined. Our forces stand for free enterprise, competition, the reward for initiative, and the realization that nothing can be accomplished without hard work. These are the principles that have made America the greatest nation in the world.

We are lined up against a foe which is not only an enemy of American medicine but one which is against every basic principle of true Americanism and which is adopting methods that have caused many great nations to deteriorate into socialistic states. Their ranks are filled with members representing all of the foreignisms and many of their members have been identified with Communistic front organizations.

We of American medicine have not been against progress. Our record is one of which we are proud. No other nation has achieved the progress in the health of its people comparable to the progress in America. This has not been accomplished by government control but under a free enterprise system of competition.

The medical profession is not opposed to progress and its record bears out this statement. We do also realize that there is room for improvement and we are trying to do something about this.

There are other factors that are important to the improved health of this nation besides the medical research phase. We must consider the socio-economic trends and view these in the over-all picture.

There has been a tendency over the years for the

Federal government to take from its citizens more and more money. In 1916 the Federal taxes were \$7 per capita, while as of 1948 these taxes were \$300 per capita. This has brought about a situation where private capital contributions which formerly supported our free institutions have now practically disappeared. The government now does not trust the taxpayer to spend what little he has left. Its first step is to tell him: give us your money and we will buy your health. How long would it be before the government advocates for socialized medicine would say: give us your paycheck and we will buy you housing, food, and clothing? The citizen is rapidly becoming a servant of the state instead of the state being a servant of the people. When will the citizenry of America awaken to this threat to their freedom? I believe that the rank and file of labor are beginning to realize it even though some of their leaders do not.

The present administration in Washington will at this time not listen to anything but compulsion. Yet we have much to be thankful for in the fact that many Democrats oppose the Administration in its health program. Gentlemen of the medical profession, we must take a more active part in politics. We must ask candidates for office to commit themselves on health problems and then we must support or oppose vigorously the candidacy of these men. It would be of greater importance, however, if the profession supported some of its own members at local, state, and national levels so that the medical profession would have direct representation in the legislative bodies.

Mr. Hoover's speech should point the way for the thinking of every citizen. The preservation of the economy of this nation is paramount in the preservation of the health of its citizens. This fact has been proved in all of the decadent nations. Our President believes, however, that American economy may be preserved only by deficit financing. I would think that the individual members of labor would begin to realize that for the preservation of our economy they must cooperate. Their leaders are pushing this nation to the brink of disaster. This disaster is the loss of private enterprise and the development of statism and a controlled economy. This would spell the end of any gains made by labor and, of far greater consequence, the loss of labor unions. The laboring man must save himself from this fate and he must do it now. I am afraid that our President has replaced his loyalty to the people he serves with loyalty to his political friends at the sacrifice of the welfare of this nation and its citizens.

This preamble to the report on my stewardship during the past year will perhaps clear in your minds the thinking which motivated my activities. I had felt for a long time that just to oppose legislation was not enough. We must actively propose legislation if we hope to be progressive and to continue to hold the respect of the American people.

We in Pennsylvania should examine the records and the thinking of our candidates who will represent us in the next Congress. I would suggest that your Board of Trustees be authorized to get a statement from each candidate as to his stand regarding the Administration's health program, and that these statements be sent to every member before election time. We must actively support sound-thinking candidates regardless of party and we must vigorously oppose those who would support the present Administration's bill on compulsory national health insurance. The battle call has been sounded by the President; we must roll up our sleeves

and go to work if we wish to preserve the health and economic soundness of this nation. It is your job. Will you meet the challenge? I wonder how many of you sitting in session here today have at any time written to your state or national legislators expressing your views. If you have not, you have failed to do your duty as an American citizen. There are still some Benedict Arnolds in America, but only a few in the medical profession. As long as they are present, America is in danger.

State Problems

I would like now to discuss with you phases of your Society which I believe are very important. I have had an opportunity to study the organization at close range over the past five years and I believe that some changes should be made in its structure in the interest of more efficiency.

Your Constitution and By-laws authorize certain standing committees appointed by the president and three committees appointed by the president with the approval of the Board of Trustees and Councilors. I have been impressed by the lack of coordination of the committee activities and the actual non-functioning of some committees. In the past two years I know of no meetings of the Commission on Acute Appendicitis Mortality, Deafness Prevention and Amelioration, Nutrition, and Tuberculosis. Certain committee activities overlap. For example, the work of the Commission on Preventive Medicine and Public Health encroaches upon the responsibilities of the Committee on Public Health Legislation. Possibly this situation should be reviewed and appropriately changed.

Our legislative job in Harrisburg is more difficult than is realized by most people. Many organizations with legislative representatives have only five or six bills in which they are interested. The number of bills affecting medicine and health are usually quite numerous. With one or two exceptions, I think we are interested in more separate pieces of legislation than any other organization with which I am familiar.

There was a time when there were between ten and fifteen doctors of medicine in the State Legislature. Since all of these men were cooperative from the point of view of the State Medical Society, they helped a great deal in our legislative problems. Today there are only two physicians in the Legislature—one in the Senate and one in the House. Both are extremely cooperative in health legislation. The situation, therefore, is quite different than it was a few years ago.

Also at times until two or three years ago Dr. Palmer had working with him the late Attorney Wassermann, also Mrs. Kech. In the last session or two, however, Dr. Palmer has been obliged to carry on pretty much alone. In my honest opinion that responsibility is too much for any one person to deal with successfully without adequate help.

It is because of the preceding statements and other observations that I would recommend for your very serious consideration the following:

RECOMMENDATIONS

That a special committee be appointed to study the over-all committee program with specific duties:

1. To recommend possible changes in the committee structure of The Medical Society of the State of Pennsylvania.
2. To recommend a system for coordinating com-

mittee activities both at the state and county level.

3. To recommend how committee programs might be used as a basis for improved interprofessional and public relations.
4. To study the administration of present committee programs and to advise what steps should be taken to improve the facilities already established.

I would like to make some specific recommendations along these lines:

1. The creation of a Disease Control Committee with subcommittees as follows: Acute Appendicitis Mortality, Cancer, Child Health, Conservation of Vision, Deafness Prevention and Amelioration, Diabetes, Industrial Health and Hygiene, Maternal Welfare, Mental Hygiene, Nutrition, Physical Medicine, Preventive Medicine and Public Health, to Study Control of Rheumatic Fever, on the Control of Syphilis and Venereal Diseases, and Tuberculosis.

The membership of this Disease Control Committee would be composed of the following: chairmen of the Subcommittees, one member of the Board of Trustees, a representative of the Public Relations Committee, the Secretary of Health of the Commonwealth, and the chairman to be appointed by the president.

This committee would supervise, coordinate, and implement the functions of the separate committees. If necessary, Mr. Richards' staff should be enlarged to handle the work of this committee and the subcommittees.

2. I would recommend the merging of the Committees on Public Relations, Public Health Legislation, and Medical Economics with the idea that these three committees would become subcommittees of the new committee. This new general committee could be well called the Committee on Public Relations since the term public relations in its broadest sense encompasses our relations not only with the general public per se but also with so-called special publics such as our representatives serving in the legislative bodies of our state and national governments. The Committee on Public Relations would become the Subcommittee on Public Education. The Committee on Public Health Legislation would become the Subcommittee on Legislation. The Committee on Medical Economics would become the Subcommittee on Medical Economics. The new Public Relations Committee, whose primary function would be the evaluation, supervision and coordination of the activities of these three subcommittees, would consist of a general chairman, the chairman and one member of each subcommittee, and a representative of the Board of Trustees.

The present public relations staff would be assigned to this new Public Relations Committee. They would then be available to serve any of the three subcommittees. Under such a setup the public relations staff, particularly the two field men, could be of real value in legislative emergencies. In addition, however, I would recommend the employment of a full-time assistant in the Harrisburg office to implement the work of the Subcommittee on Legislation.

3. I recommend the publication of a handbook containing the names of our committees, their functions, to whom they are responsible, what staff assistants they may call upon, and other pertinent information.

4. Should these two coordinating committees (the Disease Control Committee and the new and broader

Public Relations Committee) be set up, a recommendation should be made to the county medical societies to create a similar organizational setup.

5. I would recommend the study of the Michigan State Medical Society's plan of organization, which impresses me as an outstanding one.

Public Health

As you know, your society requested that a survey of the public health facilities of Pennsylvania be made. This was finally accomplished and was made by the American Public Health Association. I believe that this report is an unbiased one with opinions and recommendations given by persons expert in the field of public health. The report is contained in a book of 338 pages. The Medical Society of the State of Pennsylvania rendered a great service to the people of this Commonwealth in requesting this study, but all of its value will be lost unless recommendations which have been made and which are sound are carried out. I am afraid that the sentiment in some quarters is now that the survey has been made and published, let us forget about it.

Gentlemen, you are committed through your Constitution to fight for the good health of your fellow citizens. It is our responsibility to fight for the adoption of many of the recommendations. We must take the leadership in this movement and I can assure you that we will have the backing of many organizations that are interested in public health. The press has already done a splendid job in publicizing the criticisms and recommendations contained in the final report of the survey, and has further published an interview with the Secretary of Health. The public has also been sensitized to the problem. We must carry the crusade, and from the published interview it is going to be another tough fight for us. This campaign alone is going to be time-consuming and expensive, but we must carry out our responsibilities which we accepted when we requested this survey. I understand that Dr. Lucchesi is bringing in a report of his commission with recommendations that can be effective without legislation. I urge this House to act favorably on these recommendations. I would suggest also that this House of Delegates refer the remaining portion of the report to the Board of Trustees and that this body be charged with designation of portions of the report to the several committees involved, these committees to hold meetings and bring in recommendations to the Board of Trustees at their first meeting following this annual meeting, after which the Board, through existing Committees on Public Relations and Public Health Legislation, should carry out the approved recommendations to insure changes in the Department of Health consistent with a strengthened Health Department.

Mental Health

This House of Delegates urged the transfer of mental health to a strengthened Department of Health in this Commonwealth. In January your president, with the president of the State Psychiatric Association and the president of the Public Charities Association, met with the Governor to discuss this problem. He seemed enthusiastic about the possibilities and he requested that the Medical Society draw up proper legislation. Dr. Palmer had the legislation prepared immediately and the Governor authorized a release by the Medical Society regarding this meeting. The move of this legislation pertaining to mental health was stymied and no

pressure was put on by the Governor for its passage.

Since that time the Governor has created a new post of Commissioner of Mental Health in the Department of Welfare, at an annual salary of \$11,000. This will coordinate the Bureau of Mental Health and the Bureau of Institutional Management under the leadership of a trained Doctor of Medicine. Dr. Hilding A. Bengs, of Camp Hill, was appointed to the post.

This move on the part of the Governor is one in the right direction and we must await developments to see whether or not it will improve the mental health picture in this Commonwealth. The creation of an Eastern Psychiatric Institute during the past legislative session was another move by Governor Duff to carry out his promises of a better mental health program.

With the numerous projects facing this Society at the present time, I believe that we must be most active now in preparing the legislation and public opinion to back that legislation. Now is the time to lay the groundwork for such bills as that on animal experimentation and the like. This work must be started immediately. A program of education for the public and the legislators must be considered. The press and radio can be of inestimable value to this Society in helping it to bring the true story of prospective legislation before the people.

Woman's Auxiliary

When I mention legislation, my thoughts immediately go to the Woman's Auxiliary. During the past year under the leadership of Mrs. Paul C. Craig, the president, and Mrs. Drury Hinton, president-elect, that organization has rendered a magnificent service to the Medical Society and the citizens. They have entered actively into the educational program of the American Medical Association and have put forth much more effort than the members of this Society. They are well organized and well informed and are working like Trojans to bring our message to the public. They have been most ably assisted by Miss Susanne Treadwell and our Advisory Committee to the Woman's Auxiliary. I wish to pay tribute to Mrs. Craig, the president, for her vision, her ability, and untiring effort. Her successor, Mrs. Drury Hinton, I know, has the ability and the dynamic force to carry on the work which has been so ably started. Gentlemen, you owe the Woman's Auxiliary a great debt of gratitude.

I wish also to tell this House that it is greatly indebted to the entire staff of both the Harrisburg and Pittsburgh offices. It is true that they are employees of this Society, but during the past year they have all rendered service far beyond the call of duty. They should be commended by this House on their faithful performance.

I would like to suggest to my successor, Dr. E. Roger Samuel, that the vice-presidents again be appointed to serve on key committees and be encouraged to attend board meetings. This will familiarize them with the organization and functions of the Society.

The Medical Service Association of Pennsylvania, created originally by the House of Delegates, has done an outstanding job in the past year. Its rate of growth is truly astounding and it deserves the full support of every member of this Society. This association is Pennsylvania's answer to Mr. Oscar Ewing. He has no answer when faced with the growth of Blue Shield and Blue Cross Plans. I ask you all to become participating members of MSAP and to consistently tell your patients about it. This organization is one of the

outstanding contributions to a public service that this medical society has made.

Conclusion

In closing this address, the last time I speak to you as your president, I wish to enter a plea for my successors. Please be lenient with your demands on the time and energy of your president. I apologize for not being able to accept many invitations. The amount of work in this office is over-burdening for anyone who still wishes to practice medicine. The time consumed with board meetings, committee meetings, and handling correspondence is tremendous. Please keep these facts in mind when calling on the services and time of your president.

Gentlemen, your job in the House of Delegates is most important. What you do here is reflected to the public and creates a good or bad impression in public relations. We must be firm in our stand on basic principles and yet be progressive in our thinking. You are entrusted with serious duties—the setting of policies, the election of trustees, and the election of delegates to the American Medical Association. The American Medical Association policies are set by the men you send as your representatives to its House of Delegates. I feel that the men whom you elect to these offices are as important to this Society as any function you perform. It is a real responsibility.

You may be asked to increase the dues of the active members of the State Society as the functions of this Society become increasingly greater. You are not only contributing to the maintenance of your organization but you are committed to progressive medical service and the improved health of the nation. Petty jealousies and personal ambitions must be forgotten and ours must be a unified fight against those in political office desirous of creating a socialistic state. It is a job for every doctor and every good citizen in America. Our fight is for the survival of a free America, the last major power to enjoy the freedoms.

Again may I thank everyone for the support given me during my administration. I ask you to continue that support for my successor. Your officers need the active help of every member in these crucial times. I assure you that I have tried to do my best in serving you in the high office you entrusted to me. I will always stand ready to serve you and this Society. My record is completed. I did my best. The judgment of the success or failure of my administration rests with you, the members of the House of Delegates. May God give us all wisdom and courage in our deliberations and actions during this week so that America and this Commonwealth will, as a result, be a safer, happier, and healthier place in which to live.

APPENDIX B

Supplemental Report of Committee on Rural Medical Service

To the President and House of Delegates:

The Committee on Rural Medical Service met at the State Society headquarters in Harrisburg on September 15.

There was a general discussion regarding organization of the Pennsylvania Health Council. (Motion was unanimously passed at the Board of Trustees meeting, Dec. 17, 1948, authorizing the Committee on Rural Medical Service to organize a General Health Council.)

The Pennsylvania Health Council should be pat-

turned after the National Health Council, which organization defines a health council as follows: "A meeting ground for all forces making for good public health in a community; it is a working together—surveying the whole broad picture of community health needs, discovering unmet needs and developing plans for meeting those needs, demonstrating new services through member agencies; it is developing a well-rounded community program and keeping public interest in health at a high pitch. It is easier for a united group to accomplish this than for many isolated agencies all trying individually to bring about the same results."

"Under a health council, each member agency keeps its independence and has a vital individual part to play; but they all plan and work together on health problems to the solution of which they can all make a contribution."

On request from the committee, the following organizations have indicated their desire to participate in this council: State Departments of Agriculture, Health, Public Assistance, Public Instruction, and Welfare, Hahnemann Medical College, Jefferson Medical College, University of Pittsburgh and University of Pennsylvania Schools of Medicine, University of Pittsburgh Graduate School of Public Health, Woman's Medical College, Pennsylvania State College, American Heart Association (Pennsylvania Chapter), American Legion, American Red Cross, Association of the Junior Leagues of America, Inc., 4-H Clubs, Hospital Association of Pennsylvania, League of Women Voters of Pennsylvania, The Medical Society of the State of Pennsylvania, National Foundation for Infantile Paralysis, Inc., Pennsylvania Association for the Blind, Pennsylvania Council of Churches, Pennsylvania Division—American Cancer Society, Pennsylvania Economy League, Pennsylvania Federation of Business and Professional Women's Clubs, Pennsylvania Federation of Labor, Pennsylvania Federation of Women's Clubs, Pennsylvania League of Nursing Education, Pennsylvania Nutrition Council, Pennsylvania Organization for Public Health Nursing, Pennsylvania Pharmaceutical Association, Pennsylvania Public Health Association, Pennsylvania State Chamber of Commerce, Pennsylvania State Dental Society, Pennsylvania State Nurses' Association, Pennsylvania Society for Crippled Children and Adults, Inc., Pennsylvania Tuberculosis Society, Pennsylvania Welfare Conference, Public Charities Association, State Association for Health, Physical Education and Recreation, and State Y.M.C.A.

The following principles were adopted at the fourth national Conference on Rural Health held in February in the A.M.A. Chicago offices:

1. State and public health services for general community hygiene and communicable disease control, public health nursing, well-baby conferences and clinics.

2. The Hill-Burton Hospital Construction Act operating where the people of a community demonstrate sufficient desire for such facilities.

3. Scholarships provided by medical associations, farm organizations, and through legislative appropriation to be given to deserving boys and girls, without discrimination, for medical education where the recipients agree to practice for a time in rural areas; and for nurses, particularly from rural areas.

4. Agricultural school extension services where they utilize their home demonstration courses; 4-H clubs; health specialists whose special duty it is to organize health councils in the counties for the purpose of health

education and where appropriate to apply for Hill-Burton facilities; the teaching of better farm methods, better soil conservation and soil building practices, better grain and productive livestock methods such as calf and pig clubs, five-acre club lots, and better cost accounting and business methods.

5. Parent-teacher associations where they encourage examination of school children for hearing, sight, and heart defects, hernia, immunization, school hygiene, as well as physical education.

6. Voluntary health agencies such as tuberculosis, polio, cancer, heart, etc., which do considerable educating within narrow limits.

7. Application of voluntary prepaid medical and hospital care plans to rural communities, taking into consideration that several of the large farm groups have their own indemnity prepaid medical and hospital plans.

8. Promotion of state and county health councils, the medical profession acting cooperatively with organized farm groups and other civic, church, and school organizations and special health groups for the purpose of health education and health activities of a local character.

9. Creation of a plan to bring the medically indigent or low income farmer into voluntary prepaid medical plans.

10. Use of health education programs for rural groups.

11. Encouragement of the civilian population to help itself.

The committee agreed with these principles and approved the report of the National Committee on Rural Medical Service as presented in the handbook for the June meeting of the A.M.A. House of Delegates.

The first meeting of the General Health Council was held September 20. Dr. Gilson Colby Engel was elected temporary chairman. He should continue as such and his able leadership should continue into the permanent organization.

The principles may be carried out by the committee through the representatives of the various organizations interested in the Health Council.

The committee discussed the list containing communities in Pennsylvania in which physicians are needed and the number of locations that have been withdrawn. It was suggested that in the spring, when the interns are leaving their services in the hospitals, we again send a notice to the various hospitals and publish the latest list in the State JOURNAL.

APPENDIX C

Supplemental Report of Committee on Public Health Legislation

To the President and House of Delegates:

Legislative Program for 1949-1950

Because of experience in the last session of the Legislature, it is possible in 1951 that some member of the Legislature will introduce a compulsory health insurance bill. For this reason there must be more intense activity on the part of the Committee on Public Health Legislation of the State Medical Society and the Woman's Auxiliary, and the county medical society and county woman's auxiliary legislative committees.

It is imperative that all candidates in elections be informed of the viewpoint of the medical profession. Since this opinion coming from the candidates' own constituents bears much more weight, the county medical so-

cieties must cooperate with us in this great task. With this in mind, we submit the following plan:

Each member of the State Society Committee on Public Health Legislation must personally contact the president, secretary, and chairman of the Legislative Committee of each county medical society in the councilor district which he represents and request that two or three members of the county society and the woman's auxiliary be selected for *each* legislative district to serve as a liaison committee between the county society and the candidate.

The county medical societies will be furnished with a list advising them of the legislative districts in their county, the number of doctors and registered voters in each legislative district, and the names of the candidates.

The representatives selected must have a fair knowledge of the items to be discussed with the candidate. Informative material will be sent them from the State Society Committee on Public Health Legislation. Their duties shall be:

1. To contact doctors in the legislative district urging them and the members of their families who are eligible to register and vote.
2. To obtain from the doctors referred to above the names of at least ten individuals whom they can depend upon to write letters to the members of the Pennsylvania Legislature or Federal Congress regarding pending bills.

Also request these doctors to ascertain whether or not those consulted would be willing to vote, if properly convinced of the propriety of our viewpoint on public health legislation, either for or against a candidate, depending on their attitude regarding public health and medical service.

3. To attend meetings with candidates to discuss public health legislation in which the medical society is particularly interested.

In the larger counties such as Philadelphia, Allegheny, Dauphin, Erie, Lackawanna, Luzerne, etc., it will be necessary for your chairman to assist personally in the organization of this system.

It will also be necessary to have county medical society legislative committee chairmen attend a meeting in Harrisburg to be informed of legislation that has been presented in the past and that may be presented in the future. A brief summary of the various laws pertaining to public health and medical services in this state has been distributed to the public health legislation mailing list.

Inasmuch as legislative work is becoming so widespread, it is necessary that each county medical society have a separate Committee on Public Health Legislation and that at least some of the members of that committee be retained from year to year in order that there will be members who have an intimate knowledge of the work of the committee and that legislative activities will not be disrupted by a complete change in the membership.

Chiropractic in Pennsylvania

The chiropractors now have a board appointed by the Governor. The Attorney General has advised the Department of Public Instruction that the Chiropractic Board has no power whatsoever. The State Board of Medical Education and Licensure will still license chiropractors.

The Joint State Government Commission was established by the 1937 Legislature and consists of 13 mem-

bers of the Senate and 13 members of the House appointed by the speaker of the House and the president pro tem of the Senate. Its purpose is to study controversial subjects and report to the following session of the Legislature, making recommendations as to legislation.

During the last session of the Pennsylvania Legislature, Senators Homsher and Chapman presented Resolution No. 112 providing that this commission study the question of licensure of limited licensees. This resolution passed the Senate but did not pass the House. However, the intent of House Resolution No. 74, presented by Messrs. Brunner and Andrews, was to embody in an omnibus resolution the contents of Senate Resolution No. 112.

Under this resolution the commission can study the question of licensure of limited licensees. In order to do this, it is advisable to have the Department of Public Instruction request such a study. The Department will make the request if the Board of Medical Education and Licensure will recommend such a study.

Dr. E. Roger Samuel, president-elect, Park A. Deckard, vice-chairman, and C. L. Palmer, chairman of the Committee on Public Health Legislation, represented The Medical Society of the State of Pennsylvania at a meeting of the Board on August 31 at which the following members were present: Drs. Charles L. Shafer, Wesley D. Richards, Leopold, and Secretary of Health Vaux (ex officio).

We suggested that such a study would be helpful because the commission would then have more definite knowledge of the present method of licensing limited licensees and as a result of the study they could suggest maintaining the present system or any constructive change.

Their suggestion would be a potent force with the entire Legislature; however, it would not be binding to either the Board or the State Medical Society.

During the discussion, the following was presented: This is a political commission; and inasmuch as we had been defeated politically, we would probably be defeated again on the same basis.

If such a study was requested, the commission might suggest opening the Medical Practice Act to permit displaced persons to practice in Pennsylvania.

The Board was unable to control the chiropractors under the present laws because they could not obtain convictions from the courts.

In answer, your chairman suggested that, although the commission was a political organization, the members were very conscientious in their consideration of all subjects brought before them. They referred subjects to subcommittees composed of capable, honest individuals, and requested advice of experts on subjects under consideration.

Concerning the question of displaced persons, the Pennsylvania Commission on Displaced Persons in the State Department of Labor, of which Mr. Frank K. Boal is head, is very much interested in this question as are many others (even the A.M.A. has appointed a committee to study the question), so it is very likely that the Medical Practice Act will be opened to find some way of taking care of them.

In addition, there is now at least an unequal distribution of physicians in Pennsylvania. Some communities are justifiably urging the State Medical Society to do something about it. Those interested in chiropractors and displaced professional individuals seize upon this

condition and argue for some way to license them in order to supply the demand.

So far as enforcement is concerned, the bill passed during this session of the Legislature providing for injunctions against those practicing without a license should be of assistance to the Board. In addition, the State Medical Society has offered to provide intervening advice to assist the Attorney General's office in preparing cases against illegal practitioners by appealing cases that are lost to the higher courts and following them through.

While there is no absolute control of the chiropractors because of adverse decisions in many cases, there are sufficient law enforcement procedures which hold in abeyance the number of unlicensed chiropractors in Pennsylvania.

If The Medical Society of the State of Pennsylvania desires to maintain its attitude favoring a high standard of education, it will have to continue the fight for this principle or we will have to modify our attitude.

If chiropractors are permitted to have a board of their own and license their own individuals, it is entirely possible that they will open schools in Philadelphia, Pittsburgh, and Harrisburg and teach a large number of chiropractors by lectures, and in five years or so the State may be flooded with five or ten thousand insufficiently trained chiropractors who will practice upon the unsuspecting public.

If the State Medical Society does not try to correct the situation by developing a proper enabling act, a composite board, or through some other means, the medical profession will be criticized by the public for permitting such a situation to exist.

A composite board is distasteful to the present members of the Board; however, in states that have chiropractic or osteopathic representatives on their boards, there is agreement that limited licensees have representation. In states where there is no representation, the limited licensees justifiably argue that they should have representation because, as they indicate, it is licensure without representation which sounds good to legislators.

We have been advised that the following action was taken by the Board on August 31 after our discussion:

"A motion was made, seconded, and passed that in accordance with the suggestion of a committee from the State Medical Society recommending the preparation of a bill outlining the powers of the newly appointed Board of Chiropractic Examiners in anticipation of a bill being presented at the next session of the Legislature, the Board approves of such a procedure and suggests that the contemplated bill, upon its completion, be presented to the Board for comment."

It can readily be seen that the Board has not taken favorable action toward requesting the commission to study the question of limited licensees. Instead it suggests that the Committee on Public Health Legislation write a bill for the next session of the Legislature to be first presented to the Board for comments. A bill of this type will be very difficult to have passed because the Chiropractic Board has already been appointed by the Governor. The chiropractors will argue that they should have more to say about what that board should do than anyone else.

Therefore, your committee suggests the following resolution:

WHEREAS, The practice of medicine, surgery, osteopathy, and the several branches of limited practice have a common purpose,

are all based on the same fundamental principles, and each require, to a greater or less extent, a knowledge of anatomy; and

WHEREAS, In addition to the already existing licensing and enforcement boards there have been bills in the Legislature seeking to establish additional boards or additional phases of what appears to be the same general purpose, and bills seeking to conform the same or similar rights or powers on various branches of the general profession; and

WHEREAS, These activities are creating confusion in the minds of the administrators, licensees, and the public; therefore, be it

Resolved, That the Committee on Public Health Legislation of The Medical Society of the State of Pennsylvania be authorized to request the Joint State Government Commission to make a study of the question of limited licensees as contained in House Resolution No. 74, which provided that the Joint State Government Commission study the Administrative Code and related statutes, which includes the Medical Practice Act and licensure of limited licensees, with the idea of suggesting some constructive solution to the problem; and, also, that the Board of Medical Education and Licensure be respectfully requested to support such a request.

If the commission suggests a remedy that the State Medical Society and the State Board approve and support, it may be entirely possible, through the presentation of an amendment to the Administrative Code, to repeal the present law creating a Board of Chiropractic Examiners and establish an act which will limit the chiropractors to a definite type of treatment.

Inasmuch as there have been two unlicensed chiropractors appointed to the Board of Chiropractic Examiners, there is a question as to whether these appointments conform to state and Federal laws. The committee therefore will explore the legality of this question.

Federal Legislation

As soon as the Washington office of the A.M.A. distributes the final report on Federal legislation and public health legislation, the Committee on Public Health Legislation will distribute its final bulletin containing a summary of all bills introduced in which we were interested and their disposition.

In case legislation is introduced that requires hurried consideration and decision, the committee desires the privilege of making such decisions after consultation with the Board of Trustees and others interested.

The committee will study:

1. The section of the Administrative Code pertaining to the Board of Medical Education and Licensure and related statutes, namely, the Medical Practice Act. We should have sufficient knowledge to present facts to the Joint State Government Commission and to prepare bills for introduction at the next regular session of the Pennsylvania Legislature, after due consideration has been given them by the Board of Trustees, the State Board of Medical Education and Licensure, and the House of Delegates during the next annual meeting.

If there is a special session of the Legislature in the interim between meetings of the House of Delegates, the committee desires the privilege of drafting these bills and presenting them to the Board of Trustees and the State Board for their consideration and approval.

2. The Mental Health Code in case the Joint State Government Commission investigates the mental health laws of the State, so that we can be of service to the commission.

The Committee on Public Health Legislation will request the Joint State Government Commission to study the Mental Health Code, which is contained in House Resolution No. 74.

In the original report, as published in the August PENNSYLVANIA MEDICAL JOURNAL, mention was made of the fact that the recent session of the Pennsylvania

Legislature was very confusing. In considering the record, however, it can be seen that The Medical Society of the State of Pennsylvania probably fared better than any other group. A proper bill including osteopaths and dentists in MSAP was passed by the Legislature and signed by the Governor. The Legislature disapproved making osteopaths qualified physicians in Pennsylvania which would make them eligible to sign commitment papers. Chiropractic legislation was not completed. No compulsory health insurance bills were introduced. The Department of Health was able to obtain most of the legislation it desired in the interest of public health; therefore, legislative activities were considerably more favorable to us than to many other groups.

APPENDIX D

To the President and House of Delegates:

Again this year it is my proud privilege to report to you further growth, greater service, and wider acceptance of Blue Shield.

The progress achieved by the Medical Service Association of Pennsylvania during these past twelve months would have been impossible without the cooperation of the medical profession. Last year I urged the House of Delegates to institute two campaigns for the purpose of accelerating MSAP's program: (1) to recruit additional participating physicians; (2) to inform physicians on the importance of their whole-hearted cooperation with Blue Shield.

The officers and directors of the association are grateful for everything that has been done by the State Society as the result of the action taken by the 1948 House of Delegates. Appeals for physicians to cooperate have resulted in increasing the number of Doctors of Medicine participating with the plan from 6537 on July 31, 1948, to 7735 on July 31, of this year. This is a gain of over 18 per cent. The Society's Public Relations Committee has performed an invaluable service in gaining a better understanding for Blue Shield among the physicians of the State.

The acceptability of Blue Shield as a practical, workable plan has been demonstrated again this year by a substantial increase in the number of subscribers, assets, and payments to physicians.

A Year of Substantial Progress

On July 31, 1948, there were 244,170 subscribers enrolled. As of July 31, 1949, there were 461,799 enrolled—an increase of 217,629 or almost 90 per cent.

The total assets of the association at the end of July, 1948, amounted to \$620,135, whereas on July 31, 1949, they were \$1,694,223—an increase of 173 per cent.

During 1948 the first seven months of operation resulted in earned subscription fees of \$988,319. During the present year, our earned subscription fees for the first seven months are \$2,325,687. This increase amounts to \$1,337,368, or 135 per cent.

In 1948 doctors were paid \$682,332 during the initial seven months. In the first seven months of this year, the association paid \$1,481,548 to doctors, representing an increase of 117 per cent.

In April of this year, a formal agreement was consummated with the Hospital Service Plan of the Lehigh Valley, Allentown, and actual operation under this agency agreement began on May 1, 1949. At the present time, therefore, the association has formal working

agreements with the Inter-County Hospitalization Plan at Glenside and the Blue Cross Plans located in Pittsburgh, Philadelphia, Wilkes-Barre, and Allentown. It is a pleasure to acknowledge the fine service these organizations are providing the association.

Changing Conditions

Keeping abreast of changing conditions is one of the problems to which the association's officers and staff have given much attention during the past year. The Blue Shield Plan in Pennsylvania was instituted as a "service plan" for prepaid medical care for low-income groups. Many of you will recall the debate on whether MSAP should offer an indemnity form of agreement or a service form of agreement. Experience has shown the wisdom of the decision in favor of the service plan.

Since 1939 income levels have increased, but MSAP's income limits have remained the same, with the result that present Blue Shield agreements in this state are in effect indemnity contracts. The result is that the acceptance and sale of Blue Shield is encountering resistance.

Through the action of the State Society's legislative committee, the first step was taken this year to permit MSAP to correct this condition. The act under which MSAP is organized was amended to permit the members of the association to establish income limits subject to the approval of the Insurance Commissioner.

The members of the corporation have caused the by-laws to be changed in conformity with this legislation. This amendment also requires that any change in income limits must be approved by the Board of Trustees of The Medical Society of the State of Pennsylvania.

Committees of the State Society's trustees and MSAP'S Board of Directors are now studying this problem of income limits with a view to meeting conditions as they exist today. Their purpose is to restore the "service" feature in fact, and thus preserve the very heart of the voluntary prepaid plan.

If I may harken back again to the mandate of the 1938 House of Delegates, MSAP was directed to provide for *all* of the people of Pennsylvania a practical plan of voluntary prepaid medical care. From time to time Blue Shield benefits have been increased and services have been expanded as the association has grown in experience and assets.

Non-Group Agreement

For several years the Board of Directors has considered developing a non-group agreement by which individuals, regardless of their employment status, could gain the protection of Blue Shield. Just this month this new agreement is being offered to the public.

Generally, the non-group agreements conform to the Group Surgical and Medical-Surgical Agreements that will continue to be available to groups of employed persons. The broad services are the same, but there are several important changes which have been dictated by actuarial experience. There are waiting periods of 12 months for removal of tonsils and adenoids, conditions existing at or prior to enrollment, and for medical care resulting from pregnancy; also 24 months waiting period for obstetrical delivery and other surgical operations arising from pregnancy.

The other important change is that subscription rates are slightly higher than for group agreements, and they must be paid quarterly, semi-annually, or annually instead of monthly.

Additional Benefits to Subscribers

With the approval of the Insurance Commissioner, MSAP has recently increased its benefits to its over half a million subscribers at no extra cost to them. These increased benefits include surgical, obstetrical, and osteopathic services provided by doctors of osteopathy participating with the Blue Shield Plan, and also dental services requiring a surgical operation when such services are provided by a doctor of dental surgery, who is a hospital staff member, participating with the Plan. Dental services will not include the extraction or care of teeth, although the extraction of an impacted tooth is included.

These additional services are the result of legislation passed at the 1949 session of the Legislature. In announcing approval of this program, the Insurance Commissioner paid this tribute to our profession when he said: "... the medical care provided by Blue Shield is an outstanding accomplishment and a tribute to the medical profession of Pennsylvania."

Home Office Building

Erection of its own building is now being completed by the association in order to provide adequate facilities for the rapidly growing Blue Shield operations and services. The decision to construct a building as an investment was made by the MSAP Board of Directors because of Blue Shield's substantial membership growth throughout the State, the scarcity of suitable office space in Harrisburg, and the high cost of preferred accommodations in rented facilities.

Scheduled for occupancy on October 1, the new building will house both the state headquarters and the Harrisburg district office.

Among the many advantages of owning our own building will be savings in taxes which are presently reflected in rent paid to a landlord. As a non-profit organization, MSAP is exempt from taxes on property which it owns.

Professional Support Is Necessary to Guarantee Success

Measured by practical accomplishments, Blue Shield has recorded substantial progress during the past twelve months, but its full growth and maximum service have not been reached. I feel that those to whom you entrusted this voluntary plan of prepaid medical care have rendered a stewardship which justifies your confidence for future development and the solution of many problems. Results to date warrant continued cooperation by every physician in Pennsylvania to insure complete effectiveness.

Every month finds more and more physicians joining the ranks of those who are lending enthusiastic personal support to Blue Shield, but there remain some whose apathy is hindering this successful alternative to socialized medicine.

It is high time that every physician realize the truth and full implication of this fact: the increased cost of medical care has made the prepayment of medical care an absolute necessity for a very large segment of the population. Dr. Paul R. Hawley, Chief Executive Officer of the Blue Cross-Blue Shield Commission, is emphasizing that "medical care today is very fine, very luxurious, very efficient, but very costly." "We must accept the fact," says Dr. Hawley, "that medical care insurance is here to stay. That has already been decided by the American people. . . . The only question now about this medical care insurance is whether it shall be

voluntary or compulsory, free enterprise or socialistic. That is the only question left to be answered."

The American Medical Association in its outline to strategy and policies against compulsory health insurance has said that its long-term objective is to put a stop to the agitation for compulsory health insurance—"and the most vital step in achieving that objective will be an all-out campaign to enroll the American people in voluntary health insurance systems."

In Pennsylvania that means that Pennsylvania physicians must step up their individual support of their own plan. We who have the responsibility for MSAP join the A.M.A. in asking every physician to take time to encourage patients who are in need of "budget-basis medicine" to enroll in Blue Shield. We join the A.M.A. in declaring that we need to take health insurance out of the luxury category and let the people know that it can be bought economically and should be included as a necessity in the home budget, just as food and shelter and life insurance are budgeted.

MSAP is faced with many problems in perfecting Blue Shield and making it completely acceptable. Of paramount importance during this next year will be the sympathetic understanding and patience of the medical profession as we work out these problems. We are just inaugurating non-group agreements; we have just increased benefits. These innovations involve administrative adjustments and actuarial responsibilities that must be studied and coordinated to insure the same sound progress which has marked our growth to date.

While we are giving the best we have to improving and perfecting Blue Shield, we need every physician seizing every opportunity to enlist the participation of his patients, his friends, and community leaders in this sound development in medical economics. With your help in the future as in the past, we will prove once and for all that the finest antidote for compulsory health insurance is the voluntary plan conceived and sponsored by the medical profession.

Respectfully submitted,

J. ARTHUR DAUGHERTY, *President.*

Record of Attendance of Members of the House of Delegates Representing Component County Societies at the 1949 Session in Pittsburgh

(Figure indicates the number of elected delegates to which the county society is entitled plus its secretary or its president. The House of Delegates met on Monday, September 26, at 10 a.m.; Monday afternoon at 3 p.m.; Tuesday at 10 a.m.; and Wednesday at 10 a.m. The figure 1 following a name indicates the presence of the delegate at the first meeting; 2, at the second meeting; 3, at the third meeting; and 4, at the fourth meeting.)

Adams (2), Roy W. Gifford, 1, 2, 3, 4.

Allegheny (18), William F. Brennan, 1, 2, 3, 4; William A. Bradshaw, 1, 3, 4; John W. Fredette, 1, 2, 3, 4; Harold B. Gardner, 1, 2, 3, 4; Wendell B. Gordon, 1, 2, 4; James Hodgkiss, 1, 2, 3, 4; Frederick M. Jacob, 1, 2, 3, 4; George F. Kowallis, 1, 3, 4; George W. Lang, 1, 2, 3, 4; George Leibold, 1, 2, 3, 4; John F. McCullough, 1, 2, 3, 4; Carl F. Nill, 1, 3, 4; Nor-

man C. Ochsenhirt, 1, 2, 3, 4; C. L. Palmer, 1, 2, 3, 4; George C. Schein, 1, 3, 4; John W. Shirer, 1, 2, 3, 4; John E. Weigel, 1, 2, 3, 4; Elizabeth R. Childs, 1, 2, 3, 4.

Armstrong (2), Cyrus B. Slease, 1, 2, 4; William J. Ralston, 1, 2, 3, 4.

Beaver (3), J. Willard Smith, 1, 2, 4; Thomas W. McCreary, 1, 2, 3, 4; Fred B. Wilson, 1, 2, 3, 4.

Bedford (2), Joseph A. Eyler, 4.

Berks (4), Archibald R. Judd, 1, 2, 3, 4; William J. Goetz, 1, 2, 3, 4.

Blair (3), Robert M. Keagy, 1, 4; Ralston O. Gettemy, 1, 2, 3, 4; Augustus S. Kech, 1, 2, 3, 4.

Bradford (2), Stanley D. Conklin, 1, 2, 3, 4; Morgan F. Taylor, 1, 2, 3, 4.

Bucks (2), Arthur Ricker, 4.

Butler (2), Joseph Van S. Donaldson, 1, 3; Donald E. Goehring, 1, 2, 3.

Cambria (3), Francis T. Carney, 1; John W. Barr, 1, 2, 3, 4; Daniel Ritter, 1, 2, 3.

Carbon (2), Marvin Evans, 1, 2, 3; B. Frank Rosenberry, 1, 2, 3, 4.

Centre (2), Hiram T. Dale, 1, 2, 3, 4; Joseph A. Parrish, 1, 2, 3, 4.

Chester (3), Michael Margolies, 1, 2, 3, 4.

Clarion (2), Theodore R. Koenig, 1, 2, 3, 4.

Clearfield (2), Ward O. Wilson, 1, 2, 3, 4.

Clinton (2), David W. Thomas, 4.

Columbia (2), Otis M. Eves, 1, 2, 3, 4.

Crawford (2), no representation.

Cumberland (2), E. Blaine Hays, 1, 2, 3, 4; Newton W. Hershmer, 1, 3, 4.

Dauphin (4), Hamblen C. Eaton, 1, 2, 3, 4; Carl E. Ervin, 1, 2, 3, 4; Constantine P. Faller, 1, 2, 3, 4; George L. Laverty, 1, 2, 3, 4.

Delaware (4), Ralph E. Bell, 1, 3, 4; Joseph F. Dougherty, 1, 2, 3, 4.

Elk (2), no representation.

Erie (4), Russell B. Roth, 1, 2, 3, 4; John F. Hartman, Jr., 1, 2, 3, 4; George H. Ledger, 1, 2, 3, 4; Elmer G. Shelley, 1, 2, 3, 4.

Fayette (3), L. Dale Johnson, 1, 2, 3, 4; Ralph L. Cox, 1, 2, 3, 4.

Franklin (2), Paul A. Clutz, 1, 2, 3, 4.

Greene (2), C. Leonard O'Connell, 1.

Huntingdon (2), Charles L. Schucker, 1, 4; John M. Keichline, Jr., 1, 4.

Indiana (2), Harry B. Neal, Jr., 1, 2; Daniel H. Bee, 1, 2, 3, 4.

Jefferson (2), S. Meigs Beyer, 1, 2, 3, 4.

Juniata (2), Robert P. Banks, 1, 2, 3, 4; Stephen I. Dodd, 1, 2, 3, 4.

Lackawanna (4), William A. Coggins, 1, 2, 3, 4; William J. Corcoran, 1, 2, 3; John P. Donahue, 1.

Lancaster (4), Charles W. Ursprung, 1, 2, 3, 4; Joseph Appleyard, 1, 2, 3, 4; Roy Deck, 1, 2, 3, 4; Henry Walter, Jr., 1, 2, 3, 4.

Lawrence (2), Wilbur E. Flannery, 1, 2, 3, 4; Charles H. Whalen, 1, 2, 3, 4.

Lebanon (2), Herbert C. McClelland, 2; Walter H. Brubaker, 1, 2, 3, 4.

Lehigh (4), J. Frederic Dreyer, 1, 2, 3, 4; Robert L. Schaeffer, 1, 2, 3, 4; Willard C. Masonheimer, 1, 2, 3, 4; Joseph D. Rutherford, 1, 3, 4.

Luzerne (5), Marvin C. Johnson, 1, 2, 3, 4; Herman A. Fischer, Jr., 1, 2, 3, 4; Louis W. Jones, 1, 2, 3, 4; Frank M. Pugliese, 1, 2, 3, 4; Charles L. Shafer, 1, 2, 3, 4.

Lyeoming (3), Raymond A. Davis, 1, 2, 3, 4; Charles S. Tomlinson, 1, 2, 3, 4; Wilfred W. Wilcox, 1, 2, 3, 4.

McKean (2), Persis Straight Robbins, 1, 2, 3, 4; Robert D. Donaldson, 1, 2, 3, 4.

Mercer (2), Joseph J. Bellas, 1, 2, 3, 4.

Mifflin (2), no representation.

Monroe (2), no representation.

Montgomery (5), Alice E. Sheppard, 1, 2, 3, 4; Elwood T. Quinn, 1, 2, 3, 4; Edgar S. Buyers, 1, 2, 3, 4; M. Louise Gloeckner, 1, 2, 3, 4; James J. McShea, 1, 2, 3, 4.

Montour (2), J. Reed Babcock, 1, 2, 3; Henry F. Hunt, 1, 2, 3, 4.

Northampton (3), Thomas H. A. Stites, 1, 2, 3, 4; Dudley P. Walker, 1, 2, 3, 4.

Northumberland (2), Mark K. Gass, 1, 2, 3, 4; T. Lamar Williams, 1, 2, 3, 4.

Perry (2), Amos G. Kunkle, 3, 4; Leonard B. Ulsh, 1, 2, 3, 4.

Philadelphia (31), William Bates, 1, 2, 3, 4; Dorothy C. Blechschmidt, 1, 2, 3, 4; Francis F. Borzell, 1, 2, 3, 4; Charles L. Brown, 1, 2, 3, 4; Carl J. Bucher, 1, 2, 3, 4; Walter S. Cornell, 1, 2, 3, 4; John T. Farrell, Jr., 1, 2, 3, 4; Theodore R. Fetter, 1, 2, 3, 4; Leonard D. Frescoln, 4; Pascal F. Lucchesi, 1, 2, 3, 4; Theodore Melnick, 3, 4; Roy W. Mohler, 1, 2, 3, 4; Milton F. Percival, 1, 2, 3, 4; William H. Perkins, 1, 2, 3, 4; Joseph W. Post, 1, 2, 3, 4; Joseph J. Toland, Jr., 1, 2, 3, 4; John V. Blady, 1, 3; Nathan Blumberg, 1, 2, 3; Garfield G. Duncan, 1, 2, 3; John W. Egoville, 1, 3, 4; Charles B. Hollis, 3; Henry L. Gowans, Jr., 1, 2, 3, 4; Malcolm W. Miller, 1, 2, 3, 4.

Potter (2), no representation.

Schuylkill (3), William T. Leach, 1, 2, 3; John C. Bryson, 1, 2, 3.

Somerset (2), Charles I. Shaffer, 1, 2, 3, 4.

Susquehanna (2), no representation.

Tioga (2), Thomas Dimitroff, 1, 2, 3, 4.

Venango (2), James E. Hadley, 2, 3, 4; James A. Welty, 1, 2, 3, 4.

Warren (2), William M. Cashman, 4.

Washington (3), Albert E. Thompson, 1; Milton F. Manning, 1, 2, 3, 4; Guy H. McKinstry, 1, 2, 3, 4.

Wayne-Pike (2), no representation.

Westmoreland (4), William E. Marsh, 1, 3, 4; Willis H. Schimpf, 1, 2, 3, 4; Dan G. Bierer, 1, 3, 4; Carl R. Limber, 4.

Wyoming (2), Charles J. H. Kraft, 1, 2, 3, 4.

York (3), H. Malcolm Read, 1, 2, 3, 4; Wallace E. Hopkins, 1, 2, 3, 4; Charles L. Fackler, 1, 2, 3, 4.

REGISTRATION OF MEMBERS BY COUNTIES

	<i>At Pittsburgh Membership</i>	
Adams	1	30
Allegheny	954	1728
Armstrong	16	45
Beaver	40	136
Bedford	4	15
Berks	13	273
Blair	25	129
Bradford	13	53
Bucks	3	94
Butler	32	75
Cambria	36	164
Carbon	2	35
Centre	6	35
Chester	6	113
Clarion	6	24
Clearfield	8	50
Clinton	3	27
Columbia	4	47
Crawford	4	58
Cumberland	4	48
Dauphin	34	257
Delaware	6	298
Elk	3	25
Erie	25	208
Fayette	23	119
Franklin	9	77
Greene	8	28
Huntingdon	4	28
Indiana	14	43
Jefferson	19	58
Juniata	2	7
Lackawanna	15	292
Lancaster	8	231
Lawrence	17	85
Lebanon	3	68
Lehigh	13	224
Luzerne	16	384
Lycoming	15	148
McKean	2	54
Mercer	31	96
Mifflin	3	38
Monroe	..	39
Montgomery	16	342
Montour	14	41
Northampton	6	201
Northumberland	7	76
Perry	2	14
Philadelphia	110	3257
Potter	2	13
Schuylkill	14	158
Somerset	17	30
Susquehanna	..	17
Tioga	2	28
Venango	14	53
Warren	9	48
Washington	65	148
Wayne-Pike	..	25
Westmoreland	66	218
Wyoming	1	12
York	8	174
	1,803	10,841

SUMMARY OF REGISTERED ATTENDANCE

Members	1803
Guest physicians	18
Visiting physicians	218
Total physicians	2039
Medical students	164
Nurses	57
Exhibitors	256
Woman's Auxiliary	307
Other visitors	95
Grand total registered attendance	2918

SCIENTIFIC MEETINGS

Monday, Sept. 26, 1949

SYMPOSIUM ON THE PRESENT STATUS OF THE SILICOSIS PROBLEM

The scientific program of the ninety-ninth annual session of The Medical Society of the State of Pennsylvania was called to order by William A. Bradshaw, Pittsburgh, chairman of the Committee on Scientific Work, at one o'clock on Monday afternoon, September 26, in the Urban Room of the Hotel William Penn, Pittsburgh.

A symposium on the present status of the silicosis problem was presented. Burgess L. Gordon, Philadelphia, was moderator and presented the first paper entitled "The Clinical Aspects of Anthracosilicosis and Its Complications." The second paper, "Evaluation of Function in Pulmonary Disease," was read by Hurley L. Motley, Philadelphia. "Pathogenesis" was the title of the paper read by the guest speaker, Silas Evans, Milwaukee, Wis. William J. Corcoran, Scranton, read a paper entitled "Roentgenologic Aspects of Anthracosilicosis" which was followed by "Tuberculosis as a Complication" by C. Howard Marcy, Pittsburgh. The closing paper of the symposium was presented by Penrose Hertzler, Esq., Pottsville, entitled "Medicolegal Aspects."

Following a question and answer period, the symposium adjourned at 2:50 p.m.

SYMPOSIUM ON THE NEWER ASPECTS OF CARDIOVASCULAR DISEASE

The second scientific session was devoted to a symposium on the newer aspects of cardiovascular disease and convened in the Urban Room at 3:20 p.m. Andrew B. Fuller, Pittsburgh, was moderator. The first paper, "Anticoagulant Therapy in Acute Coronary Thrombosis," was presented by William L. Mullins in collaboration with William R. Bailey, Mary K. Helz, Stephen R. Kiester, and James D. Purvis, Jr., all of Pittsburgh. The second paper, "Commissurotomy for Mitral Stenosis," was written by three Philadelphians, Robert P. Glover, Thomas J. O'Neill, and Charles P. Bailey, and was read by Dr. Bailey. Rachel Ash, Philadelphia, read the next paper, "The Clinical Aspects of Congenital Heart Disease," which was followed by a paper entitled "Angiocardiography and Cardiac

Catheterization as Aids in the Diagnosis of Congenital Heart Disease" by Harry F. Zinsser, Jr., Pittsburgh. Julian Johnson, Philadelphia, read a paper entitled "The Surgical Aspects of Congenital Heart Disease" which was followed by the presentation of Walter Kempner, Durham, N. C., entitled "Treatment of Heart and Kidney Disease and of Hypertensive and Arteriosclerotic Vascular Disease with the Rice Diet." Following a question and answer period, the meeting adjourned at 5:20 p.m.

Tuesday, Sept. 27, 1949

SECTION ON MEDICINE

The Section on Medicine convened at 9 a.m. in the Urban Room of the Hotel William Penn, the chairman of the section, Ralph L. Shanno, Forty-Fort, presiding.

The first session was devoted to a symposium on diabetes mellitus with George F. Stoney, Erie, acting as moderator. Arthur R. Colwell, Chicago, Ill., the guest speaker, read his prepared paper entitled "Types of Diabetes Mellitus and Their Treatment," which was followed by a paper entitled "The Treatment of Juvenile Diabetics" by W. Wallace Dyer, Philadelphia. The following physicians participated in the general discussion: J. West Mitchell, Thaddeus Danowski, and Joseph H. Barach, Pittsburgh; Garfield G. Duncan, Philadelphia; and Charles S. Morrow, Butler.

Following a twenty-minute recess to visit the exhibits, the Section on Medicine reconvened and held a symposium on pediatrics endocrinology. The first paper, "Hypothyroidism in Infancy and Childhood," was read by R. Marvel Keagy, Altoona. The second paper "Can Mongolism Be Eliminated?" was read by Russell E. Sangston, Uniontown. Benjamin J. Wood, Sharon, read a paper entitled "Pituitary Disorders in Childhood," which was followed by the presentation of the guest speaker, Wolf Zuelzer, Detroit, Mich., entitled "The Anemias of Infancy and Childhood." Following a question and answer period, the meeting adjourned at 12:05 p.m.

Reconvening at 1:20 p.m. to hear a symposium on dermatology, the members of the Section on Medicine listened first to Louis Schwartz, Washington, D. C., read his paper entitled "Dermatitis and Fabrics." The second paper was entitled "Skin Diseases in Children" and was read by Samuel R. Perrin, Pittsburgh. The final paper of the symposium, "Further Observations on the Use of Undecylenic Acid Administered Orally in the Treatment of Psoriasis," was presented by Sigmund S. Greenbaum and Henry H. Perlman, Philadelphia, and was read by Dr. Perlman. A question and answer period was conducted by James M. Flood, Sayre, and was participated in by Theodore Melnick and Claude P. Brown, Philadelphia, and William B. Guy, Pittsburgh. This session adjourned at 3 p.m.

The final session for the day was a clinicopathologic conference which convened at 3 p.m. Elwyn L. Heller, Pittsburgh, was the pathologist, and William W. G. MacLachlan, Pittsburgh, and Kendall A. Elsom, Philadelphia, were the clinicians. The session adjourned at 5 p.m.

SECTION ON SURGERY

The first session of the Section on Surgery, devoted to eye, ear, nose, and throat diseases, convened at 9

a.m. in the Monongahela Room of the Hotel William Penn. John R. Simpson, Pittsburgh, presided. The first paper, "Ocular Aspects of Systemic Disease," was read by Jay G. Linn, Pittsburgh. The second paper, "Acute Obstructive Laryngitis in Children," was presented by Francis W. Davison, Danville, and was discussed by Alec R. Schwartz and Henry M. Hall, Pittsburgh. The third paper, presented by the guest speaker, Fletcher D. Woodward, Charlottesville, Va., was entitled "Deaths and Injuries as Related to the Automobile and to the Engineering and Medical Professions."

Following a twenty-minute recess, the Section on Surgery reconvened at 10:50 a.m. to hear a symposium on the advances in surgery. John H. Gibbon, Jr., Philadelphia, acted as moderator. The first paper read by James Vickers Scott, Pittsburgh, was entitled "The Use of Tantalum Gauze Mesh in the Repair of Fascia-Deficient Hernias," and the second presentation, "Modern Treatment of Actinomycosis," was given by Walter S. Nettrour, Pittsburgh. These were followed by papers entitled "Recent Advances in Surgery of the Esophagus" by Frank F. Allbritten, Jr., Philadelphia, and "The Surgical Treatment of Pancreatic and Bile Duct Tumors" by William G. Watson, Pittsburgh. The last paper of the morning was presented by the guest speaker, John D. Stewart, Buffalo, N. Y., entitled "Surgical Aspects of Gastric and Duodenal Ulcer." Moses Behrend, Philadelphia, and August F. Jonas, Erie, discussed Dr. Stewart's paper.

At 1:20 p.m. the Section on Surgery met for a symposium on surgery of trauma, moderated by Samuel P. Harbison, Pittsburgh. The first paper, "The Treatment of Compound Fractures of the Long Bones," was read by George V. Foster, Pittsburgh. The next paper entitled "Immediate Treatment of Soft Tissue Injuries" was read by S. Milton Dupertuis, Pittsburgh. The next speaker was Chester A. Phillips, Jr., Pittsburgh, who spoke on "Tendon Injuries." William H. Erb, Philadelphia, presented the fourth paper entitled "Abdominal Trauma" which was followed by a paper on "Thoracic Injuries" by George P. Rosemond, Philadelphia. Stuart N. Rowe, Pittsburgh, read the next paper entitled "Cerebral Trauma." The guest speaker of this session was Donald A. Covalt, New York City, who spoke on "Rehabilitation." An intermission was taken at 2:50 o'clock.

The Section on Surgery reconvened at 3:20 p.m. to hear a group of papers on obstetrics and gynecology. The first paper, entitled "Hysterectomy—Indications and Contraindications," was read by Elvin J. Bateman, Pittsburgh. The next paper, "Management of Toxemias of Pregnancy in an Open General Hospital," was read by Joseph J. Kocyan, Wilkes-Barre. The third paper, "A Decalogue for Early Diagnosis of Pelvic Cancer," was presented by John Y. Howson, Philadelphia. James S. Taylor, Altoona, and Joseph A. Hepp, Pittsburgh, discussed the papers of Drs. Howson and Kocyan. The guest speaker of the afternoon was Charles A. Gordon, Long Island, N. Y., whose subject was "Obstetric Hemorrhage—Cesarean Section." Following Dr. Gordon's presentation, a general question and answer period took place with all of the speakers of the afternoon participating. Howard A. Power, Pittsburgh, Roy E. Nicodemus, Danville, James S. Taylor, Altoona, and Joseph A. Hepp, Pittsburgh, entered into the discussion. The session adjourned at 5:45 p.m.

Wednesday, Sept. 28, 1949

SECTION ON MEDICINE

The Section on Medicine convened at 9 a.m. in the Urban Room, Hotel William Penn. Ralph L. Shanno, Forty-Fort, was the presiding officer of the session, which opened with a miscellaneous symposium. Thaddeus Danowski, Pittsburgh, presented the first paper entitled "Present Ideas Concerning Body Fluids and Electrolytes." The next presentation was "Some Aspects of the Relation of Cholesterol to Vascular Disease" by John H. Peters, also of Pittsburgh. Samuel Bellet, Philadelphia, read his paper entitled "Clinical Manifestations of Hypo- and Hyperpotassemia," and was followed by John Eiman, Abington, whose subject was "Etiology and Pathology of Rheumatic Fever." The last speaker on this part of the program was John P. Hubbard, Philadelphia, who discussed "Pennsylvania's State Rheumatic Fever Program."

At 10:40 a.m. the Section on Medicine reconvened for a symposium on modern therapy. The first paper was delivered by Murray B. Ferderber, Pittsburgh, whose subject was "Medical Rehabilitation of the Physically Handicapped." Harold A. Zintel, Philadelphia, read his paper entitled "Clinical Use of the Newer Antibiotics." William A. Jeffers, Philadelphia, presented his paper on "Treatment of Hypertension" and Irwin M. Pochapin, Pittsburgh, spoke on "The Medical Aspects of Atomic Weapons." Adjournment was at twelve o'clock.

The afternoon session began at 1:20 p.m. with a symposium on mental and nervous diseases moderated by James M. Henninger, Pittsburgh. Edward E. Mayer, Pittsburgh, read his paper entitled "Sex Deviate," which was discussed by Rodney H. Kiefer, Pittsburgh. Howard K. Petry, Harrisburg, and Yale D. Koskoff, Pittsburgh, discussed the paper on "The Place of Psychosurgery in the Treatment of Mental Diseases" which had been presented by Francis C. Grant, Philadelphia. Elmer L. Horst, Reading, spoke on "Psychiatric Unit in the General Hospital." The last speaker on this part of the program was a guest from Cleveland, Ohio, Louis J. Karnosh, who spoke on "The Problem of Neuritis."

A symposium on virus diseases convened at 3:20 p.m. Joseph Stokes, Jr., Philadelphia, was the moderator. Werner Henle, Philadelphia, was invited to speak on "The Virus Diagnostic Research Laboratory." Dr. Stokes discussed his paper as well as the one presented by Jonas E. Salk, Pittsburgh, which was entitled "Viral and Rickettsial Diseases Affecting the Lung." The last subject on the program, "Viral Hepatitis—Progress and Problems," presented by W. Paul Havens, Jr., Philadelphia, was discussed by Dr. Stokes, and the meeting adjourned at 5 p.m.

SECTION ON SURGERY

The first session of the Section on Surgery began at 9 a.m. in the Monongahela Room of the Hotel William Penn. A symposium on pediatric surgery was moderated by Joseph A. Soffel, Pittsburgh. The first paper was read by Elmer S. A. King, Pittsburgh, entitled "Emergency Congenital Surgery of the Newborn," followed by "Malignant Tumors in Childhood" by John H. Wolf, Philadelphia, and "Congenital Anomalies of the Urinary Tract in Infants and Children" read by Samuel H. Johnson III, of Pittsburgh. C. Everett

Koop, Philadelphia, spoke on "The Management of Imperforate Anus." The guest speaker was Orvar Swenson, Boston, Mass., who presented a paper on "The Etiology and Treatment of Hirschsprung's Disease." Thomas N. Meredith, Pittsburgh, discussed Dr. Swenson's paper.

After a fifteen-minute recess the Section on Surgery reconvened at 10:45 a.m. to hear papers on miscellaneous subjects of interest at the present time, with Julian Johnson, Philadelphia, presiding. A paper entitled "Mammaplastic Procedures in the Female" was read by Hans May, Philadelphia. "The Treatment of Fractures of the Shaft of the Radius and Ulna" was presented by Leonard F. Bush, Danville, and "Reconstruction of the Common Bile Duct" was the subject discussed by Isidor S. Ravdin, Philadelphia. Robert M. Zollinger, Columbus, Ohio, spoke on a subject that is most important in modern surgery—"Some Practical Aspects of Nutrition in Surgery Patients." The meeting adjourned at 12:05 p.m.

Reconvening at 1:40 p.m., the clinicopathologic conference of the Section on Surgery was called to order by Joseph A. Soffel, Pittsburgh, and Allen Graham, Pittsburgh, acted as moderator. The first case was discussed by James J. Lee and Richard E. Haber, both of Pittsburgh. The second case history was read by Frank N. Tetlow and discussed by Richard E. Haber. The meeting recessed at 3 p.m.

The session on urology began at 3:35 p.m. with William Baurys, Sayre, presiding. The guest speaker, Lloyd G. Lewis, Washington, D. C., presented the first paper entitled "Testis Tumors," and was followed by Axel K. Olsen, Sayre, whose subject was "The Care of the Man with Advanced Malignancy of the Prostate." Elmer Hess and Hamilton P. Dorman, Erie, presented a paper on "Prostatic Surgery" which was read by Dr. Hess. Harold E. Brown, Danville, read his paper on "Lower Urinary Tract Infections in the Female," and the last paper of the session was presented by Stanford W. Mulholland, Philadelphia, on "Chemotherapy and Antibiotics in Urology." The meeting adjourned at 5:30 p.m.

Thursday, Sept. 29, 1949

SECTION ON MEDICINE

The Section on Medicine held a symposium on gross gastro-intestinal hemorrhage in the Urban Room of the Hotel William Penn at 9 a.m. The program was moderated by John H. Willard, Philadelphia. "The Diagnostic Problems of Gross Hemorrhage from the Upper Gastro-intestinal Tract" was presented by Henry J. Tumen, Philadelphia. The next speaker was Thomas A. Johnson, Philadelphia, whose subject was "The Medical Management of Gross Gastro-intestinal Hemorrhage." Calvin M. Smyth, Jr., Philadelphia, read his paper entitled "The Surgical Management of Massive Hemorrhage from Peptic Ulcer." The guest speaker of the symposium was David J. Sandweiss, Detroit, Mich. Dr. Sandweiss spoke on "The Present Status of the Treatment of Duodenal Ulcer," after which there was a ten-minute intermission.

The second portion of the session was devoted to preventive medicine and public health, and Thomas McC. Mabon, Pittsburgh, was moderator. Perrin H. Long, guest speaker from Baltimore, Md., gave a paper entitled "A Future for Preventive Medicine." Clarence E. Perkins and Walter S. Cornell, both of Philadel-

phia, discussed Dr. Long's paper. Thomas A. Parran, Pittsburgh, delivered his paper on "Public Health Schools and the Medical Profession," and Charles L. Brown, Philadelphia, spoke on "The Teaching of Public Health and Preventive Medicine at Hahnemann Medical College." A general discussion of Dr. Brown's paper followed in which Clarence E. Perkins and Pascal F. Lucchesi, Philadelphia, and Dr. Mabon participated. The meeting adjourned at 12:30 p.m.

The Section on Medicine reconvened at 1 p.m. This final session was a symposium on problems of the newborn. Carl C. Fischer, Philadelphia, was moderator. Walter E. Starz, Pittsburgh, was the first speaker. His topic was "Management of Premature Labor." "Physiologic Problems of the Premature and Newborn Infant" was presented by Charles C. Chapple, Philadelphia. The next paper, "Care of the Premature Infant," was read by Edmund R. McCluskey, Pittsburgh, and followed by Robert C. Beswick, also of Pittsburgh, who spoke on "Congenital Anomalies Following Maternal Rubella." The final paper presented was "Infections of the Newborn and Premature Infant" by Stewart H. Clifford, guest speaker from Boston, Mass. After a general discussion of all the papers read, the meeting adjourned at 3:40 p.m.

SECTION ON SURGERY

A symposium on anesthesia was held in the Monongahela Room, Hotel William Penn, at 9 a.m. Henry S. Ruth, Philadelphia, was moderator. "Anesthesia for Outpatients" by Robert L. Patterson, Pittsburgh, was the first paper read. The next presentation was "The Management of Spinal Anesthesia" by William F. Brchm, Sayre, followed by "Recent Advances in Anesthesia for Thoracic Surgery" by D. Dwight Grove, Philadelphia. The final paper was by Emanuel M. Papper, New York City, guest speaker of the session, which was entitled "Evaluation of Analgesics." After a question and answer period, an intermission was taken at 9:45 a.m.

A symposium on surgery of malignancy was begun at 10:15 a.m., and Edwin P. Buchanan, Pittsburgh, acted as moderator. The first paper of this session was read by Henry P. Royster, Philadelphia, entitled "Cancer of the Mouth, Jaws, and Lip." The second paper, "Carcinoma of the Esophagus," was presented by Herbert R. Hawthorne, Philadelphia. Donald Guthrie, Sayre, spoke on "Carcinoma of the Breast," his paper having been written in collaboration with Donald M. Clough, Sayre. A paper written by John W. Stinson and August V. Casillo, Pittsburgh, entitled "Carcinoma of the Colon and Rectum—Modern Trends in Management," was read by Dr. Stinson. The last speaker on the program was George T. Pack, guest from New York City, whose subject was "Carcinoma of the Stomach." After a general discussion of the papers presented, the meeting adjourned at 12:40 p.m.

The session on pathology and radiology convened at 1:10 p.m. with Charles L. Hinkel, Danville, presiding. Robert C. Horn, Jr., Philadelphia, was the first speaker and his subject was "The Diagnosis of Cancer." The next paper prepared by William C. McCarthy and John C. Henthorne, both of Pittsburgh, entitled "Tuberculosis in Infants," was read by Dr. Henthorne. Regis A. Wolff and Samuel R. Haythorn, Pittsburgh, presented their paper entitled "The Place of Liver Biopsies in the Diagnosis of Liver Disease." After a question

and answer period on the three pathology papers, there was a five-minute recess.

The portion of the program devoted to radiology was begun by James Jackman, Erie, whose paper was entitled "Syphilitic Aortitis." The second paper, "Recent Advances in Contact Therapy Equipment and Usage," by Richard H. Chamberlain, Philadelphia, was followed by "Modern Radiologic Diagnostic Procedures" presented by George E. Fissel, Williamsport. The meeting adjourned at 3:20 p.m.

INSTALLATION MEETING

Tuesday Evening, Sept. 27, 1949

The formal program was preceded by a thirty-minute organ recital.

The Installation Meeting at the ninety-ninth annual session of The Medical Society of the State of Pennsylvania convened in Carnegie Music Hall, Forbes Street at Bellefield Avenue, Pittsburgh, at eight-twenty o'clock. President Gilson Colby Engel, of Philadelphia, presiding.

PRESIDENT ENGEL: I now call the meeting to order.

I would ask those in the audience who rise for the invocation if they will remain standing for the In Memoriam which will follow the invocation.

The invocation will be presented by the Right Reverend Monsignor Andrew J. Pauley, rector of St. Paul's Cathedral in Pittsburgh.

RIGHT REVEREND MONSIGNOR ANDREW J. PAULEY: Dear Lord God, we beseech Thee that all our actions may be by the Holy inspiration and by Thy gracious assistance every thought, word and work may begin from Thee and be by Thee happily ended. Bless in particular the deliberations of this meeting, bless our every thought, our every word; keep us mindful of the provisions of Thy inspired word which bids us to honor the physician—honor that he is worthy of—whom mankind hath a mind to honor. Keep this, Thy chosen people, honorable; guard their honor, keep them honorable by keeping them close to Thee; keep them close to Thee by keeping them zealous for Thy law and for Thy will. Bless especially those and most especially him who will guide the destinies of this Association dedicated to the divine art of healing; we ask it in Thy name, for Jesus Christ, our Lord. Amen.

PRESIDENT ENGEL: Please remain standing. Dr. Milton F. Percival will give the In Memoriam.

[Dr. Percival read the report of the Committee on Necrology (see page 1263 of the August JOURNAL.)]

PRESIDENT ENGEL: We will now have the address of welcome. It is with a great deal of pleasure that I present Dr. Paul G. Bovard, president of the Allegheny County Medical Society.

DR. PAUL G. BOVARD: Mr. President, Board of Trustees, Officers and Members of The Medical Society of the State of Pennsylvania; its Woman's Auxiliary and Distinguished Guests: On behalf of the Board of Directors, the officers and members of the Allegheny County Medical Society, it is my privilege and honor to welcome you to this meeting. We are confident that the beginning of the second century of our Medical Society will be written in the annals of our history in the same

glowing terms of success that characterized any earlier period of our progress.

The Committee on Scientific Work is presenting an excellent array of talent for your edification. The scientific and technical exhibits represent much effort on the part of the exhibitors. Your careful perusal of these displays will be time well spent.

The office staffs from Harrisburg and Pittsburgh and the local Committees on Arrangements have worked diligently to make this meeting a profitable one for all. These committees stand ready to serve you during your attendance. Your wish is our command. Please make your wishes known.

SECRETARY DONALDSON: President Engel, at the conclusion of your term, which witnesses the ninety-ninth presidential installation of this one hundred and one year-old society, mine is the distinct privilege of presenting to you this ebony gavel, silver-mounted and duly inscribed, as a token of the great satisfaction which you have given to the 11,000 members of this Society throughout your entire administration. We trust that it will occupy an honored place on your desk and constantly remind you of associations in a period of service which we trust has been as rewarding to you as it has been gratifying to our membership.

PRESIDENT ENGEL: Thank you! I don't know whether I should take that home and let it get into the hands of my wife or not. I am deeply grateful to the Society for this award.

I could not very well let my last opportunity here go by without presenting to this audience those present tonight who have preceded me as president. I see a group of them sitting together.

I would like to ask all the former presidents of The Medical Society of the State of Pennsylvania who are present tonight to please stand for a moment so that we may honor them.

At this, the last time I may speak to you as President, I would like to congratulate and thank the members of the Woman's Auxiliary to The Medical Society of the States of Pennsylvania for their outstanding work during the past year and to express to them my personal appreciation for what they have done to help me during my administration.

We have had victories during the past year, but do not be lulled into a sense of security by those victories. We must all continue to oppose vigorously the passage of any legislation or the election to legislative office of candidates committed to socialized medicine or statism. We must likewise support any candidate or any legislation that is going to preserve the American way of life and to promote a strong and secure nation with a more spiritual, healthy, and happy citizenry.

My final plea as your president is—don't give up our fight for more and better medical service for all. I have had many pleasant duties as president of this Society, but I must say that tonight and at this very moment the most pleasant duty I have had in the entire year is to present to you your new president. I would like first to indoctrinate him. [President Engel pinned the President's badge on Dr. Samuel.]

May I present to you the new president of The Medical Society of the State of Pennsylvania—Dr. E. Roger Samuel.

PRESIDENT SAMUEL: One of the things you learn as you become indoctrinated, as Dr. Engel calls it, into the business of becoming president of this Society is to have your picture taken on all and numerous occasions. Dr.

Engel's wonderful administration in this past year promises to make my task in following him successfully tremendously difficult.

My first duty this evening will be very pleasant. I have been empowered to present to two very charming ladies our Society's annual Benjamin Rush Award. The Benjamin Rush Award in bronze is presented each year to the lay person decided upon as having shown leadership in a community service devoted day after day to improved health and hygiene.

The career of Benjamin Rush, M.D., a signer of the Declaration of Independence, is very dear to me because he was a doctor and was connected with the two institutions that I attended in my formative period of education, namely, Dickinson College in Carlisle and the University of Pennsylvania in Philadelphia.

The individual award I present in the name of our society to Mrs. Leonard D. Doggett of State College, the first woman in Centre County to serve on the Centre County Hospital Board. She is a member of the local Cancer Society Board and has been responsible for making cancer dressings for those unable to pay. As chairman of the Health Committee of the Business and Professional Women's Club, she campaigned and promoted better sanitary conditions in restaurants, improved water supply and sewage disposal, and was back of many other public health improvements. She has been an active worker in the local Red Cross unit, the State College Nurses' Association, the Centre County Hospital Auxiliary, and many other civic groups. She has given freely of her time and talents to improve public health and individual well-being and to help those with incurable diseases to live more comfortably. Mrs. Doggett has devoted the major portion of her life to serving others, always without pay and often at cost to herself.

It is with a great deal of pleasure at this time that I present to Mrs. Doggett this beautiful emblem symbolic of her unselfish services freely given to the health interests of the community in which she lives.

[The audience arose and applauded as Dr. Samuel presented the award to Mrs. Doggett.]

PRESIDENT SAMUEL: The lay organization which will receive the Benjamin Rush Award is the Emergency Aid of Pennsylvania, a volunteer organization of women organized in 1914. Its purpose is to carry on both at home and abroad emergency relief work for the benefit of the military forces and civilian population of the United States and of their allies. The organization is sponsored by the Governor of Pennsylvania and the Mayor of Philadelphia and is financed by dues paid by 1984 members and by the proceeds from certain money-raising projects. Their activities are divided into the following services: emergency, war, medical and health, and civic and welfare.

The Emergency Aid medical and health service has promoted the following projects: provided transportation service for cerebral palsy patients to and from clinics; staffed exhibits at venereal disease centers; assisted in a survey of the relationship between diabetic and tuberculous patients; distributed gifts yearly to all tuberculous patients in Municipal and Philadelphia General Hospitals; mended hospital garments for the Municipal Hospital; clothed and paid carfare for patients sent to State tuberculosis sanatoriums; a special relief bureau has served more than 2000 families; sponsored after-school recreation in three public schools, as well as numerous other health and welfare projects.

Such service dedicated to improving health standards,

assisting during financial hardships, and bringing cheer and hope to the more unfortunate surely is deserving of the Benjamin Rush Award.

The purpose of the Emergency Aid of Pennsylvania became very apparent back in 1914. At that time the active chapters of the Red Cross and other lay groups were not active, as they should have been, and this emergency aid group of Pennsylvania did a heroic job. They raised funds during those early days of the first war; they gave of their assistance on numerous occasions—medical and health, emergency, war, civic and welfare services. They raised over \$500,000 at one time in their efforts to take care of the needy in this and other nations. Their work in Pennsylvania has been of such a nature that their contribution to better health and medical care alone fills two typewritten pages. I can't give you all that; but the people in Philadelphia, in Pennsylvania, and many nations appreciate the wonderful work that this volunteer organization has done.

Mrs. H. Norris Harrison, who is the president of this organization, relates that her great-great-grandfather was traveling from Philadelphia to Boston in 1813 and when he learned of the death of Dr. Benjamin Rush, he delayed his trip to attend the funeral. So that there is a great deal of personal interest in giving this award to Mrs. Harrison, and I am sure that you will all join me in extending this organization and this fair lady our very best wishes. Mrs. Harrison!

[The audience arose and applauded as Dr. Samuel presented the award to Mrs. Harrison.]

[President Samuel read his presidential address.]

PRESIDENT SAMUEL: Ladies and gentlemen, our next speaker this evening is Dr. Ralph J. Gampell, recently of England but now of California. He will tell us about his personal experience with socialized medicine in Great Britain.

Again, I feel a great personal interest in this message, for in the first World War I was attached to the British for two years.

Dr. Gampell was graduated from the University of Manchester. He joined the forces in 1941 and did his share in the Royal Air Force. Upon being demobilized, he attempted to practice medicine in his native home. He found conditions such that he preferred to come to America rather than stay home under nationalized medical service.

It is with great pleasure that I give you Dr. Ralph J. Gampell.

[Dr. Gampell addressed the audience at this time—see excerpts, page 1633, this issue.]

PRESIDENT SAMUEL: This concludes the speaking part of this program. You will now listen to some beautiful music by the Pittsburgh Little Symphony Orchestra and by vocal soloists.

The meeting adjourned at nine forty-five o'clock to be followed by the concert.

MEDICAL PROBLEM MUST BE RESOLVED

The heated opposition to national health insurance and to socialized medicine in any form on the part of doctors, organizations, and other groups has considerable merit in fact; however, just opposing the national health insurance program will not solve the very real existing difficulties. Medical associations, doctors, dentists, and other groups must take some positive constructive action to insure adequate medical care to all persons who need it.

Government medicine is not a desirable thing. It would be a costly program, and the cost of that program would be borne by every citizen on an inequitable basis. In addition, it would discourage the individual initiative which is a basic part of our way of life. The public reaction to the so-called "free" services in Great Britain has created there an abnormal condition. Everyone rushes to the doctor whether he actually needs help or not, and the burden has become tremendous. The demand for eyeglasses in England is one example. Before socialized medicine was introduced, the average demand for spectacles was five million pairs a year. Today it is 7.8 million pairs. A similar situation exists in all forms of medical treatment.

While the disadvantages of any form of socialized medicine or health insurance far outweigh its advantages, the cry of "socialism" or mere vociferous opposition is not going to correct the medical conditions which do need changing.

In every community throughout the nation there are certain persons who need medical care or treatment and who do not get it because they cannot afford to pay the costs. These people and all people deserve the oppor-

tunity to receive adequate medical care. The American Medical Association, through its thousands of doctors and all interested groups, would do well therefore to initiate a positive program to insure proper treatment for all.

Stress should be placed on preventive measures—the various steps that people can take to ward off ill health and its subsequent financial load. Participation in voluntary health insurance programs should be encouraged. Enrollment in medical schools should not be limited—every student who desires to become a doctor and who passes the required standards should have an opportunity to go through medical school. Additional medical schools should be established so that the need for additional doctors can be fulfilled. Perhaps a free medical clinic could be established in each county to care for those whose financial condition is such that it is legitimately impossible for them to afford proper medical care.

The A.M.A. through its thousands of doctor members has the facilities to do many things which will eliminate the criticism of our present medical system. By so doing, it will also eliminate completely the need or the desire for any form of socialized medicine or health insurance.

Medical care in the United States is the best in the world, which indicates that the medical profession has performed and is performing a highly creditable job of inestimable value to every human being. A few necessary progressive changes on the part of the A.M.A. and a slightly broader outlook will make everyone more fully conscious of the benefits of our present medical system.—Logansport (Ind.) *Pharos-Tribune*.

Pictorial Report

OF THE NINETY-NINTH ANNUAL SESSION



TOKEN OF APPRECIATION—Gilson Colby Engel, left, receives from Secretary-Treasurer Donaldson the traditional past president's gavel as a token of appreciation for the service rendered to the membership.



STATE DINNER—The annual dinner was a gala affair with an attendance of 450. The above picture shows a portion of the speakers' table.

(Below) **ENGLISH MEDICINE**—Ralph J. Gampell is pictured addressing the Installation Meeting audience on his personal experience of practicing socialized medicine in England.



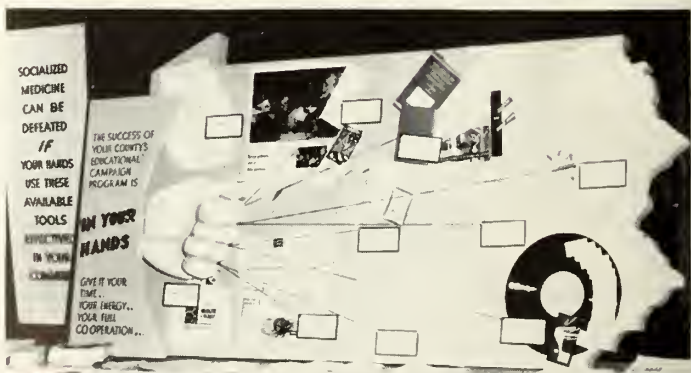
(Above) **BENJAMIN RUSH AWARDS**—President E. Roger Samuel presents the plaques to Mrs. Leonard D. Doggett, State College, left, individual winner, and Mrs. H. Norris Harrison, Philadelphia, center, who represented the Emergency Aid of Pennsylvania, the winner of the organization award.

(Below) Outgoing president of the Auxiliary, Mrs. Paul C. Craig, installs Mrs. Drury Hinton as president.



(Below) **GUEST SPEAKERS**—Congressman Clarence J. Brown of Ohio, left, State Dinner speaker, looks over the program of the session with Colonel Howard W. Glattly, center, Surgeon of the Second Army, who addressed the House of Delegates, and George S. Klump, Trustee and Councilor of Williamsport.







OUR PRESIDENT—Shown above is President E. Roger Samuel and Mrs. Samuel at the reception given in their honor.



THE AUXILIARY — (Above) Chairman of the Auxiliary Convention Committee, Mrs. Jay G. Linn, center, is shown with her two vice-chairmen, Mrs. Walter F. Donaldson, left, and Mrs. Howard A. Power. (Below) J. S. DeTar, M.D., Michigan's foremost family physician for 1948 and author of "The Country Doctor Answers the Ewing Report," addresses the Auxiliary.



(Above) POSTER CONTEST—The judges of the poster contest, including artists, newspapermen, and a physician, try to determine the winner. (Below) President-elect of the Auxiliary, Mrs. Howard H. Hamman, is shown with her husband at the President's Reception.



(Below) RELIGIOUS HOUR—Principal participants in the Religious Hour are shown as they entered Heinz Chapel. The group is led by the speakers, Howard C. Scharfe, D.D., Solomon B. Freehof, D.D., and Raymond F. Brittain, D.D.



OFFICERS' DEPARTMENT

WALTER F. DONALDSON, M.D., *Secretary-Treasurer*

8104 Jenkins Arcade

Pittsburgh 22, Pa.

Medical Statesmanship Comprises the Art of Changing the Health Condition of a Community, County, or State from What It Is to What It Ought to Be.

MINUTES FOR REVIEW

This issue of the JOURNAL devotes a heavy percentage of its pages to the minutes and the story of the Society's ninety-ninth annual convention. To thus preserve such records for future review and guidance comprises but a small ratio of their potential value. Their finest application awaits the attention of the member reader who was not among those so fortunate as to have been in Pittsburgh September 25 to 29.

The minutes of the House of Delegates as printed have been indexed for ready reference, permitting the reader to follow the fate of reports by officers or committees, or of resolutions introduced, through the processing to which they are subjected by the several studious reference committees and then back to the floor of the House for final disposition by vote of the delegates present.

The fiscal year of the Society, which ended Sept. 30, 1949, brought forth many socio-economic policy problems, stemming largely from the executive branch of the current Federal Administration, which are reflected mostly in the address to the House of Delegates by retiring President Engel, and in the reports of such committees as public health legislation, public relations, and medical economics. (If you must short-circuit your reading, at least pick up the statements by reference committees on the reports here mentioned.) If you are concerned about the finances of your state medical society, read the reports and the discussions on that subject. The same advice should be accepted by members who are interested in relations between hospitals and practitioners. Your Board of Trustees and Councilors presented the House of Delegates with a studious report on that subject. It aroused discussion before it was adopted. Licensing of limited practitioners and extension of insurance benefits under workmen's compensation are additional subjects considered by the House and recorded in its minutes. All of these matters were completed before the election of officers.

So much for the minutes! But don't fail to read the reports on scientific section programs. This will enable you to list papers read which you did not hear and to determine to watch for their subsequent publication in the PENNSYLVANIA MEDICAL JOURNAL.

The story of the social and entertainment features of the convention, also to be found in this issue of the JOURNAL, may help you to determine that you and your wife will not miss another annual meeting of The Medical Society of the State of Pennsylvania.

EIGHTY PER CENT PAID AS OF DECEMBER 16

As of Friday, December 16, The Medical Society of the State of Pennsylvania had collected \$203,370 in 1949 assessments for the American Medical Association.

Since the list of county medical societies indicating the percentage of \$25 A.M.A. assessments paid was distributed Sept. 28, 1949, to the members of the House of Delegates, 468 additional members have paid said assessment.

The appended list reflects this improvement by certain counties, and as a result the total average percentage paid for all counties in Pennsylvania has been increased to 80 per cent.

Officers and committee chairmen of some county societies are still endeavoring to increase their own society's average, and it may be said of several that disappointing results do not reflect lack of sincere effort on their part. But all of this leaves unanswered this very pertinent question—can it be neglect, or indifference, or inability, or determination that leads so many to thus weaken the great structure of American medicine? No hardship or discipline is to be invoked or visited on members who do not pay this voluntary 1949 assessment, all of which adds to the mystery—how can so many non-paid members in 22 of 60 component societies face the 80 to 100 per cent of their fellow A.M.A.

members who have loyally, with or without inconvenience, paid their just share?

The opportunity to pay the 1949 A.M.A. \$25 assessment will remain open until Feb. 1, 1950.

County	Total Active Members	Paid Active Members	Per- centage Paid
Lawrence	82	82	100
Potter	10	10	100
Jefferson	60	60	100
Columbia	45	43	96
Crawford	56	54	96
Wayne-Pike	24	23	96
Lancaster	227	215	95
Cambria	166	154	93
Clinton	27	25	93
Somerset	30	28	93
Tioga	27	25	93
Adams	26	24	92
Clearfield	49	45	92
Centre	34	31	91
Northampton	191	173	91
Wyoming	12	11	91
Blair	124	111	90
Bradford	51	45	90
Cumberland	47	42	90
Dauphin	247	222	90
Indiana	42	38	90
Mercer	93	83	90
Berks	263	234	89
Warren	45	40	89
Lehigh	226	200	88
Juniata	7	6	86
Chester	114	97	85
Erie	203	173	85
Montgomery	337	287	85
Washington	145	123	85
Westmoreland	208	177	85
Fayette	119	99	83
McKean	53	44	83
Allegheny	1626	1329	82
Elk	25	20	80
Greene	26	20	80
Lycoming	141	117	80
Mifflin	37	29	80
Butler	72	57	80
Lebanon	68	53	78
York	168	131	78
Beaver	136	105	77
Armstrong	42	32	76
Clarion	24	18	75
Franklin	77	58	75
Bucks	89	66	74
Carbon	35	26	74
Venango	53	39	73
Delaware	293	209	71
Montour	39	28	72
Huntingdon	28	20	71
Philadelphia	3150	2203	70
Lackawanna	280	196	70
Luzerne	365	243	67
Susquehanna	17	11	65
Monroe	39	25	64
Schuylkill	151	94	62
Northumberland	75	51	61
Bedford	15	9	60
Perry	14	8	60

WRITE FOR YOUR COPY

Bulletin No. 69 of the A.M.A. Bureau of Medical Economic Research—Analysis of the Ewing Report—should be in the hands of every alert practitioner, not only as a source of personal information or review but to be loaned to lay persons who have or should have authentic information before taking a stand in favor of any compulsory sickness insurance expense.

Bulletin No. 70 is "A Brief History of the Attitude of the American Medical Association Toward Voluntary Health Insurance."

In the face of the equivocations to be found in the booklet, "Restrictions on Free Enterprise in Medicine," issued last April by Michael Davis, Ph.D. (discussed on page 985 of June, 1949 PENNSYLVANIA MEDICAL JOURNAL) and in the implications in October news releases by the Justice Department, it behooves each practitioner to obtain copies of Bulletin No. 70, which meticulously and categorically answers charges and suspicions expressed against the organized profession and further spotlights the pertinent and pointed query "Is Governmental Propaganda Ever Trustworthy?"

Don't fail to write to Director Frank G. Dickinson, Ph.D., 535 North Dearborn St., Chicago 10, Ill., requesting copies.

A.M.A. PUBLIC RELATIONS CONFERENCE

More than 250 leaders of state medical societies from across the Nation charged with the responsibility of conducting public relations programs to advance public understanding and health care met in Chicago, November 5 and 6. The occasion was the second annual Medical Public Relations Conference sponsored by the American Medical Association and attended by physician chairmen of state medical society public relations committees, lay executive secretaries and public relations directors, and representatives of 20 allied national health organizations.

Dr. Ernest E. Irons, of Chicago, president of the association, told the conference that it was concerned not only with the question of medicine but with that of survival of the American way of life.

"That is why the medical profession must depart from its traditional aloofness from social and political activities," Dr. Irons said. "It must devote itself to the dangers of nationalized medicine and the social state. That is why we must accept a new kind of public relations."

Dr. Irons promised frankness with the press, adding: "We shall see that the press has information when it is timely."

Dr. Louis H. Bauer of Hempstead, N. Y., chairman of the A.M.A. Board of Trustees, told the conference that "it doesn't make so much difference what happens to the doctor under socialized medicine. More important is what is going to happen to the public."

The campaign for a paternal state has forced business and professional men into politics to protect their independence, according to Averell Broughton of New York, president of the Public Relations Society of America.

"The best answer to one pressure group, those of the left wing or New Deal, is another pressure group," Mr. Broughton said. "But while it is the army that moves, it is the individual who fights, and it is the many little local campaigns that win the big campaign."

He urged doctors to participate in the efforts to keep the profession from losing its independence through socialized medicine legislation.

The adoption of a code of cooperation by the medical profession and the press and radio in Colorado was detailed by Dr. McKinnie Phelps of Denver, chairman of the public policy committee, Colorado State Medical Society.

Out of meetings with the working press developed the Colorado Code of Cooperation, under which all the parties acknowledge certain responsibilities. Spokesmen for the medical profession were designated in every area and newspapers and radio stations were supplied names, addresses, and telephone numbers.

"Officers, committee chairmen, or designated spokesmen of the medical society may be quoted by name in matters of public interest, and often are," Dr. Phelps said. "Such statements by authorized spokesmen are not considered by their colleagues as a breach of the time-honored practice of physicians to avoid personal publicity, since it is done in the best interests of the public and the profession."

"Essentially, news is neither suppressed nor censored. It is rather encouraged, but channeled through devices which see to it that the news is accurate."

Leonard E. Read of Irvington-on-the-Hudson, N. Y., president of the Foundation for Economic Education, and dinner speaker, warned of the spreading "coercive collectivism."

"When the state starts to assume a certain amount of our welfare it assumes certain authority over our lives," Mr. Read said.

He pointed to the collapse of governments in Europe when the "take" in taxes passed the 25 per cent figure. This has reached 29 per cent in the United States, he said.

Dr. Donald B. Koonce of Wilmington, N. C., chairman of the public relations committee of the Medical Society of the State of North Carolina, told of the rapid development of a public relations program in that state.

"President Truman deserves all the credit," Dr. Koonce said. "If it had not been for the imminent danger of compulsory health insurance it would have been physically and financially impossible to take the rapid steps in public relations that we have."

The favorable results from the establishment of a grievance committee by the Oklahoma State Medical Association were reported by Dr. George H. Garrison of Oklahoma City, president of the association.

Dr. Garrison explained that the primary objective of the committee is to see that the public interest is fairly and honestly served and to correct misunderstandings and abuses which the patients believe have occurred.

Following the announcement of the formation of the committee, which was hailed by the press in editorials and columns, many letters were received, he said, adding:

"Surprisingly enough, most of them were not complaints against the members of the profession but rather entreaties for help in obtaining medical care."

As a result, he said, a cooperative program was worked out with private and governmental welfare groups to meet the problem. He also said that every grievance had been satisfactorily adjusted.

Dr. J. H. A. Peck of St. Francis, Kan., president of the Kansas Medical Society, detailed a program in that state aimed to provide doctors for rural areas.

WESTERN UNION

WALTER F. DONALDSON, Secretary

MEDICAL SOCIETY STATE OF PENNSYLVANIA

500 Penn Ave. Pittsburgh

Chicago

December 9, 1949

HOUSE OF DELEGATES OF AMERICAN MEDICAL ASSOCIATION AT MEETING
DECEMBER 6 TO 8, 1949 ADOPTED \$25 DUES FOR ACTIVE MEMBERS OF
AMERICAN MEDICAL ASSOCIATION FOR YEAR 1950, SAID DUES WILL BE
COLLECTED BY STATE OR COUNTY SOCIETIES IN ACCORDANCE WITH LOCAL
CUSTOM FOR COLLECTING YOUR OWN DUES AND WILL BE TRANSMITTED TO
SECRETARY OF AMERICAN MEDICAL ASSOCIATION.

GEORGE F. LULL, Secretary

AMERICAN MEDICAL ASSOCIATION

The program besides covering medical care provides for better schools, more scientific farming, the establishment of adequate libraries, attractive parks, effective chambers of commerce and the establishment of churches, businesses, and homes.

"Our efforts are directed toward health, but we physicians also are cooperating with our rural communities in those other phases of this program," Dr. Peck said. The emphasis in getting a doctor to practice in a community is to stimulate the community to establish proper medical care facilities that will attract a doctor.

Dr. A. E. Cardle of Minneapolis, chairman of the health education committee of the Minnesota State Medical Association and chairman of the session on "State Society Public Relations Projects," cited the new concept in professional thinking.

"Five years ago, a conference like this would have produced many an unfavorable reaction," Dr. Cardle said. "Commercialism, we would have said. Lowering of ethical standards. Selling medicine like soap.

"We have an important message to give the public now and we cannot overlook the media by which we communicate this message. I do not mean that we should be hypocritical or servile in seeking the co-operation of press and radio. They would be the first to detect and expose any lack of sincerity on our part. But, we should deal with them fairly and honestly, giving out information that is reinforced with facts."

Woman's auxiliaries to medical associations are potent factors in the profession's public relations program, according to Dr. C. Allen Payne of Grand Rapids, Mich., chairman of the advisory committee of the Woman's Auxiliary to the Michigan State Medical Society.

Dr. Percy E. Hopkins of Chicago, chairman of the committee on medical service and public relations, Illinois State Medical Society, told of a full-scale public relations program established in 1945. Dr. Hopkins pointed out, however, that the Illinois Society has had a program for twenty-six years. He explained how the public relations committee works with other committees of the state society.

Rhode Island though small in area has an effective program, according to Dr. Charles L. Farrell of Pawtucket, R. I., chairman of the committee on public policy and relations of the Rhode Island Medical Society.

Other participants in the conference were Dr. George F. Lull, general manager and secretary of the A.M.A., who welcomed attendees and emphasized that the 48 states' attendance was "a clear-cut indication that the medical profession is convinced of the urgent necessity for an over-all continuing long-range public relations program"; Dr. Max H. Hattaway of New Orleans, chairman of the council on medical service and public relations, Louisiana State Medical Society, and chairman of the session on "Organizing for an Over-all Public Relations Program," and Dr. F. S. Winslow of Rochester, N. Y., chairman of the public relations committee, New York Medical Society, and chairman of the session on "Get It Off Your Chest."

The conference was directed by Lawrence W. Rember, public relations director of the A.M.A.

The public relations activities of The Medical Society of the State of Pennsylvania were represented at this conference by Messrs. Perry and Brown.

VIOLATION

The Bureau of Narcotics, United States Treasury Department, has recently advised that "Dr. Adrian T. Griswold, 467 West Market St., York, Pa., pleaded guilty to violation of Section 2554 of the Internal Revenue Code, in the District Court at Harrisburg, Pa., on Sept. 30, 1949, and the sentence was suspended. He was placed on probation for a period of three years on Count 2, and on Count 1 was fined the sum of \$2,000."

Dr. Griswold is not a member of The Medical Society of the State of Pennsylvania.

A.M.A. SECRETARY'S LETTER NO. 126

DEAR DOCTOR:

Many of the country's leading newspapers have expressed editorially candid resentment toward the U. S. Department of Justice for using Federal police powers to intimidate doctors in their fight against compulsory health insurance. . . .

The front page of a folder containing reprints of these editorials carried a *Baltimore Sun* editorial entitled "Why Don't the Doctors Just Get a Franchise from the CIO?" Both the *Sun* and the *Chicago Tribune* held that if anyone ever created a monopoly it is the unions.

Here are some of the editorial headlines, indicating clearly that public sentiment, as expressed through the newspapers, is against the socialistic tendency in government: "Police State Review"; "Below the Belt"; "Dirty Pool"; "F.B.I. on Griddle for Probe Disclosure"; "The Police State"; "A Cheap Job to Dump on the F.B.I."; "Shocking Abuse"; and "Must We Share Britain's Ill Health?"

Meanwhile, J. Howard McGrath, the attorney general who initiated the A.M.A. probe, spoke before the National Press Club and lashed out at the 90-year-old A & P food concern, which is also under monopolistic investigation, for using full-page newspaper advertisements to tell its story to the people. He asserted that the ads are false "from beginning to end . . . they take sentences out of context" and that it became his duty to set the public straight.

Mr. McGrath said the newspaper advertisements have been successful to the extent that they have inspired "little people" to flood the department and their congressmen with mail protesting against the anti-trust suit. Evidently the people, hearing both sides, are getting fed up with government interference and are speaking out in a flood of letters to Washington. . . .

All this comes at a time when the British Socialists, who once boasted that there would be no cuts in the "free medical treatment" experiment, are beginning to back water.

Now, if a Briton wants a box of aspirin, a package of laxative, or a wisp of cotton, he has to pay for it. Under the modification, patients will have to pay up to a shilling (14 cents) each for medicines they used to get free. The government thus expects to save \$28,000,000 a year. As one *Chicago Daily News* writer said: "It used to be only critics of the Socialists who said that one reason for the high cost of socialized medicine was that the public was abusing it. Now the Socialists themselves admit it."

P.T.A. Group Opposes Socialized Medicine. The West Virginia Congress of Parents and Teachers, representing a membership of 85,000, is the first state

PTA group in the Nation to adopt a resolution opposing socialized medicine. . . .

Lawrence W. Rember, A.M.A. public relations director, attended the three-day convention and spoke on the subject, "Health Problems: How the Medical Profession and the PTA's Can Cooperate." Dr. Thomas G. Reed, president of the West Virginia Medical Association, and Charles Lively, executive secretary, also participated in the convention. . . .

A.M.A. Never Opposed Voluntary Plans. In a bulletin just published by the A.M.A. Bureau of Medical Economic Research, Director Frank G. Dickinson says that "the A.M.A. has never opposed development of voluntary sickness insurance plans in this country as they exist today. . . . It has never objected to the individual or family purchase of health insurance from the firmly established insurance companies, many of which had been writing this type of coverage long before the development of what usually are called voluntary plans. . . . As early as 1934 the association drew up ten principles to serve as a guide in development of these plans and to insure soundness in their execution.

"Through experience a new type of voluntary insurance developed in which the harmful features gradually were eliminated. With the establishment of this new type of insurance, the House of Delegates in 1938 gave its wholehearted approval to voluntary sickness insurance as a means of meeting the costs of medical and hospital care.

"Since that date, there has been no question as to the support of voluntary sickness insurance by the American Medical Association."

GEORGE F. LULL, M.D.,
Secretary and General Manager.

Nov. 7, 1949

CHANGES IN MEMBERSHIP

New (53) and Reinstated (6) Members

ALLEGHENY COUNTY: Eugene W. Kelly, Sewickley. (Reinstated) A. Ralph Marmins, Pittsburgh.

ARMSTRONG COUNTY: (R) Sidney Sedwick, Kittanning.

BEAVER COUNTY: John G. Hallisey, Aliquippa.

CHESTER COUNTY: Malcolm S. Byers, Coatesville.

CRAWFORD COUNTY: Robert J. Gilardi and Thomas H. Vetter, Meadville; Harry C. Smith, Cambridge Springs.

DAUPHIN COUNTY: Arthur Edw. Brown, Camp Hill; Robert S. Christman and Wilson C. Everhart, Harrisburg.

DELAWARE COUNTY: Charles R. Barton, Jr., Glenolden; Robert H. Bedrossian, Drexel Hill; Howard H. Lyons, Linwood; Robert T. Pfeifer, Swarthmore; William N. Stecher, Havertown. (R) William J. Padgett, Chester.

ERIE COUNTY: John H. Petre, Jr., Erie; John N. Sherwood, Union City.

INDIANA COUNTY: Harold L. Edison, Indiana.

LACKAWANNA COUNTY: Victor J. Covalessky, Louis R. Murphy, Paul A. Ryan, and Thomas J. Strunk, Scranton; Vincent E. Wall, Jermyrn.

LANCASTER COUNTY: Virginia G. Mears, Lancaster; Howard Shaub, Jr., Mt. Joy.

LEHIGH COUNTY: Theodore A. Beck and Donald J. Klotz, Jr., Allentown; Hilda G. Ruch, Flicksville. (R) Harold M. Tuberty, Allentown.

MIFFLIN COUNTY: Michael L. De Vita, Lewistown; Robert W. Leipold, McClure.

MONTGOMERY COUNTY: Forbes B. Connor, Lafayette Hill; Irwin L. Peikes and Edwin C. Tait, Norristown; Joseph T. Zukoski, Pottstown.

PHILADELPHIA COUNTY: Edward W. Bixby, Jr., Alfred S. Bogucki, William E. Brady, Richard A. Brunner, William A. Buck, Israel Glick, Barnard Goluboff, Harold I. Lecks, Robert D. Leggett, Francis L. Richardson, John M. Rhoads, Richard M. Roque, and William H. Whitely, 3d, Philadelphia; George E. Covintree, Collingswood, N. J.; Philo W. Rugh, Ardmore. (R) Charles R. Tatnall, Ardmore.

WESTMORELAND COUNTY: Charles H. Dow, Monessen; Andrew J. Cerne, Herminie; Winter T. Varner, Torrance; and Robert S. Van Dervort, New Kensington. (R) Robert M. Johnston, New Kensington.

YORK COUNTY: Leon N. McLin, Hanover.

Resignations (3), Transfers (8), Deaths (11)

ALLEGHENY: *Transfers*—William L. White, Pittsburgh, from Philadelphia County Society; M. Esther Cushnie, Sewickley, from Mercer County Society. *Death*—John P. Hegarty, Pittsburgh (Univ. Pgh. '02), October 11, aged 81.

ARMSTRONG: *Transfers*—Samuel V. King, Templeton, from Mercer County Society; Robert H. Yockey, Kittanning, from Butler County Society.

BERKS: *Death*—Frank Womer, Reading (Jeff. Med. Coll. '89), October 4, aged 90.

CAMBRIA: *Transfer*—Kenneth R. Fickes, Johnstown, from Blair County Society.

CLEARFIELD: *Death*—Arthur D. Cowdrick, Clearfield (Univ. Pa. '09), August 19, aged 62.

DELAWARE: *Transfer*—Ruth N. Miller, Sharon, to Mercer County Society.

LANCASTER: *Resignation*—Luther F. Vozel (by transfer to Maryland State Society). *Transfer*—Elmer F. Toth, Lancaster, from Dauphin County Society. *Deaths*—William G. Hess, Holtwood (Univ. Pa. '98), October 5, aged 74; Joseph P. Kennedy, Columbia (Jeff. Med. Coll. '00), September 28, aged 81.

MONTGOMERY: *Resignation*—Philip E. Hertz, Lyons, N. J.

PHILADELPHIA: *Deaths*—William D. Baum, Philadelphia (Jeff. Med. Coll. '15), October 19, aged 60; Joseph A. Coscarello, Philadelphia (Hahn. Med. Coll. '24), October 15, aged 51; Sigmund S. Greenbaum, Philadelphia (Jeff. Med. Coll. '13), October 3, aged 59; S. Morrison Saltus, Philadelphia (Temple Univ. '25), June 11, aged 51; Henry A. Shute, Philadelphia (Univ. Pa. '94), September 26, aged 87.

YORK: *Transfer*—S. Philip Laucks, Red Lion, from Dauphin County Society. *Resignation*—Alan E. Smith, Shaker Heights, O. *Death*—Arthur C. Kalisch, York (Johns Hopkins Univ. '32), October 5, aged 43.

Educational Fund M. S. S. P.

Article IX, Section 5 (see page 516, February, 1949 PENNSYLVANIA MEDICAL JOURNAL) of the Constitution of The Medical Society of the State of Pennsylvania provides for the collection, investment, and use of funds accumulated from the allotment (\$2.00) annually from the dues paid by each active member of the Society.

Chapter VII, Section 9, of the By-laws sets forth the provisions under which financial assistance may be rendered from the fund.

The appended copy of the application form has been evolved by the Committee on Educational Fund—M. Louise Gloeckner, Elmer Hess, James L. Whitehill, chairman, and Walter F. Donaldson, secretary.

Applications* will be received beginning January 1 each year until April 1 and such applications shall apply only to the beginning of the school year in September of that year.

— APPLICATION —

TO COMMITTEE ON EDUCATIONAL FUND OF THE MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA

1. Name
Last name First name Middle name
2. Address
3. Parent's name
Name Address
4. Member of what county medical society Year
5. Secretary of county medical society
Name Address
6. Sponsoring member of county medical society
Name Address
7. Names of three businessmen for letters of recommendation
.....
.....
8. School to which applicant has been admitted
9. What course do you intend to pursue?
10. College entrance examination board test
11. Reasons for applying for assistance
.....
.....
.....
12. Other sources of income which may supplement the assistance from the Educational Fund for furthering your education ..
.....
.....

(Signed) ..

(Address) ..

* For application forms, write the committee at 8104 Jenkins Arcade, Pittsburgh 22, Pa.

CONTRIBUTIONS TO MEDICAL BENEVOLENCE FUND

The Committee on Medical Benevolence makes grateful acknowledgment of the following contributions to the medical benevolence fund. These have also been acknowledged individually.

Woman's Auxiliary, Berks County	
A friend, in memory of Mrs. C. H. Muhlenberg, Sr.	\$5.00
Woman's Auxiliary, Lawrence County	
A friend, in memory of Mrs. James Blackwood	2.00
Woman's Auxiliary, Mifflin, Juniata, and Perry Counties	
Honoring Mrs. Drury Hinton, president of State Auxiliary	10.00
Total contributions since 1949 report ..	\$17.00

PAYMENT OF PER CAPITA ASSESSMENT

The following payment of per capita assessment has been received since September 30. Figures in first column denote county society numbers; second column, State Society numbers.

Oct. 1	Bucks	91	10632	\$7.50
	Mercer	96	10633	15.00
	Philadelphia	3189-3213	10634-10658	262.50
4	Erie	205-206	10659-10660	15.00
5	Chester	121	10661	7.50
6	Lehigh	221-226	10662-10667	67.50
12	York	169	10668	7.50
13	Delaware	298-303	10669-10674	52.50
	Armstrong	43	10675	15.00
	Indiana	42	10676	15.00
	Westmoreland	213-217	10677-10681	45.00
18	Lancaster	233-234	10682-10683	15.00
24	Montgomery	342-345	10684-10687	30.00
	Crawford	56-57	10688-10689	30.00
	Beaver	138	10690	7.50
	Dauphin	258-260	10691-10693	22.50

ARE YOU USING THE PACKAGE LIBRARY SERVICE?

Are you taking advantage of the facilities offered by the package library service of The Medical Society of the State of Pennsylvania? There are, at the present time, over 102,000 reprints and tear sheets from current periodicals filed in the library for your use.

Prior to 1944 the average yearly number of requests was approximately 350. However, from 1944 to 1948 inclusive, there has been a continuous increase in borrowers. A total of 1192 requests were received during 1948, an increase of 293 requests over the total for 1947.

A package of reprints will be sent immediately for a loan period of two weeks to any member of the State Society. There is a charge of 25 cents for each subject requested to cover postage and part of the expense of collecting the material. Send requests to the Librarian, 230 State St., Harrisburg, Pa.

The following requests were filled during the month of October:

Streptomycin	Prostateria
Antibiotics (2)	Use of cytochrome C
Constipation	Scurvy
Diarrhea	Ectopic pregnancy
Blood platelets	Ménière's disease
Physiotherapy	Sex education
Antihistamine	Venereal disease
Digitalis	Social hygiene
Anticoagulants	Electrocardiography
New drugs	Radioactive iodine
Parkinsonism	Intravenous procaine
Treatment of tetanus	Exophthalmos
Treatment of obesity	Dermatology
Antidiuretic hormone	Psychoses
Meaning of neuroses	Hospitals
Industrial medicine	Public Health
Diabetes mellitus (2)	Tuberculosis
Pernicious anemia	Child welfare
Hyaluronidase	Chronic malaria
Periarthritis nodosa	Undulant fever
Lupus erythematosus	Air sterilization
Diabetes and pregnancy	Duodeno-colic fistula
Blalock operation	School health programs
Peyronie's disease	Deafness in children
Paravertebral block	Cataract extraction
Recreation and health	Chemotherapy of cancer
Oxyuriasis	Leukemia in children
Diabetes in children	Physical medicine
Skin diseases	Exercise
Diseases of infants	Research laboratories
Lipoid nephrosis	Nutrition
Arteriosclerosis	Medical ethics
Sickle cell anemia	Dermatitis
Hodgkin's disease	Intravenous injections
Medicine and religion	Use of coramine
Sex	Treatment of asthma
Nostrums and quackery	Fibroids of the uterus
Treatment of psoriasis	Scleroderma
Socialized medicine	Ophthalmology
Carbon dioxide therapy for cystic acne	
Cholesterol metabolism (2)	
Insulin for depressive states	
Pulmonary effects of toxic gases	
Use of para-aminosalicylic acid in tuberculosis	
Paravertebral injection	
Injection of sensory nerves	
Physiology of respiration	
Disseminated lupus erythematosus	
Cytologic diagnosis of cancer	
Control of air-borne infections	
Inhalation of ammonia fumes	
Blood protein determination	
Urologic problems in pregnancy	
Urologic problems in the newborn	
Tuberculin in tuberculosis	
Cytochrome C in myocardial anoxia	
Congenital disease of the hip	
Convalescent homes in Pennsylvania	

THE BUREAU OF DENTAL HEALTH

Published Through the Cooperation of the Pennsylvania Department of Health
and The Medical Society of the State of Pennsylvania

The dental program of the State Health Department was started in September, 1920. The work was entirely educational in that the purpose was to encourage local communities, through their school system, to care for the dental needs of children. Non-official agencies, such as service clubs, tuberculosis societies, the Red Cross, and parent-teacher associations, frequently cooperated in raising funds to pay for services and equipment.

It was a pioneer program which over a ten-year period succeeded in having over 250 similar ones started and maintained by their own local funds. The work was discontinued in April, 1933, but re-established in November, 1935.

In 1940 the program was again enlarged. The principal objective, to stimulate the community to establish its own dental programs, was adhered to, but financial assistance was provided by the State.

If a local school board, board of health, or some other tax-supported agency will set up and operate a dental clinic for school children, the State Department of Health will pay a fee to the dentist whom they appoint to conduct that clinic. There are some conditions which must be met in order to obtain this aid. *First*, it must be an extension of a service now being rendered, or a new service. If a dentist is already being employed, the Department will not take over the salary or fee already being provided from another source. It will, however, pay for an additional clinician if conditions warrant. *Second*, the clinic sponsor must be a school board, board of health, or other tax-supported agency or governmental unit. *Third*, the clinicians will be selected by the sponsoring agencies, and be appointed by the State Department of Health. They must be ethical practitioners, licensed to practice in Pennsylvania. *Fourth*, each clinician will receive \$3.00 per clinic hour, but no one clinician may receive a fee for more than fifteen hours in any one calendar month. *Fifth*, the sponsoring agency must agree that the State Department of Health shall have the right to inspect the clinic, and to be guided by suggestions made for improving the quality of the service rendered, also to submit such periodical reports of the clinic activities as the Department of Health may require. *Sixth*, inasmuch as the new School Health Act makes provisions for dental examinations, clinician's fee will not be allowed under the dental clinician program for anything but corrective service.

Last year, 103 communities were assisted in this way. A clinician's fee was paid to 121 dentists for a total of 13,387 hours. A total of 8434 children made 26,877 visits to the various clinics. There were 5749 children discharged with all necessary corrections completed.

The Dental Bureau also administers that section of the School Health Act which calls for dental examinations. Last year, 831,775 pupils were given dental examinations. In these pupils there were 1,893,355 permanent teeth requiring filling; 660,812 permanent teeth which had been extracted, or extraction was indicated; and 1,434,585 permanent teeth which had been filled and for which no further correction was indicated.

From these figures, it appears that only 36 per cent of the permanent teeth which had been attacked by decay were satisfactorily filled at the time of the examinations. In other words, teeth are decaying three times as fast as they are being filled. In fourth-class school districts the percentage of care is lower than in the State as a whole. The percentage of care is only 31.8 per cent.

With the help of the three dental schools in the State and Pennsylvania State College, a series of refresher courses has been established for the dental profession. These courses are financed by the State Health Department and include children's dentistry, cleft palate prosthesis, oral surgery, and diagnosis and management of oral malignancy. Several courses for dental hygienists have also been given by the above-mentioned institutions.

Expansion of the Dental Bureau's work has necessitated field supervision, which is handled at the present time by ten district dental officers.

Dental health education is carried on by a staff of dental hygienists, but all have had, in addition to instruction as hygienists, two or more years' training in the field of education. Literature on the subject of dental health has been prepared and distributed free to anyone who is interested in receiving it.

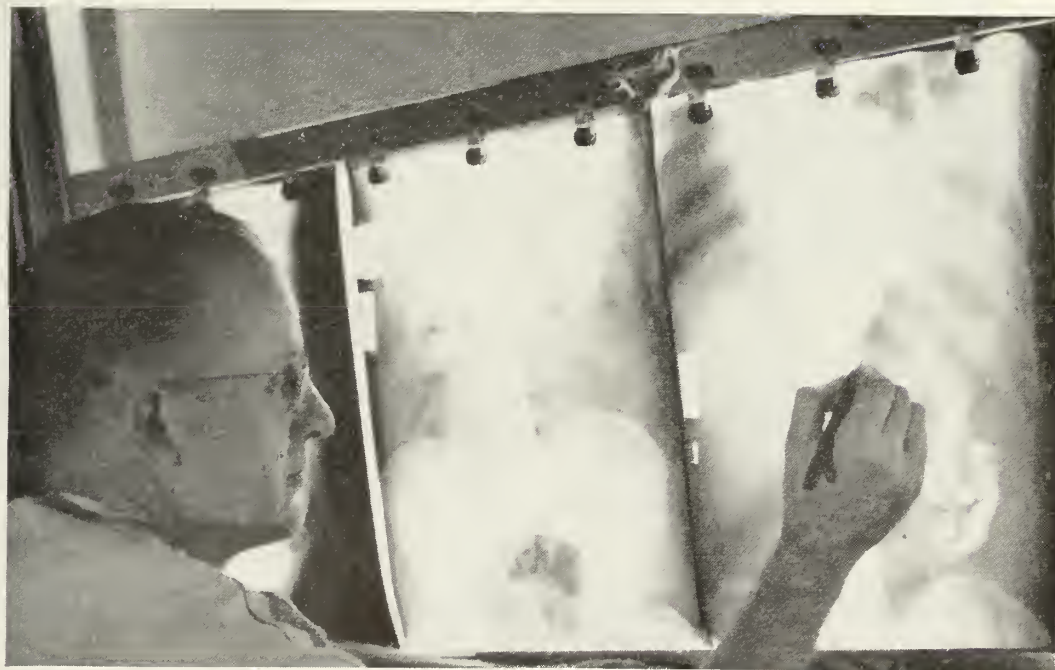
At the present time the Dental Bureau is supervising the work of a demonstration team. This team consists of a dentist, two dental hygienists, and a clerk. They are showing how to make topical applications of sodium fluoride to the exposed surfaces of teeth for the purpose of reducing the incidence of tooth decay. The demonstration has two objectives: first, to show the technique to dentists and dental hygienists; and second, to demonstrate to a community a procedure which it is believed should be a part of a school health service program.

LINWOOD G. GRACE, D.D.S., *Director.*

Radiopaque diagnostic medium...
Original development of Searle research

now
Iodochlorol[®] *council
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Clear visualization of body cavities—for the roentgen investigation of pathologic disorders involving sinuses . . . bronchial tree . . . uterus . . . fallopian tubes . . . fistulas . . . soft tissue sinuses . . . genitourinary tract . . . empyemic cavities.

Iodochlorol is notably free from irritation, free-flowing, highly stable and has pronounced radiopaque qualities. It contains the two halogens, iodine, 27 per cent, and chlorine, 7.5 per cent, organically combined with a highly refined peanut oil.

Iodochlorol is available in bottles containing 20 cc. of the radiopaque medium; each one is packed in an individual carton. G. D. Searle & Co., Chicago 80, Illinois.

Searle

RESEARCH IN THE SERVICE OF MEDICINE

PENNSYLVANIA CANCER FORUM

A monthly presentation by the Pennsylvania Division of the American Cancer Society in cooperation with the Pennsylvania Department of Health, the Philadelphia Division of the American Cancer Society, and the Commission on Cancer of The Medical Society of the State of Pennsylvania.

Aims of the American Cancer Society

The basic aim of the American Cancer Society is to bring to every person in the country sufficient knowledge about cancer so that he will not lose his life needlessly, as approximately half of present cancer patients do. This is an enormous task because ignorance of the facts, misconceptions about the disease, superstitions and fears still are widespread and prevent life-saving action.

The society uses every conceivable means to present cancer facts to the public. Millions of pamphlets, in which virtually every phase of cancer is outlined, are distributed free every year. Motion pictures are shown before club groups and in local theaters. Exhibits of every type are set up in public places, at county fairs, in store windows, at large conventions. Program outlines as well as trained medical and lay speakers are provided to organizations which wish to have cancer programs. A steady flow of educational material in its most usable form is poured into radio stations and newspapers. Posters are displayed indoors and out, and transportation companies give free space for educational bus cards.

Because cancer is chiefly a disease of adult life, the bulk of the society's educational effort is aimed at the adult population which is in the "cancer age." At the same time, the importance of educating young people is not overlooked. Material is developed for use in high schools and guidance made available to teachers, so that students who will be tomorrow's adults will be equipped to face the cancer problem constructively, both as it concerns them personally and as it affects the community.

Alongside its extensive lay educational activities the society has developed a program to keep the professional man informed of all that is currently known about the diagnosis and treatment of cancer. In no profession are there such continuing changes and advances as in the field of medicine, and within the medical field no disease presents more complex problems than does cancer. To help the physician—especially the general practitioner—keep abreast of current developments, the society provides medical speakers' bureaus, cancer "refresher courses," motion pictures, slides, monographs and brochures, as well as exhibits for national, state, and county meetings of medical groups. An opportunity for postgraduate study is made available through fellowships in clinical cancer, of which forty were granted by the national organization in 1948.

Advanced training for the specialist is provided through fellowships in special fields, such as exfoliative cytology, in which new diagnostic procedures have been developed recently. A professional journal for the specialist, entitled *Cancer*, is published bimonthly. In addition, the society assumes leadership in staging national conferences at which top specialists in the cancer field gather to explore specific medical aspects of the disease. These conferences afford the opportunity for

discussion and evaluation of new technical developments which are indispensable to maximum progress in the professional attack on cancer.

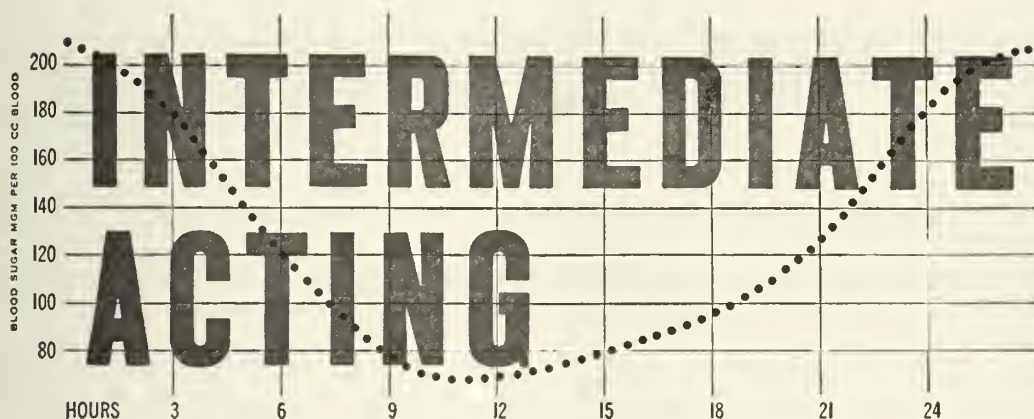
The society's national office maintains a medical library of cancer literature, films, and slides which is rapidly becoming the most complete repository of such material in existence. Any physician in the country may refer to this library and make use of its "package-lending library service" which assembles and sends out packets of material in answer to a wide variety of specific requests. A bibliography and digest of current cancer literature is published monthly.

Special grants are made by the society to support worth-while educational projects and investigations in the cancer field not otherwise provided for—programs to teach advanced cancer nursing, the preparation of special films, the publication of texts and laboratory manuals, and special studies of factors which influence the effectiveness of cancer education.

In its earliest years the society's activities in professional education were concentrated on bringing to the medical profession an awareness of the importance of cancer as a menace to the nation's health. That job has long since been finished. The first and foremost aim of the program now is to make it easier in every way for the practicing physician to keep himself informed of the latest techniques in detection, diagnosis, and treatment of the disease. At the same time, other professional groups—dentists, nurses, and medical social workers—also are kept abreast of information of concern to them in the cancer field.

The American Cancer Society, under its articles of incorporation, may not own or operate medical or laboratory facilities, nor actually treat cancer patients, but since its very beginning one of its chief purposes has been to encourage the establishment of adequate cancer facilities to assist in developing, equipping, and maintaining them wherever necessary. The primary facilities for the control of cancer are the detection center, the diagnostic clinic, and the cancer clinic which is equipped to treat as well as diagnose the disease. A considerable part of the society's fund is spent by its divisions, including the Pennsylvania Division, in establishing and supporting these facilities. The number of these centers and clinics has been growing steadily, but is still far from adequate. The best medical authorities explain that seven times as many cancer clinics as now exist are needed.

Nationally, the Service Department of the American Cancer Society makes studies of cancer facilities throughout the country and gives guidance in their most effective operation. Inspection of these clinics and centers is made by the American College of Surgeons and is partially financed through a grant from the American Cancer Society. The society keeps practicing physicians throughout the country informed of any developments which may improve service to cancer patients, such as availability of drugs, special diagnostic services, and rehabilitation training and devices.



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1. Rohr, J.H., and Colwell, A.R.: Arch. Int.
Med. 82:54, 1948.

2. *ibid* Proc. Am. Diabetes Assn. 8:37, 1948.



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TUBERCULOSIS ABSTRACTS

A Review for Physicians

PREPARED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Published through the co-operation of the Pennsylvania Tuberculosis Society
and The Medical Society of the State of Pennsylvania

AS THE mortality from tuberculosis continues its downward trend, the question of whether or not it will finally be eradicated becomes less speculative and more practical. This question was asked and answered by Wade Hampton Frost in 1937 and his answer now has been reviewed with the added experience of the last ten eventful years.

IS AREA ERADICATION OF TUBERCULOSIS POSSIBLE?

Wade Hampton Frost, in 1937, presented a thoughtful appraisal of the question "How Much Control of Tuberculosis?" After marshalling the available evidence, he concluded that in this country we had already reached a stage at which the biologic balance was against the survival of the tubercle bacillus and that eventually this disease would disappear.

A British opinion of the same year was: "It is idle to speak of the conquest of tuberculosis; tuberculosis has not been and so far as one can see never will be conquered." This opinion was endorsed recently by Medlar, who found many tuberculous pulmonary lesions unrecognized during life in persons in the older age groups coming to autopsy in New York City.

The question of the validity of Frost's thesis is of great practical as well as theoretic importance. His reasoning was briefly this: There were many and sound reasons for doubting that the rapid decline in tuberculosis in the preceding half century had been due *principally* to the measures which had been taken for the purpose of preventing infection. Without question the factors lumped together under the terms "advancing civilization and better living conditions" had played an important role. There was reason to believe, however, that the decline was due *in some part* to the efforts made to control the disease.

The direct attack has proved to be a more formidable undertaking than was at first realized, but in Frost's words, "If the effective control of tuberculosis required *complete* isolation of *all* open cases, . . . the present (i.e., 1937) status could not be considered encouraging, for

. . . (many) such cases are discovered in a fairly advanced stage, and the isolation even of cases known to the authorities is probably less than 50 per cent complete. However, for the eventual eradication of tuberculosis, it is not necessary that transmission be immediately and *completely* prevented but only that the rate of transmission be held permanently below the level at which a given number of infection-spreading cases succeed in establishing an equivalent number (of 'open' cases) to carry on the succession. If the number of infectious hosts is continuously reduced, the end result . . . must be extermination of the tubercle bacillus."

He placed a single qualification upon his conclusion, namely, "As to the maintenance of this balance, favorable to us, unfavorable to the tubercle bacillus, there are, of course, elements of uncertainty, among them uncertainty as to the stability of our civilization."

Only twelve years have passed—too short a period upon which to base inferences in regard to long-time trends—during which the very existence of civilization has been threatened. The world has undergone one of the greatest military, social, and economic upheavals in history. It is, therefore, pertinent to review the experience of this decade and inquire whether the Frost thesis is still tenable.

Despite their limitations, mortality rates provide the best available index of the biologic balance over long periods of time. During the war years, mortality from tuberculosis increased in most of the western European nations involved in the conflict, while those countries that escaped the rigors of war were little affected. In western

	Calories	Protein Gm.	Calcium Gm.	Copper mg.	Iron mg.	Phosphorus Gm.	Vitamin A I. U.	Thiamine mg.	Riboflavin mg.	Niacin mg.	Ascorbic Acid mg.	Vitamin D I. U.
National Research Council Allowances, Sedentary Man (154 lbs.)	2,400	70	1.0	1.2	12	1.5	5,000	1.2	1.8	12	75	Small Amount
Ovaltine in Milk, 3 Servings*	676	32	1.12	0.5	12	0.94	3,000	1.16	2.0	6.8	30	417
Percentages of N. R. C. Allowances Provided by 3 Servings* of Ovaltine in Milk	28%	46%	112%	42%	100%	63%	60%	97%	111%	57%	40%	Abun- dance

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Germany the rate is still higher than in 1938. In Belgium and the Netherlands, as in England and France, the rate rose during the war, but by 1946 was already down to or below the 1938 level. In Denmark, Sweden, Switzerland, and the United States, mortality continued downward during the war.

It appears, therefore, that the disturbances due to the war have been insufficient to effect more than a temporary setback in declining death rates. It would appear then that, where civilization is relatively advanced, the biologic balance is still against survival of the tubercle bacillus.

To what extent this is due to indirect socioeconomic causes or indirectly to control measures is still a difficult question to answer. In the United States, progress has been made toward more effective measures of control despite the war. In the field of specific therapy the most important contribution was, of course, the discovery of streptomycin, which is now receiving extensive clinical trial. Experience with it thus far gives hope that eventually an antibiotic may be discovered which will suppress growth of the microorganism in the tissues and rapidly terminate the infectious state in pulmonary tuberculosis. With such an agent, the seedbed of the disease could be more rapidly reduced.

The search for a practical and effective method of artificial immunization has progressed. The techniques related to the use of BCG vaccine have been improved and its safety established. Critical trials support the judgment that

this procedure affords some protection against post-primary tuberculous lesions, for at least a limited period. Its long-range effect in reducing the incidence of pulmonary tuberculosis has yet to be determined. In the United States, BCG is still under investigation.

Thus, the past ten years have brought forth no really new principle of prevention. The main objective is still avoidance of exposure, and the strategy is still that of a frontal assault on discoverable sources of infection. Progress has also been made in "case finding" and isolation. The tools used in diagnosis have undoubtedly been sharpened.

While there are still manifest deficiencies in the preventive program, it is better than it was a decade ago. There are reasons for believing that it is progressively reducing the frequency of transmission from infected to non-infected individuals.

Granting continuation or strengthening of control efforts in addition to favorable socioeconomic developments in a world at peace, it would seem not unreasonable to expect that the balance, favorable to us, unfavorable to the tubercle bacillus, will be maintained and that the decline in mortality from tuberculosis will be sustained, even to the point of disappearance from some areas. There is nothing in the record up to date that is inconsistent with Frost's thesis.

Is Area Eradication of Tuberculosis Possible?
Editorial, *American Journal of Public Health*,
June, 1949.



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1. Best, R. R.; Ann. Surg. 128: 348 (Sept.) 1948.

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THE WOMAN'S AUXILIARY

MRS. DANIEL H. BEE, *Editor*

547 Water Street

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PRESIDENT'S MESSAGE



The New Year will soon be upon us, the traditional time for taking inventory, evaluating ourselves, and making resolutions for improvement. The woman's auxiliary in each county should also be taking stock, clearing the way for positive action, and improving the year ahead.

It might be well to look into our investments to see if they are paying worth-while dividends. What assets have we and upon what basis shall we continue in business?

Visits to the county groups so far have been most revealing, and it is with optimism that I look forward to the remaining months of this term of office. Everywhere there is enthusiasm for auxiliary work—new members are joining the ranks and a great upsurge of interest in the type of organization we represent is manifesting itself. Once our physicians' wives realize the true purpose of our existence as an auxiliary to the medical profession, they come forward with willing hands and open hearts to serve.

To insure continued interest and a working force for the years ahead, we must train leaders for the future. It is to the advantage of each county unit and each individual member to consider this matter seriously.

Our greatest asset is our ability to serve as a public relations agent for the medical society, and recognition in every phase of our endeavor was accorded us at the recent annual convention in Pittsburgh. To keep up this fine record of achievement we must invest more and more in the business of auxiliary organization.

Our working capital is increasing with the increase in membership, and we look forward to being very "wealthy" by the end of the year. Whether or not the goal will be reached depends upon the cooperation of every county auxiliary—that willingness to exert an effort to approach every eligible woman and "sell" her on auxiliary membership.

As membership increases, so the balance

grows and we have more and more from which to draw for "funds." Each member possesses some talent which can be used to advantage in the auxiliary program, and the more that talent is brought to light and put to work, the greater it will grow. Many members, particularly new ones, have hidden talents which are not discovered until those members take active part in the work. By placing all members on at least one committee, and by expecting them to be responsible for some activity during the year, we shall find a gold mine of ability which can be used later in the form of chairmen and officers for the county and state auxiliary.

We need ever to be on the lookout for leaders, and the only source of "income" is the rank and file of the general membership. The greater the membership, the greater the number of leaders we will find produced; but their talents cannot manifest themselves unless they are used and brought to the attention of the county and state.

There will always be a leader—you may find her in your quiet and shy member just as well as in your most aggressive member. Bring her out by using her in the work of some committee to show forth her talents, and she may surprise herself as well as you. Leaders need to acquire confidence—confidence comes from practice.

If members individually or county groups collectively are wasting talent, or worse yet, failing to recognize or use it, they are cheating themselves and the auxiliary too. Leaders are nothing more nor less than talent which is paying dividends.

We have the assets and our working capital is growing steadily. Investment of your talents in the corporation will produce huge dividends of satisfaction to you personally and to the Auxiliary and Medical Society in services rendered.

Take stock, check your inventory, and prepare for the New Year by investing wisely in the Woman's Auxiliary. You won't go wrong and, best of all, you can't lose.

The best of the Season's Greetings to all of you is the wish of your president.

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The crowd that packed Heinz Memorial Chapel to hear distinguished clergymen remind the medical profession of their spiritual responsibilities.

The five o'clock tea at the Faculty Club and the greeting of old friends.

The record of this year's amazing progress as told by committee chairmen at Mrs. Paul Craig's pre-convention board meeting.

Mrs. David B. Allman's beautiful hats and winning smile.

Mrs. David Thomas' poetry at the opening luncheon.

The useful things we all learned at the panel discussion on poster contests, health meetings, public relations, and legislation.

The fun of dressing up for the state dinner and the reception.

Mrs. Daniel H. Bee as busy as her name with the photographer and the press.

Dr. Pauline Berry Mack who talked steadily without a note and told us so much about "vim, vigor, and vitality."

The pride of the medical society officials as they spoke of our work at the Tuesday luncheon.

The ammunition provided in the addresses of Dr. J. S. DeTar and Dr. Frank Dickinson.

The smoothness with which the business sessions ran.

The stark truth and realism of Dr. Ralph Gampell's address at the installation meeting.

The firmness with which Mrs. Drury Hinton took over the reins at her post-convention board meeting.

The brilliance of Mrs. Charles Shafer's discussion of public relations.

The amazing feats performed by Mrs. Albert Doyle and others in the field of legislation.

The "something" that got in Mrs. Paul Craig's eye as she pinned the Pennsylvania laurel leaf and caduceus on Mrs. Drury Hinton's dress.

The ingenuity of Dr. Paul Craig's presenta-

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tion of traditional can opener and recipes to Dr. Drury Hinton.

Dr. Drury Hinton's broad smile as he donned the chef's cap and apron.

Mrs. Frank Dwyer's amazed expression as she was made our second honorary member and her comment that this was the only thing the Auxiliary had ever done that she didn't know about.

Mrs. Rufus Bierly's lovely voice and even lovelier sentiments as she announced Mrs. Dwyer's honorary membership.

The fashion show and our Mrs. Edmund Boots' expert modeling.

The nice people from out of state and the incredulous way they viewed our achievements.

The beautiful bird on Mrs. Drury Hinton's hat.

The old times recalled at the Past Presidents' Tea.

The sweetness of Mrs. Edgar Buyers' smile.

The vibrant spirit of Mrs. Paul Craig throughout the whole convention.

SUZANNE TREADWELL, *Staff Assistant*,
Committee on Public Relations, MSSP.

MINUTES (SHORT FORM) OF CONVENTION SESSIONS—1949

The twenty-fifth convention of the Woman's Auxiliary to The Medical Society of the State of Pennsylvania was called to order at 9:30 a.m., Sept. 27, 1949, in the Roosevelt Hotel, Pittsburgh, by the president, Mrs. Paul C. Craig of Reading, Pa.

The invocation was given by Mrs. James I. Johnston of Pittsburgh, the second president of the Auxiliary. The pledge of loyalty was led by Mrs. Charles C. Crouse of Greensburg, the eighteenth president of the Auxiliary.

The convention body was welcomed by Dr. Paul G. Bovard, Pittsburgh, president of the Allegheny County Medical Society, and by Mrs. Lester L. Bartlett, presi-

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dent of the Allegheny County Auxiliary. Mrs. Charles H. Smith of Uniontown, the fourth president of the Auxiliary, responded to the welcomes.

A solemn memorial service for thirty-three members who passed away during 1948-49 was conducted by Mrs. Harry B. Jones of Aliquippa. The Lord's Prayer was sung during this service by Mrs. T. Fulton Linn of Pittsburgh.

The rules and procedures were accepted and the minutes of the last convention were not read on motion. Mrs. Rufus M. Bierly reported that the slate prepared by the nominating committee was posted for study by the delegates.

Mrs. Maxwell Lick of Erie, seventeenth president of the Auxiliary, was named chairman of resolutions and she appointed Mrs. Charles G. Eicher of California and Mrs. Wellington D. Griesemer of Reading, both past presidents of the Auxiliary, as her committee.

Mrs. David B. Allman of Atlantic City, N. J., president of the Auxiliary to the American Medical Association, addressed the convention body.

Mrs. Paul C. Craig gave a résumé of the activities of the Auxiliary for the year 1948-49. Vast changes in auxiliary endeavor, broadened concepts, and new approaches to old problems made it a memorable year. The Auxiliary was honored when Mrs. Craig was asked to address the Secretaries' and Editors' Conference of The Medical Society of the State of Pennsylvania, and was also invited to sit in on the meetings of important committees of the State Society. Cooperation of the Medical Society in varied ways and the fine cooperation of county presidents and committee chairmen made the year most successful. Miss Suzanne Treadwell assigned by the Medical Society to help

Mrs. Craig in public relations matters, was of inestimable value to Mrs. Craig, to the officers, and to the Auxiliary.

Mrs. Drury Hinton, president-elect, organized eight county units during the year: Adams, Perry, Cumberland, Wayne-Pike, Bedford, Columbia, Monroe, and Susquehanna. Only two counties having medical societies remain to be organized.

The reports of all officers and county presidents were compiled in a booklet which was given to each delegate, thus eliminating the reading of reports. The editing and stencils of the booklet were done by Miss Treadwell and the assembling by others in the office. Mrs. Craig passed on the cuts. These were compiled in various colored units for easy reference. Sixty-one stencils and twenty-eight thousand sheets of paper were used in the making of the report résumé.

Dr. Pauline Berry Mack, director of the Ellen H. Richards Institute of Pennsylvania State College, addressed the convention on "Vim, Vigor, and Vitality." It was the story of mass nutrition experiments made in Pennsylvania since 1935.

Mrs. Charles L. Shafer conducted a panel on "Study Groups and How They Function." She was assisted by Mrs. J. William Jones, Mrs. Rufus M. Bierly, Mrs. William M. Jacoby, Mrs. J. Frederic Dreyer, Mrs. Harry M. Buzzerd, and Mrs. J. M. Stowell.

Mrs. Albert J. Doyle, of Johnstown, presented the practical angles of the Auxiliary's part in legislation. With Mrs. Daniel H. Bee, of Indiana, she explained the part that three county auxiliaries took in the Twenty-sixth Congressional District election. One of the issues in this fight was the compulsory insurance platform of one of the candidates. On this issue the

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Auxiliary took the opposite side with excellent results.

Mrs. Edward H. Bedrossian, of Drexel Hill, presented the changes in the by-laws made necessary by the new fiscal year in the State Auxiliary, and other changes made to clarify meanings. These changes approved by the executive board were also approved by the House of Delegates, and a unanimous vote of the body asked for complete revision of the constitution and by-laws for presentation to the convention in 1950.

A resolution against compulsory health insurance was passed, the entire membership of 3825 being included in the resolution.

The convention offered a resolution requesting The Medical Society of the State of Pennsylvania to petition the Commonwealth of Pennsylvania for the return of the Auxiliary Memorial Exhibit, once displayed in the State Museum and now in storage in Commonwealth possession.

Twenty-nine members of the Auxiliary were nominated and elected as delegates to the convention of the Auxiliary to the American Medical Association, to serve at the annual meeting in San Francisco, June, 1950. Pennsylvania is allowed thirty-nine delegates, twenty-nine elected by the convention body and ten by the post-convention executive board.

Mrs. S. Dale Spotts presented the budget for 1949-50 based on a possible 3900 membership, with total receipts of \$7,825 anticipated and budgeting planned within this income.

A total of 274 had registered at the end of the first day of the convention.

(MRS. PAUL C.) CATHARINE P. CRAIG, *President*,

(MRS. FRANK P.) MARY H. DWYER, *Secretary*.

The second day of the convention opened with a prayer by Mrs. Laurie D. Sargent of Washington, eleventh president of the Auxiliary.

Dr. Frank G. Dickinson, director of the Medical Economics Research Bureau of the American Medical Association, addressed the convention on "Man's Greatest Half Century."

Mrs. Charles L. Shafer, of Kingston, presided at a discussion on practical approaches to good public relations.

Mrs. John V. Foster, Jr., of Harrisburg, presented the list of winners in the Health Poster Contest conducted in the schools of Pennsylvania by the Medical Society and by the Auxiliary. Prize-winners were from schools in Johnstown, Reading, Allentown, Plains, West Newton, North Braddock, Shenandoah, and Top-

Mrs. Frank P. Dwyer, recording secretary of the Auxiliary since 1934, was made an honorary member of the Auxiliary, thereby joining the other honorary member, Mrs. Edgar S. Buyers, in a very special honor society.

Mrs. Rufus M. Bierly, immediate past president of the Auxiliary, presented the slate of officers prepared by the nominating committee. As there were no nominations from the floor, the entire slate was declared elected as follows:

President-elect: Mrs. Howard H. Hamman, Westmoreland County.

First vice-president: Mrs. J. Frederic Dreyer, Lehigh County.

Second vice-president: Mrs. Archibald Laird, Tioga County.

Third vice-president: Mrs. James L. Whitehill, Beaver County.

Recording secretary: Mrs. Frank P. Dwyer, Clinton County.

Treasurer: Mrs. Edmund C. Boots, Allegheny County.

Directors (two years): Mrs. Randall R. Strawbridge, Philadelphia County; Mrs. Frank Theuerkauf, Erie



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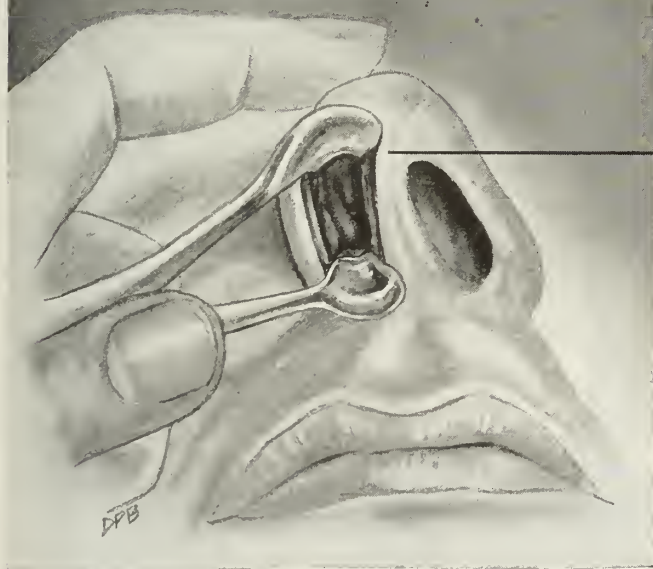
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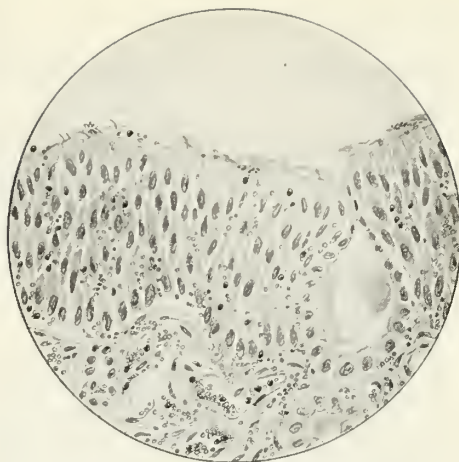
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Ninth District—Mrs. Robert S. Lucas, Butler County.

Mrs. Bierly conducted the installation ceremony for the officers just elected and Mrs. Craig gave the gavel of authority to Mrs. Drury Hinton of Drexel Hill, who thus became the twenty-sixth president of the Auxiliary. Mrs. Charles J. Swalm, chairman of the nominating committee which chose Mrs. Craig in 1947, presented the president's pin to Mrs. Craig.

Mrs. Hinton gave a résumé of her plans for the coming year. With a visual wheel as her symbol and her theme, "As the wheel goes, so goes the Auxiliary," she put each part of auxiliary endeavor into its proper place in the wheel which "is going places."

The final registration was 307, as announced by Mrs. Robert C. Hibbs of Pittsburgh, chairman of registrations.

Mrs. Jay G. Linn, of Pittsburgh, was general chairman of the convention with Mrs. Walter F. Donaldson and Mrs. Howard A. Power, both of Pittsburgh, as her co-chairmen.

The convention sessions adjourned at 12 noon, Sept. 28, 1949.

(MRS. PAUL C.) CATHARINE P. CRAIG, *President*,
(MRS. FRANK P.) MARY H. DWYER, *Secretary*.



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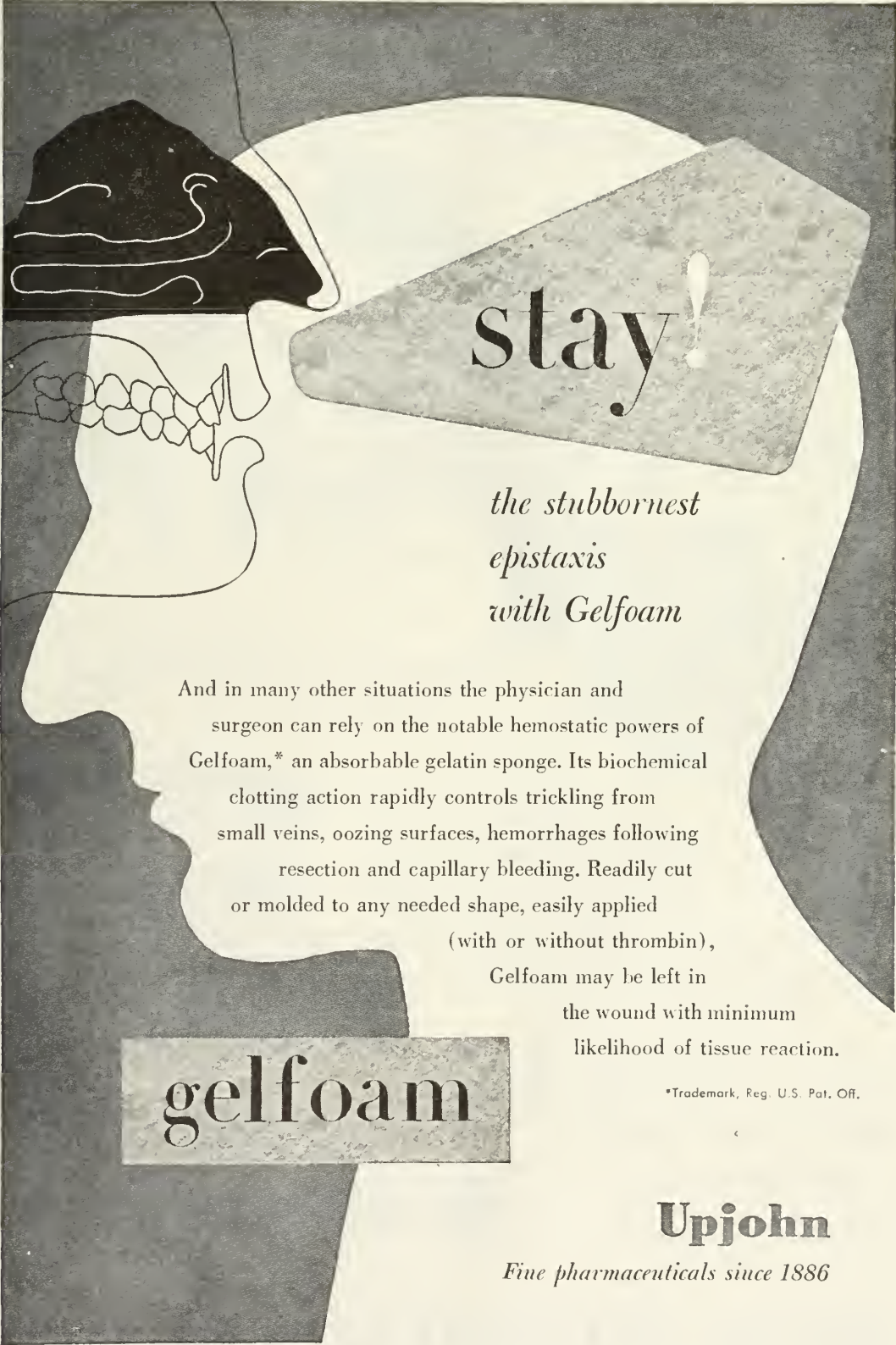
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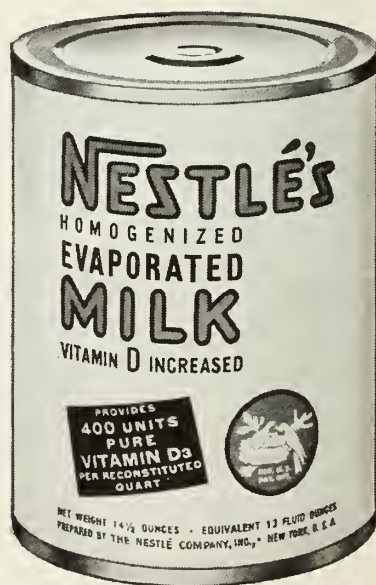
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MEDICAL NEWS

Births

TO DR. AND MRS. CLARKSON WENTZ, of Devault, a daughter, Harriet Booth Wentz, November 16.

TO DR. AND MRS. J. JAMES CANCELMO, JR., of Rosemont, a son, J. James Cancelmo, 3d, November 9.

Engagements

MISS H. MARIM PEW, of Haverford, to Mr. Thomas W. Klein, son of Dr. and Mrs. Thomas Klein, of Villanova.

MISS PHOEBE JAN EZICKSON, daughter of Dr. and Mrs. William J. Ezickson, of Merion, to Mr. Paul E. Gesregan, Jr., of Ramsey, N. J.

MISS PATRICIA MEEHAN, of Philadelphia, to Mr. Jeremiah Jennings Sullivan, Jr., son of Dr. and Mrs. Jeremiah J. Sullivan, of Lancaster.

MISS FRANCES FABER NOYES to Robert Ellwood Rowand, M.D., both of Swarthmore. Dr. Rowand is attached to the Naval Hospital in Philadelphia.

MISS EMILY FOX DORRANCE, daughter of Dr. and Mrs. George M. Dorrance, of Philadelphia, to Mr. Henry C. Mayer, 4th, of Haverford.

MISS IRENE ALLEN, of Cleveland, Ohio, to Dr. Kevin B. O'Malley, Lt. (j.g.) U.S.N.R., of Cynwyd. Dr. O'Malley is on active duty at the Naval Air Station, Norfolk, Va.

MISS AGNES HELENE CONNOLLY, daughter of Dr. and Mrs. John M. Connolly, of Philadelphia, to Capt. William A. O'Connell, U.S.A.C., of Wyomissing Park. Captain O'Connell is a flight surgeon in the U. S. Air Corps.

Marriages

MISS SARAH HOWETT FREEMAN, of Philadelphia, to Richard Leon Kendrick, Jr., M.D., of Elizabeth City, N. C., November 23.

MISS CONSTANCE LOUISE CAPLAN, daughter of Dr. and Mrs. Leon S. Caplan, to Mr. Barrie Alan Marks, all of Philadelphia, October 23.

MISS HELEN JUNE FORESMAN, of Prospect Park, to Mr. Robert Hamilton Goepp, son of Dr. and Mrs. R. Max Goepp, of Philadelphia, November 5.

MISS ELIZABETH DONNELLY, daughter of Dr. and Mrs. John D. Donnelly, of Bala-Cynwyd, to Ensign Elias Venning, Jr., U.S.N., of Charleston, S. C., November 26.

Deaths

○ Indicates membership in county medical society, The Medical Society of the State of Pennsylvania, and the American Medical Association.

○ George J. Schwartz, Philadelphia; Jefferson Medical College of Philadelphia, 1900; aged 72; died Nov. 22, 1949. Dr. Schwartz was chief of the surgical staff at Methodist Hospital for 30 years until his retirement in 1948 and chief of the surgical department at Philadelphia General Hospital from 1905 to 1928. Since 1940 he had served as police surgeon for Upper Darby Township. He served as a major in the Pennsylvania National Guard during the Mexican Border campaign and in the 110th Infantry during World War I. He is survived by five daughters and two sons, George J. Schwartz, M.D., of Wynnewood, and Charles E. Schwartz, M.D., of Philadelphia.

○ Arthur P. Keegan, Philadelphia; Medico-Chirurgical College of Philadelphia, 1913; aged 62; died Nov. 22, 1949. Dr. Keegan was chief surgeon of the Department of Public Safety of Philadelphia and a former city councilman. He also served a ten-year period with the office of Coroner. At one time he was chief surgeon on the staffs of St. Agnes and St. Mary's Hospitals, and he was one of the founders of Doctors Hospital. He had served on the State Society's Committee on Public Health Legislation and on the Commission on Cancer. During World War I, he served as an officer in the U. S. Navy Medical Corps.

○ John J. Corrigan, Hazleton; Jefferson Medical College of Philadelphia, 1896; aged 79; died Nov. 12, 1949. He was the founder of the Corrigan Maternity Hospital in Hazleton, forerunner of the \$2,000,000 St. Joseph Hospital which opened on November 3. In 1946 he was honored by the State Medical Society and the Jefferson Alumni Association for completing 50 years in the profession. Surviving are his widow, four sons, two of whom are practicing physicians in Hazleton and the other two dentists, and five daughters. Also surviving are a brother, Dr. James A. Corrigan, chief of staff at St. Joseph Hospital, and three sisters.

○ U. Grant Gifford, Kennett Square; Jefferson Medical College of Philadelphia, 1888; aged 87; died Nov. 22, 1949, after a short illness. Dr. Gifford was one of the last of the horse and buggy doctors practicing in southern Chester County and had practiced 61 years. He had been a member of the Chester County Hospital staff for 40 years and was chief of staff most of that time. He founded and donated to the hospital a cardiologic laboratory, which he headed until his death. Surviving are his widow and two sisters.

○ William A. Hausman, Jr., Allentown; University of Pennsylvania School of Medicine, 1902; aged 71; died Nov. 25, 1949, following a heart attack. Dr. Hausman was instrumental in the founding of the Sacred Heart Hospital, Allentown, and from its inception in 1915 served as surgeon and since 1918 as dean of the surgical department and chief of staff. In 1924 Muhlenberg College honored him with the degree of Doctor of Science. He was a Fellow of the American College of Surgeons. Surviving are his widow and three daughters.

○ John J. Brennan, Jr., Drexel Hill; University of Pennsylvania School of Medicine, 1929; aged 45; died Nov. 26, 1949, following a heart attack. He was a son of the late Dr. John J. Brennan, of Scranton, former trustee and councilor of the State Medical Society. Dr. Brennan was assistant chief of surgery at Fitzgerald-Mercy Hospital, Darby, since 1932. He was a Fellow of the American College of Surgeons. Surviving are his widow, a daughter, and a brother and sister.

○ Raymond L. Sheets, Beaver Falls; Hahnemann Medical College and Hospital of Philadelphia, 1920; aged 57; died Nov. 7, 1949. Dr. Sheets was fourth in line of five generations of western Pennsylvania physicians. He served on the staffs of Providence Hospital in Beaver Falls and Beaver Valley General Hospital in New Brighton. Surviving are his widow, one daughter, and two sons, one of whom, Dr. Everett O. Sheets, now practices in Beaver Falls.

Albert C. Menger, Philadelphia; Medico-Chirurgical College of Philadelphia, 1894; aged 77; died Nov. 14, 1949. During a 55-year practice as a physician, Dr. Menger had delivered more than 4000 babies. He drove

a horse and buggy in his early days of practice. He wore out half a dozen satchels, a wooden-wheeled bicycle, several horses, and ten automobiles during his long career. He is survived by his widow, four daughters, and a son.

○ **Addison W. Smith**, Fort Madison, Iowa; Jefferson Medical College of Philadelphia, 1891; aged 82; died Nov. 9, 1949. Dr. Smith, an associate member of the Lackawanna County Medical Society, was the first resident surgeon at the Moses Taylor Hospital, Scranton, and performed the first operation in that hospital. He later served at the old Lackawanna Hospital, now the Scranton State Hospital, both as a staff physician and as chief surgeon, for 35 years.

○ **James C. Fleming**, Pittsburgh; University of Pittsburgh School of Medicine, 1910; aged 65; died Nov. 13, 1949, in St. Petersburg, Fla. He was a member of the House of Delegates of the State Medical Society from the Allegheny County Medical Society for many years, and a member of the State Society Committee on Public Health Legislation. Surviving are his widow, one son, James C. Fleming, Jr., M.D., of Pittsburgh, and a daughter.

○ **Oliver W. H. Glover**, Laurelton; Jefferson Medical College of Philadelphia, 1891; aged 81; died Nov. 24, 1949. He had been in failing health for five years. Dr. Glover had practiced for 59 years, retiring in 1944. He was active in church, civic, and fraternal affairs and was a member of the board of directors of Laurelton State Village. His widow and a daughter survive.

○ **James E. Cochran**, Carlisle; Jefferson Medical College of Philadelphia, 1939; aged 35; died Nov. 1, 1949, following a heart attack. He was the son of the late Dr. Thomas P. Cochran, of Pittsburgh. During World War II, he was in military service five years and was discharged from the Army with the rank of captain. Surviving are his widow, one son, and his mother.

○ **Robert S. Marshall**, Pittsburgh; Hahnemann Medical College and Hospital of Philadelphia, 1890; aged 83; died Nov. 3, 1949. He had retired last year after practicing 55 years. He was a former member of the staff and a former president of the medical board of old Homeopathic Hospital (now Shadyside). Watson Marshall, M.D., of Pittsburgh, a brother, is the only survivor.

○ **William Bache, Jr.**, Wellsboro; Jefferson Medical College of Philadelphia, 1927; aged 50; died Oct. 24, 1949, after a short illness. He had been secretary of the medical staff of the Soldiers and Sailors Memorial Hospital, Wellsboro, from the time the hospital opened. He is survived by his parents, his widow, two daughters, a brother, and a sister.

○ **George K. Hays**, Monongahela; University of Pittsburgh School of Medicine, 1903; aged 67; died Nov. 20, 1949. Dr. Hays was on the staff of Monongahela Memorial Hospital. From 1917 to 1919 he served in World War I with the British Expeditionary Forces. He was a member of the Washington County Medical Society until 1947. His widow and one daughter survive him.

○ **Bernard S. Bretherick**, Port Allegany; Hahnemann Medical College and Hospital of Philadelphia, 1931; aged 43; died suddenly Nov. 9, 1949. Dr. Bretherick served in World War II for three years, most of this time in the European theater of the war. He was on the staff of the Port Allegany Community Hospital.

○ **Edward S. Conlyn**, Carlisle; Hahnemann Medical College and Hospital of Philadelphia, 1880; aged 92; died Nov. 1, 1949. Dr. Conlyn was Dickinson College's oldest living alumnus. He practiced medicine until 1927, when he retired. A niece and nephew are the only survivors.

○ **John W. Goodsell**, Sandy Lake; Pulte Medical College, Cincinnati, Ohio, 1898; aged 76; died Nov. 19, 1949. He was a surgeon on the famed Peary polar expedition in 1908-1909 and served later in World War I. His widow, a sister, and a brother survive.

○ **Harry E. Kilgus**, Brockway; Jefferson Medical College of Philadelphia, 1904; aged 70; died Nov. 12, 1949. He gave up the practice of medicine some years ago. In 1945 he was appointed to the Pennsylvania Game Commission. A son survives.

○ **Tello J. d'Apéry**, Philadelphia; Jefferson Medical College of Philadelphia, 1905; aged 72; died Nov. 19, 1949, following a heart attack. Dr. d'Apéry was the son of Olive Harper, novelist, and Telemaque E. d'Apéry, a former ambassador from France to Turkey. Both are deceased.

○ **Harry K. Carey**, Philadelphia; University of Pennsylvania School of Medicine, 1898; aged 73; died Oct. 31, 1949, after a long illness. Dr. Carey was a captain in the Medical Corps during World War I. He is survived by his widow and a daughter.

○ **Ira C. Harris**, Braddock; University of Louisville School of Medicine, Kentucky, 1904; aged 67; died Oct. 26, 1949. Dr. Harris is survived by his widow, a son, and two daughters.

○ **Cunningham P. Clark**, Cool Spring, Del. (formerly of Philadelphia); Jefferson Medical College of Philadelphia, 1895; aged 77; died Nov. 11, 1949.

○ **Frank L. Knox**, Claysville; Eclectic Medical College, Cincinnati, Ohio, 1898; aged 79; died suddenly Oct. 23, 1949.

○ **Arthur D. Cowdrick**, Clearfield; Medico-Chirurgical College of Philadelphia, 1909; aged 62; died Aug. 19, 1949.

○ **Hervey B. Weiss**, Philadelphia; Jefferson Medical College of Philadelphia, 1901; aged 73; died Oct. 17, 1949.

○ **S. Morrison Saltus**, Philadelphia; Temple University School of Medicine, 1925; aged 51; died June 11, 1949.

○ **William D. Baun**, Philadelphia; Jefferson Medical College of Philadelphia, 1915; aged 60; died Oct. 19, 1949.

Miscellaneous

MR. EDWARD E. JAMES, assistant administrator of Pennsylvania Hospital, Philadelphia, has been appointed to the Committee on Personnel Relations of the American Hospital Association.

THE FOLLOWING PITTSBURGH PHYSICIANS were recently elected officers of the Pittsburgh Roentgen Society: president, R. Paul Meader; vice-president, Eva S. Carey; secretary-treasurer, Edwin J. Euphrat.

CLARENCE E. MOORE, M.D., of Harrisburg, has been elected to the rank of certified fellow in the International College of Surgeons. He was inducted at a meeting of the college in Atlantic City on November 11.

OFFICERS OF THE READING EYE, EAR, NOSE AND THROAT SOCIETY for the year 1949 to 1950 are: president, William J. Hertz, M.D., Allentown; first vice-president, John M. Wotring, M.D., Reading; second vice-president and president-elect, Roy Deck, M.D., Lancaster; treasurer, Philip R. Wiest, M.D., Reading; secretary, Paul C. Craig, M.D., Reading; program chairman, C. Fremont Hall, M.D., Phoenixville.

ALMA DEA MORANI, M.D., of Philadelphia, served as program chairman of the second Congress of the Pan American Medical Women's Alliance held in Los An-

geles, Calif., in November. Dr. Morani is on the staff of the Woman's Medical College of Pennsylvania. The Pan American organization was formed in 1947 to promote the interests of women doctors in the Americas. The first congress was held in Mexico City.

AT A REGULAR MONTHLY MEETING OF THE PENNSYLVANIA ACADEMY OF PHYSICAL MEDICINE, October 20, at the Philadelphia County Medical Society Building, Joseph Moldaver, M.D., associate in neurology, Columbia University, New York City, presented a paper on "Recent Advances in Electrodagnosis and Their Clinical Significance." Officers elected for the ensuing year were: president, William H. Schmidt, M.D., Philadelphia; vice-president, Herman L. Rudolph, M.D., Reading; secretary, Herman J. Bearzy, M.D.

JOSEPH C. BOLTON, M.D., of Harrisburg, was awarded the Seibert Memorial Prize at the eighteenth postgraduate assembly of the Harrisburg Academy of Medicine held in November. The award, for outstanding service in the advancement of medicine during the past two years, provides \$500 for postgraduate medical study. Dr. Bolton was commended for his work as secretary and treasurer of the Dauphin County Medical Society from 1944 to 1948, as vice-president of the group during 1949, and as assistant editor of the Dauphin County *Academician*. He will take further study in surgery.

MAX M. STRUMIA, M.D., of Philadelphia, president of American Medical Relief for Italy, was presented with the Second Degree of the Star of Italian Solidarity, November 27, for his assistance in the reconstruction of Italy. The presentation was made by Dr. Silvio E. Daneo, Italian Consul General in Philadelphia, at a dinner attended by more than 600 persons. Dr. Strumia,

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| (5) Obstetrics and Gynecology | March 27-31, 1950 |
| (6) Psychiatry | April 3-7, 1950 |

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who is assistant professor of pathology in the Graduate School of the University of Pennsylvania and director of laboratories at Bryn Mawr Hospital, trained Dr. Francesco Perjretti, sent from Italy to study modern technique of blood and plasma banks, who then returned with medical supplies and materials donated to set up blood banks in Turin, Rome, and Naples.

THE NEXT WRITTEN EXAMINATION AND REVIEW OF CASE HISTORIES (Part I) for all candidates will be held by the American Board of Obstetrics and Gynecology, Inc., in various cities of the United States and Canada on Friday, Feb. 3, 1950. Arrangements will be made so far as is possible for candidates to take the Part I examination (written paper and submission of case records) at places convenient for them. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination to be held May 21 to 28 inclusive, 1950, at The Shelburne, Atlantic City, N. J. Application forms and bulletins will be sent upon request made to Paul Titus, M.D., Secretary-Treasurer, 1015 Highland Bldg., Pittsburgh 6, Pa.

THE PENNSYLVANIA CHAPTER OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS met at Devitt's Camp, Allenwood, October 22. A number of scientific papers were presented, after which the following officers were elected: president, Edward Lebovitz, M.D., Pittsburgh; first vice-president, Archibald Judd, M.D., Hamburg; second vice-president, Victor M. Leffingwell, M.D., Sharon; secretary-treasurer, John V. Foster, M.D., Harrisburg.

Ross K. Childerhose, M.D., chairman of the Committee for Suggested Revision of the Constitution and By-Laws, read the proposed changes in qualification for fellowship, and also proposed that the name be changed from American College of Chest Physicians to American College for Pulmonary Disease.

CHEVALIER JACKSON, M.D., honorary professor of broncho-esophagology at the Temple University Medical School, was given the Medallion of Honor of the Interstate Postgraduate Medical Association of North America at the closing session of the association's four-day meeting held in Convention Hall, Philadelphia, the early part of November. Dr. Jackson, developer of the bronchoscope and originator of the technique for removing foreign particles from the bronchial tubes and lungs, is the fourth individual to be given this high honor of the Postgraduate Association. Others to receive the coveted award were Thomas A. Edison, the inventor; Drs. William and Charles Mayo, famous Rochester, Minn., surgeons; and Dr. George W. Crile, deceased Cleveland surgeon.

PERRIN H. LONG, M.D., Baltimore, Md., will give the annual Nathaniel Bedford Lecture before the Allegheny County Medical Society on Jan. 17, 1950. His subject will be "Recent Advances in Antibiotic Therapy and Their Effect Upon General Practice." Dr. Long is professor of preventive medicine in the Johns Hopkins University School of Medicine and physician to the Johns Hopkins Hospital. During the past fourteen years he has been interested in the sulfonamides and antibiotics, from both the experimental and clinical points of view. He is a veteran of both world wars, and in World War II he served as Consultant in Medicine in the North African and Mediterranean theaters of operation. Currently, he is consultant to the Veterans Administration, the U. S. Public Health Service, and the Surgeon General of the Army.

THOMAS PARRAN, M.D., dean of the University of Pittsburgh's Graduate School of Public Health, was honored on November 1 for his achievements as surgeon general in the United States Public Health Service. In tribute to Dr. Parran, his associates in the U. S. Public Health Service have established, through a \$5,000 grant, a Thomas Parran Scholarship to the Pitt Graduate School of Public Health. The initial announcement and presentation was made by Charles L. Williams, Sr., M.D., assistant surgeon general to Dr. R. H. Fitzgerald, chancellor of the university. Dr. Parran served as surgeon general from 1936 until his retirement in 1948.

In making the presentation General Williams said: "The people of the U. S. Public Health Service wished to present Dr. Parran with some tangible evidence of the love and esteem they hold for him. Believing that a material gift is perishable and soon forgotten, they chose to honor him with this lasting gift, by establishing the Thomas Parran Scholarship fund."

According to the provisions of the grant, the principal of the fund will be administered by the university and from time to time additional contributions will be made. The income from the fund will be used for the payment of tuition for at least one student during each session.

AT THE CLOSING SESSION OF THE THIRTY-FIFTH ANNUAL CLINICAL CONGRESS OF THE AMERICAN COLLEGE OF SURGEONS held in Chicago on October 21, there were 921 initiates received into fellowship. The following 76 Pennsylvania physicians were granted fellowship:

L. Pellman Glover, Altoona; John W. Gordon, Jr., Belle Vernon; Joseph H. Reno, Bethlehem; James A. Dickson, Chambersburg; Leon Friedman, Easton; Peter F. Eastman, Usher H. Meyers, and Russell B. Roth, Erie; Alexander W. Ulin, Glenside; Richard S. Cole, Greensburg; Charles G. Jones, Grove City; Clarence M. Hawke and George E. Martz, Harrisburg;



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THE INTERNATIONAL AND FOURTH AMERICAN CONGRESS ON OBSTETRICS AND GYNECOLOGY will convene May 14-19, 1950, at the Hotel Statler, New York City. The chairman of the general program committee is Howard C. Taylor, Jr., M.D., of New York City. To date the following speakers have been placed on the program:

Professor Heinrich Martius, Department of Obstetrics and Gynecology, University of Goettingen, Germany.

Dr. Leon Gerin-Lajoie, University of Montreal.

Dr. Carlos D. Guerrero, Mexico City.

Dr. Arthur T. Hertig, Harvard Medical College.

Dr. Carl Kaufman, professor of obstetrics and gynecology, Faculty of Medicine, Phillip University, Marburg, Germany.

Dr. Hans Ludvig Kottmeier, Gynecologic Department, Radio-pathology Institute, Stockholm, Sweden.

Dr. Laksmaswami Mudaliar, Madras University, Madras, India.

Dr. Manuel Luis Perez, Buenos Aires.

S. R. M. Reynolds, Ph.D., Department of Embryology, Carnegie Institute, Washington, D. C.

Dr. Walter Seegers, Department of Physiology, Wayne University College of Medicine, Detroit.

Dr. Harold H. Sheehan, professor of pathology, School of Medicine, University of Liverpool, England.

Dr. Jean Snoek, Hospital St. Pierre, University of Brussels.

Dr. Herbert F. Traut, University of California Medical School.

The above speakers are all to appear during the five morning general sessions of the program and the list is but partially completed. The afternoon programs of the medical section of the Congress are being arranged by a subcommittee headed by Dr. Newell Philpott of Montreal. Separate afternoon programs are being arranged for nurses, for public health people, and for hospital administrators. A program of speakers on the economic aspects of obstetrics and gynecology will occupy Wednesday morning. The Wednesday afternoon program will be entirely planned and presented by the National Federation of Obstetric-Gynecologic Societies.

For registration details, housing data, and other aspects of the Congress, address inquiries to Fred L. Adair, M.D., 161 East Erie St., Chicago 11, Ill.

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BOOK REVIEWS

THE PRACTICE OF REFRACTION. By SIR STEWART DUKE-ELDER, K.C.V.O., M.A., D.Sc. (St. And.), Ph.D. (Lond., M.D., F.R.C.S., Hon. D.Sc. (North Western), Surgeon-Oculist to H.M. The King; Knight of Grace of the Order of St. John; Consulting Ophthalmic Surgeon to the Army and the Royal Air Force; Director of Research, Institute of Ophthalmology, University of London; Consulting Ophthalmic Surgeon, Moorfields Westminster and Central Eye Hospital; Ophthalmic Surgeon, St. George's Hospital. 216 illustrations. St. Louis: The C. V. Mosby Company, 1949. Price, \$6.25.

This popular little book, in its fifth edition, is a complete textbook on refraction which also embodies some newer concepts on such subjects as transient changes in refraction and a new approach to the explanation of the cause of myopia. Methods of examination have been amplified with descriptions of streak retinoscopy and velonioskiascopy.

ATLAS OF ROENTGENOGRAPHIC POSITIONS. By VINITA MERRILL while Educational Director of the Picker X-Ray Corporation. In two volumes. St. Louis: The C. V. Mosby Company, 1949. Price, \$30.00.

This two-volume work was brought about through the efforts of the Picker X-ray Corporation to answer the long-felt need for a truly authoritative book on accurate body-part positioning. To fill this lack, Picker engaged Miss Vinita Merrill, a technician of widely recognized skill, to conduct the necessary research. Miss Merrill was able to augment her own knowledge with that of many other authorities in the field. Due credit is given for their contributions. Miss Merrill has also reviewed the literature of the world and incorporated useful facts and methods from this source in her presentation.

As mentioned above, the main theme of this work is accurate positioning. The text of the book does not contain data on exposure, kilovoltage, milliamperes-seconds, or other technical factors. The presentation of the various techniques is preceded by a discussion of the anatomy involved. The actual method of positioning is well illustrated by drawings, photographs, and radiographs. These show how the body part is placed in relation to the film and the central ray, as well as methods of immobilization, uses of cones and positioning boards. Each technique is presented so that the average technician can easily reproduce the desired radiograph.

This volume is a truly definitive work. A host of techniques for each body part are described. Every conceivable method of body-part positioning is described. The book will be of inestimable value to both the radiologist and x-ray technician. It is truly a notable addition to the literature on radiography.

CORONARY ARTERY DISEASE. By ERNST P. BOAS, M.D., Associate Physician, Mount Sinai Hospital, New York City, and NORMAN F. BOAS, M.D. Chicago: The Year Book Publishers, Inc., 1949. Price, \$6.00.

This volume has been written to better acquaint the practicing physician with the ever increasing and important problem of coronary heart disease. The book is broken down into 17 chapters and 88 illustrations. The first four chapters are a general résumé of anatomy, physiology, and pathology of the coronary ar-

teries. Correlation of the above with the clinical findings has been carried out.

Coronary artery disease is divided clinically into the following: sudden death, angina pectoris, coronary insufficiency, cardiac infarction, and myocardial insufficiency. These all represent different phases of the evolution of coronary artery disease.

The chapter on precordial pain not caused by coronary disease seems to the reviewer to be very important in this day of overemphasis of coronary heart disease. This should help to reduce the percentage of false diagnoses in this respect.

Therapeutics is discussed at some length giving the indications and the accepted treatment up to the present.

A well-written volume on a problem of ever increasing proportions should be a helpful review to the cardiologist as well as a valuable adjunct to the busy general practitioner.

LUNG DUST LESIONS VERSUS TUBERCULOSIS. By LEWIS GREGORY COLE, M.D., F.A.C.R. Cloth. 496 pages with 500 illustrations. White Plains, N. Y.: American Medical Films, Inc., 1948. Price, \$10.00.

This book is somewhat difficult to review because of the author's style of writing. It is intimate and argumentative and clearly reports the personality of the writer. The book, however, is easy to read.

The reviewer probably should be a pathologist in order to pass fairly on the merits of the material contained in the book. Although the author is a well-known roentgenologist, his approach to the subject is from the viewpoint of the pathologist and not from that of the clinician or roentgenologist.

According to the author, dusts other than silica or the silicates, such as talc, coal, iron, copper and beryllium, can cause pulmonary lesions indistinguishable one from the other by x-ray, pathologic and conventional light field microscopic examinations. He attempts to differentiate the lesions of silica, silicotuberculosis, and tuberculosis one from the other. His contention is that all lesions are not caused by tissue reactions to silica alone, but also to micro-organisms carried in with dust particles. Distinction is made between collagen and reparative fibrous connective tissue and their effects upon the x-ray appearance of the lungs and other structures of the chest.

He believes that the picture of silicosis cannot be differentiated from that of tuberculosis and other chronic infections of the lungs by ordinary x-ray and pathologic means, but only by the use of cross-polarization, by use of cross Nicols or cross polaroids inserted into the optical system.

The book is profusely illustrated with x-ray pictures and pictures of pathologic material, both gross and microscopic. It is an extremely interesting book and provokes much thought. It is bound to create controversy. It should serve well as a research text, but will prove valuable to industrial physicians and clinicians interested in chest disease. It should help to answer many of the perplexing questions arising in the court of the industrial referee and help to clarify the grading of silicosis from the x-ray standpoint.

Much more work in this field of investigation is necessary before the author's views can be accepted. On the other hand, he offers a new approach to a controversial subject.

TEXTBOOK OF OPHTHALMOLOGY. By SIR W. STEWARD DUKE-ELDER, K.C.V.O., M.A., D.Sc. (St. And.), Ph.D. (Lond.), M.D., Ch.B., F.R.C.S., Hon. D.Sc. (Northwestern), Surgeon Oculist to H.M. the King; Knight of Grace, Order of St. John; Consulting Ophthalmic Surgeon to the British Army and the Royal Air Force; Director of Research, Institute of Ophthalmology, University of London; Fellow, University College, London; Consulting Surgeon, Moorfields Westminster and Central Eye Hospital; Ophthalmic Surgeon, St. George's Hospital, London. Vol. IV, The Neurology of Vision Motor and Optical Anomalies. With 1081 Illustrations, including 71 in color. St. Louis: The C. V. Mosby Company, 1949. Price, \$20.00.

This fourth volume of the author's monumental work on ophthalmology has recently been completed. It continues to maintain the high standards of the previous books. Without a doubt this book should be of interest to the physicians interested in this field.

Much material is to be found in this volume. The contents are presented in three main sections. Part 1 concerns itself with the neurology of vision, namely, the visual pathways, the higher visual mechanisms, and the pupillary pathways and centers. Part 2 covers motor anomalies under the following headings: anomalies of the ocular movements, binocular fixation, concomitant squint, noncomitant squint, ocular deviations, and nystagmus. Part 3 includes optical anomalies of the eyes in relationship to errors of refraction, anomalies of accommodation, aniseikonia, eyestrain and visual hygiene, and visual optical appliances.

The printing and paper are good and one feature of the book is the many illustrations and photographs. References covering the subject matter of each separate subject are found at the end of each portion. The book covers in a rather thorough manner the subject matter and altogether is a well-integrated textbook serving as a companion volume to previous books of the series.

One may look forward to the contemplated volumes now in preparation. This book is recommended.

OPERATIVE TECHNIC IN SPECIALTY SURGERY. Edited by WARREN H. COLE, M.D., F.A.C.S., Professor and Head of the Department of Surgery, University of Illinois College of Medicine; Director of Surgical Service, Illinois Research and Educational Hospitals, Chicago. Introduction by Allen O. Whipple, M.D., F.A.C.S. 725 pages with 394 illustrations. New York: Appleton-Century-Crofts, Inc., 1949.

This book is a companion text of the editor who has secured the contributions of various physicians who are well qualified to present their particular surgical specialties. Each chapter incorporates the new and pertinent material relative to the subject concerned and each is so well done that no one section appears more outstanding than the other. This book may well be recommended to the young surgeon who is in his residency and the busy practitioner.

The book is organized into the following chapter headings: plastic surgery, thoracic wall and diaphragmatic hernia, heart and mediastinum, fractures, hematogenous osteomyelitis, deformities and neoplasms of the bone, surgical approaches to the joints, surgical treatment of spastic paralysis and poliomyelitis, scalp and brain, spinal cord, surgery of the intracranial nerves, peripheral nerves, autonomic nervous system, gynecologic surgery, male genito-urinary system, and an index.

The printing is good and the illustrations are instructive. The literature is covered rather adequately by references at the end of each chapter. Because the newer proven concepts of physiology and proven therapy are included in this book, which make the contents both scientific and practical, this book may be considered as one of the best textbooks of its kind.



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THE EPITOME OF ANDREAS VESALIUS.

Translated from the Latin with preface and introduction by L. R. LIND, Ph.D., University of Kansas, Lawrence, Kan. With anatomical notes by C. W. Asling, M.D., Ph.D., and a foreword by the late Logan Clendening, M.D. Publication No. 21, Historical Library, Yale Medical Library. Pp. 103, with 27 facsimile pages including reproductions of the 13 original illustrations. New York: The Macmillan Company, 1949. Price, \$7.50.

This book is divided into three sections—a brief history of the "Epitome" and life of its author, a translation of the work with the translator's notes, and a facsimile reproduction of the "Epitome" reduced to about half its original linear size.

The book itself is a credit to the editors and publisher. The 10 x 7½ inch size is convenient, the printing and format are both pleasing, while the reproductions of the "Epitome" will enable any student to refer directly to the original text and figures with the certainty of being able to recognize every letter.

Dr. Lind is to be congratulated on his handling of the translation. The text is in clear simple English which conveys to the reader, it would seem, the same ideas that the Latin original conveyed to the student of four hundred years ago. It moves forward freely, unencumbered with glosses or footnotes. Dr. Asling's illuminating anatomical comments and explanations are placed at the end of each chapter where they can be properly assimilated.

A serious widespread interest in the history of medicine is relatively recent on this side of the Atlantic. Scholars in this field, however, have already contributed a significant number of studies, from McMurrich's "Leonardo da Vinci" twenty years ago to the more recent work of Adelman and Hieronymus Fabricius. Vesalius has naturally come in for an outstanding amount of study represented by such works as Cushing's "Bio-bibliography" and the new edition of the "Fabrica" by the New York Academy of Medicine—to mention but two. The present volume is a worthy addition to these scholarly works whose virtue it is that they make available to the student the actual words of the masters and not a second-hand interpretation filtered through the mind of a commentator.

ATLAS OF SURGICAL OPERATIONS. By ELLIOTT C. CUTTLER, M.D., late Mosely Professor of Surgery, Harvard University, and Chief Surgeon, Peter Bent Brigham Hospital, and ROBERT M. ZOLLINGER, M.D., Professor and Chairman of the Department of Surgery, Ohio State University College of Medicine, and Chief of the Surgical Service, University Hospitals. Second edition. New York: The Macmillan Company, 1949. Price, \$9.00.

It is just ten years since the first edition of this unusual book on surgical technique appeared. Designed for the young surgeon, it admirably depicts by means of line drawings the various stages of the more common operative procedures which make up the routine practice of the general surgeon. The drawings are supplemented by brief descriptions of the operations together with suggestions as to the preparation of the patient and his care after operation. The second edition is larger than the first, there being many new drawings as well as the inclusion of thirty additional operative procedures. The only questionable addition is the operation of vagotomy for duodenal ulcer, a procedure which has not yet been adequately evaluated to warrant its inclusion in such a book. One other procedure which is described in both editions and which seems to be out of place is tonsillectomy.

This book is well done and will serve as a handy reference for even the experienced surgeon. It makes an excellent gift for the surgical resident.

BOOKS RECEIVED

The following books have been received for review and are hereby acknowledged. This listing should be considered a sufficient return for the courtesy of the sender. Books appearing to be of unusual interest will be reviewed as space permits. Readers desiring additional information relative to the books listed may write to the Book Review Editor, who will gladly furnish available information.

DISEASES OF THE HEART. By CHARLES K. FRIEDBERG, M.D., Associate Physician, Mount Sinai Hospital, New York; Lecturer in Medicine, Columbia University. Philadelphia: W. B. Saunders Company, 1949. Price, \$11.50.

ACUTE LARYNGOTRACHEOBRONCHITIS. By A. HARRY NEFFSON, M.D. New York: Grune & Stratton, 1949. Price, \$5.00.

AN ATLAS OF THE BLOOD AND BONE MARROW. By R. PHILIP CUSTER, M.D., Director, Laboratories of the Presbyterian Hospital in Philadelphia; Assistant Professor of Pathology, University of Pennsylvania School of Medicine; Consultant to the Armed Forces Institute of Pathology. 285 illustrations, 42 in color. Philadelphia: W. B. Saunders Company, 1949. Price, \$15.00.

NUTRITIONAL DATA (formerly "Nutritional Charts"). Compiled by HAROLD A. WOOSTER, JR., and FRED C. BLANCK, Heinz Nutritional Research Division, Mellon Institute, Pittsburgh, Pa. First edition, 120 pages, plastic-bound. Published and distributed gratis by H. J. Heinz Company, Pittsburgh, Pa., 1949.

CLINICAL AUDIOLOGY. By MAURICE SALTZMAN, M.D., Assistant Professor of Otorhinology, Temple University School of Medicine; Associate Otolaryngologist, Mount Sinai Hospital, Philadelphia; Diplomate, American Board of Otolaryngology. Introduction by George M. Coates, M.D., Chief Editor, *Archives of Otolaryngology*, and Professor of Otolaryngology Emeritus, University of Pennsylvania. Foreword by Matthew S. Ersner, M.D., Professor and Head of the Department of Otorhinology and Rhinoplasty, Temple University School of Medicine. New York: Grune & Stratton, 1949. Price, \$5.00.

NORMAL VALUES IN CLINICAL MEDICINE. By F. WILLIAM SUNDERMAN, M.D., Ph.D., Professor of Experimental Medicine and Clinical Pathology, University of Texas Postgraduate School of Medicine; Chief of Department of Clinical Pathology and Director of Clinical Research, Anderson Hospital for Cancer Research, Houston, Texas; and FREDERICK BOERNER, V.M.D., Late Associate Professor of Clinical Bacteriology, Graduate School of Medicine, University of Pennsylvania, and Assistant Professor of Bacteriology, School of Medicine, University of Pennsylvania; Bacteriologist, Graduate Hospital of Philadelphia; Advanced Bacteriologist, Pennsylvania Department of Health. Illustrated. Philadelphia: W. B. Saunders Company, 1949. Price, \$14.00.

THE CLINICAL EXAMINATION OF THE NERVOUS SYSTEM. By G. H. MONRAD-KROHN, M.D., F.R.C.P., Professor of Medicine in the Royal Frederick University, Oslo; Physician-in-Chief to the University Clinic for Nervous Diseases, Oslo; Consulting Physician to the Epileptic Colony of the Norwegian State; Fellow of the Norwegian Academy of Science in Oslo; Honorary Member of the American Neurological Association, of the New York Neurological Society, of the Newcastle-Upon-Tyne and Northern Counties Medical Society, of the Medical Society of Copenhagen, and of the Neurological Society of Estonia; Corresponding Member of the Swedish Medical Society in Stockholm, and of the Neurological Societies of Paris and Copenhagen. Ninth edition, with 131 illustrations. New York: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1949. Price, \$5.00.

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Ordinarily an operation or an autopsy must be performed strictly within the limits of the authority that has been given. Authority may be given, however, for the operating physician to use his own judgment, and this usually should be demanded by the physician.

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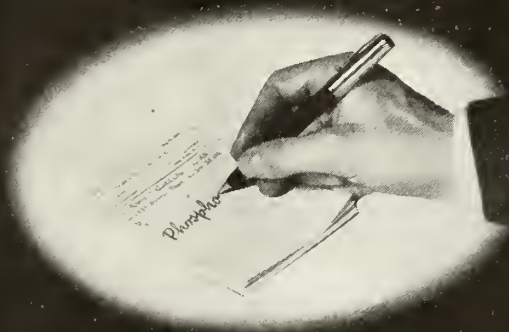
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